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ARTICLES

The Medicalization of Misspelling: *DSM* and the Management of Life

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Some years ago when I was talking with a university president, the conversation turned to students who do poorly in foreign language courses. "We're just going to have to declare it a learning disorder," he said, and not being bashful about the use of power, he meant his words. He seemed to think declaring a disorder was as straightforward as designating a state flower.

In contrast to my interlocutor, the provost, later president, of Boston University (BU), Jon Westling, stated in a speech in 1995, "We need to be cautious in applying the label, 'learning disabled.' Finding a subject difficult is not, in itself, evidence of a disability."[1] A year later BU was sued by a group of learning-disabled (LD) and other students alleging that university policy and practice, including the enforcement of foreign language requirements, violated the Americans with Disabilities Act and the Massachusetts constitution. In 1997 and 1998 Federal District Judge Patti Saris issued the *Guckenberger v. Boston University* decision,[2] which reproached President Westling for his "reliance on discriminatory stereotypes" of LD students, invalidated a number of BU's efforts to tighten up the certification of learning disabilities, but ultimately upheld BU's decision not to allow substitutions for required foreign language coursework—upheld it because it was clearly based on "reasoned deliberation" and a principled vision of the importance of foreign language study to a liberal

[1]Cited in Linda Siegel, "Issues in the Definition and Diagnosis of Learning Disabilities: A Perspective on *Guckenberger v. Boston University*," *Journal of Learning Disabilities* 32, no. 4 (July/August 1999): 305. On the accommodation of learning disabilities, see Gerald Zuriff, "Learning Disabilities in the Academy: A Professor's Guide," *Academic Questions* 10, no. 1 (Winter 1996–97): 53–65.

[2]Guckenberger v. Boston University, 974 F. Supp. 106 (D. Mass. 1997).

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education. While other universities could have held the line on foreign language requirements following *Guckenberger*, doing so would have meant taking a controversial position and digging in as BU did, and few have the will for that. The tide was against BU. Named in the coda to the *Guckenberger* decision are a number of Ivy League schools that had already, by 1998, either abandoned foreign language requirements or allowed substitutions. It's an indicator of which way the current was running that by the time of the decision, the practice of granting accommodations for learning disorders already extended to the bar exam.[3]

Presumably many of the law students seeking accommodation claimed the most common learning disorder, dyslexia. But while "dyslexia" has entered common parlance, we have no term for the disorder responsible for poor essay-writing, even though impaired reading and impaired writing stand side by side as variant forms of Specific Learning Disorder (SLD) in the current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). While certain *Guckenberger* plaintiffs were diagnosed with dyslexia, in principle a suit could just as well have been brought by students seeking accommodation of the sister disorder. After all, for every student who runs into difficulty learning a foreign language there are others who abuse their own in ways that point to SLD with "impairment in written expression." The term "specific learning disorder" features in *Guckenberger*.

Compiled and published by the American Psychiatric Association (APA), the *DSM*, now in its fifth edition, is our official index of mental disorders, its codes recognized by payers, its categories and criteria cited throughout the medical literature, its influence incalculable.[4] Yet for all its sway, the Bible of mental disorders, as it's called, is a sort of self-demystifying document. The current diagnostic system, installed in 1980, was born of dispute, and its serial revisions open it to challenge. While *DSM-V* was in preparation, a former director of the National Institute of Mental Health criticized the diagnostic categories of *DSM-IV*—the same volume cited as authoritative in the *Guckenberger* decision—as a fatally flawed scheme that "creates epistemic blinders that impede progress toward valid diagnoses."[5] Over the decades *DSM* text has been argued into and out of existence, sometimes amid great ridicule and acrimony. So it is that experts have debated a bereavement exception to the criteria for

[3]John Ranseen, "Lawyers with ADHD: The Special Test Accommodation Controversy," *Professional Psychology: Research and Practice* 29, no. 5 (October 1998): 450–59. As it happens, Guckenberger herself was a law student.

[4]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-V*, 5th ed. (Washington, DC: American Psychiatric Association, 2013).

[5]Steven Hyman, "The Diagnosis of Mental Disorders: The Problem of Reification," *Annual Review of Clinical Psychology* 6 (2010): 155.

depression, cited Compulsive Buying Disorder in one edition of the *DSM* only to drop it from the next, allowed television viewers to succumb to Post-Traumatic Stress Disorder (PTSD) from 1994 to 2013,[6] considered but ultimately decided against canonizing Hypersexual Disorder, and recently enshrined the disorder of Binge Eating.

Both *DSM-IV* (1994) and its revision (2000) contain entries for Disorder of Written Expression (DWE).[7] In *DSM-V*, which was introduced in 2013 after considerable drama (its most cutting critic being the editor of *DSM-IV*), writing problems are classified under Specific Learning Disorder. Whereas *DSM-IV* and *DSM-IV-TR* advise against diagnosing DWE on the basis of spelling errors alone, the primary diagnostic criterion for SLD-Written Expression (call it SLD-WE) can be met *either* by "difficulties with written expression" ranging from punctuation mistakes to poor exposition[8] *or* spelling errors, glossed redundantly as "e.g., may add, omit, or substitute vowels or consonants."[9] Much as my conversational partner thought trouble with other languages should be made a disorder by declaration, the *DSM-V* text declares SLD "a neurodevelopmental disorder with a biological origin" even though nothing is actually known about its origin.[10] Thus the APA asserts its jurisdiction over "there" and "their."

But what exactly is the relation between symptom and disorder in a case like this? Diagnosed with SLD-WE, student Jones gets the message that the disorder explains his spelling mistakes and confused exposition, while the fact is, the only evidence for the disorder comes from these problems, these symptoms, themselves. In other words, the disorder represents an official tautology, a cover story invented to frame its own elements. Just as many psychologists have interpreted a candidate's failure on the bar exam, in and of itself, as a symptom of Attention Deficit/Hyperactivity Disorder (ADHD),[11] the diagnosis of SLD-WE represents nothing more than a pseudo-inference.

[6]See, for example, Richard McNally, "Can We Fix PTSD in DSM-V?" *Depression and Anxiety* 26, no. 7 (July 2009): 597–600.

[7]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*, 4th ed. (Washington, DC: American Psychiatric Association, 1994); *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*, rev. 4th ed. (Washington, DC: American Psychiatric Association, 2000). Before that came Developmental Expressive Writing Disorder.

[8]APA, *DSM-V*, 66: "E.g., makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organization; written expression of ideas lacks clarity." Note broken parallelism.

[9]Ibid.

[10]Ibid., 68. The text continues, "The biological origin includes an interaction of genetic, epigenetic, and environmental factors, which affect the brain's ability to perceive or process verbal or nonverbal information efficiently and accurately" (ibid.).

[11]Ranseen, "Lawyers with ADHD," 454.

In the seminal study *Persuasion and Healing*, the case is made that psychotherapy of any school, if it is to benefit the patient, must offer "a rationale, conceptual scheme, or myth that provides a plausible explanation of the patient's symptoms."[12] The diagnosis of Specific Learning Disorder constitutes just this: a construct that sounds like an explanation. If you use commas or nothing at all where periods should be, this is because you have a disorder that generates those very symptoms. As if to complete the process of invention, a second fiction—the biological origin of the disorder, also plausible—is advanced in support of the first.[13] It's the *DSM* diagnostic system itself, its method of assembling symptoms into disorders, that produces this conceptual confusion; and by the same token SLD is but one of many examples of common problems configured into a diagnostic entity that is then spoken of as if it had an independent existence.

Such entities aren't just reified in the abstract but have a way of coming to life Pygmalion-style, thus illustrating the human risks of the *DSM* project of legislating disorders into being.[14] The popularity of ADHD, which went on the books as ADD in 1980 with *DSM-III* and is now diagnosed in 11 percent of American children of school age and almost 20 percent of boys of high school age,[15] dramatizes what it means for a disorder to spring to life and gives some notion of the epidemiological potential of a diagnosis like SLD-WE. (The *Guckenberger* suit was brought by "students with ADHD, ADD, and learning disorders," and the ruling actually contains a "Primer" on the attention disorder[s]. Judge Saris estimated that "three percent of the young adult population demonstrates symptoms of ADD or ADHD.")[16] Given that the rise of special tests to accommodate learning disorders parallels the rise of the ADHD diagnosis and the transmutation of ADHD into adult ADHD,[17] the now-astounding prevalence of ADHD undoubtedly has practical consequences for colleges and universities.

[12]Jerome Frank and Julia Frank, *Persuasion and Healing: A Comparative Study of Psychotherapy* (1961; Baltimore: Johns Hopkins University Press, 1991), 42.

[13]On the supposition of causal mechanisms, see Robert Aronowitz, "When Do Symptoms Become a Disease?" *Annals of Internal Medicine* 134, no. 9 (May 2001): 80: The stigma on nonspecific diagnoses, "combined with many other cultural developments, such as a more widespread consumer ethos [and] lay advocacy for specific diseases…has led to intense pressure to find mechanisms for, redefine, or simply rename nonspecific diagnoses so that they seem more specific and imply putative underlying mechanisms."

[14]On the reification of faulty *DSM* categories including ADHD, see Hyman, "Diagnosis of Mental Disorders."

[15]Alan Schwarz and Sarah Cohen, "A.D.H.D. Seen in 11% of U.S. Children as Diagnoses Rise," *New York Times*, March 31, 2013, http://nyti.ms/YV7Fg4.

[16]The court upheld BU's requirement that only a person with a doctorate can certify "ADD/ADHD."

[17]Ranseen, "Lawyers with ADHD," 452.

The ADHD diagnosis seems to appeal to parents looking for some kind of neurological cause that will both account for a child's problems and, perhaps, exonerate their own inattention to the child's care.[18] It also appeals as a magic word opening the door to special accommodations. In the case of the learning disorders afflicting college students, not only the students themselves but their parents may be invested in diagnostic labels that explain poor performance and secure exemptions from academic requirements.[19] As yet, though, SLD-WE hasn't caught on. Apparently college students whose writing is deficient don't realize they could seek relief from English 101 on the grounds that they suffer from a recognized disorder. Amid the hundreds of diagnoses in *DSM-V*, the clauses governing punctuation and spelling haven't attracted general notice either. Before the APA's adoption of *DSM-V*, while its contents were still under debate, SLD was upstaged by more colorful diagnoses, and even now it seems lost in the immensity of a volume of almost a thousand pages, one whose table of contents alone is more than two dozen pages long. To a hammer everything looks like a nail, and to the *DSM* everything looks like a disorder.

The sheer magnitude of *DSM-V* seems to be one of the most significant things about it. As many have argued, the *DSM* diagnostic system is committed to medicalization—the transformation of normal problems into medical matters—and this is a large ambition, in principle as large as life itself. Fidgeting becomes a symptom of ADHD,[20] emotional vicissitudes a symptom of Bipolar Disorder, imperfections that might blemish a Tolstoyan happy family give evidence of "Parent-Child Relational Problem," sadness is recast as Major Depressive Disorder, shyness as Social Anxiety Disorder. (In turn, the prevalence of depression and social anxiety among the learning-disordered is cited as probable evidence of the impact of LDs[21]—an example of the sort of inflationary argumentation common in the *DSM* era.) So determined and radical is the *DSM* assault on the concept of normality that both the architect of the *DSM* diagnostic system, Robert Spitzer, and his successor Allen Frances have

[18]For a study in which the parents of ADHD children learned to be "more attentive," see Adrian Sandler, Corrine E. Glesne, and Gail Geller, "Children's and Parents' Perspectives on Open-Label Use of Placebos in the Treatment of ADHD," *Child: Care, Health and Development* 34, no. 1 (January 2008): 111–20, esp. 118.

[19]At one point the father of a *Guckenberger* plaintiff "contacted the Provost's office" to voice his displeasure at the denial of a substitution for BU's foreign language requirement. Another plaintiff "first became aware of BU's new accommodations policy when her father read about it in the *New York Times* in February of 1996." Parents figure as offstage presences in the *Guckenberger* ruling. Guckenberger v. Boston University, 974 F. Supp. 106 (D. Mass. 1997), 125, 127.

[20]See *DSM-V*, 60: "often fidgets with or taps hands or feet or squirms in seat."

[21]Siegel, "Issues in Definition and Diagnosis," 311.

themselves become critics of medicalization.[22] Not even they have been able to arrest the annexation of territory by the *DSM*, a process without a stopping-point either in theory or practice. While conceding that none is a mental disorder per se, *DSM-V* has diagnostic categories and codes for "Discord with Neighbor, Lodger, or Landlord," "Low Income," and "Religious or Spiritual Problem." Who would have expected to find any of these headings in a psychiatric taxonomy?

As its scope suggests, *DSM-V* is powered by a utopian vision of bringing human life in its entirety under enlightened management. Look into More's *Utopia* and you find a society without discord, where not only economic but religious problems are already solved. In the *DSM*, which has long since outgrown the dimensions of a manual, the drive for totality takes the form of a diagnostic system wherein "virtually any human difference" can be interpreted as a mark of pathology.[23] (How such an intolerance of variation can coexist with our culture's official affirmation of diversity is hard to fathom.) In More's fantasy the drive for totality gives rise to a commonwealth where everyone undergoes the same conditioning and, as a result, all are so alike that no one except the founder, King Utopus, is given a name by More. In Utopia the few actual laws are "supplemented by an oppressive number of codes, customs and conventions,"[24] which do the real work; the *DSM* consists of an inordinate number of categories and clauses that, in combination, deeply influence the way we think, speak, and ail. A utopia like More's is in many ways a chilling vision, and chilling, too, is the prospect of life under the reign of a psychiatric code nearly a thousand pages long and evidently still growing: a code in which not liking to fill out forms is an official symptom of adult ADHD[25] and the use of commas is a medical matter.

A risk of the micromanagement of behavior in the name of therapeutic benevolence is that making human life into a medical problem will erode, not enhance, well-being. A century and a half ago John Stuart Mill decried the subtle

[22]See Spitzer's foreword to Allan V. Horwitz and Jerome C. Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (Oxford and New York: Oxford University Press, 2007). Spitzer and co-authors deplore the "medicalisation of normal human emotions" in Gerald Rosen, Robert Spitzer, and Paul McHugh, "Problems with the Post-Traumatic Stress Disorder Diagnosis and Its Future in *DSM-V*," *British Journal of Psychiatry* 192, no. 1 (January 2008): 4. See also Allen Frances, *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis,* DSM-5*, Big Pharma, and the Medicalization of Ordinary Life* (New York: William Morrow, 2013).

[23]Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (Baltimore: Johns Hopkins University Press, 2007), 148.

[24]Thomas More, *Utopia*, ed. George Logan and Robert M. Adams, tr. Robert M. Adams (Cambridge: Cambridge University Press, 1989), 37n86.

[25]See *DSM-V*, 59: "Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers)."

dictatorship of public opinion, "a social tyranny more formidable than many kinds of political oppression, since, though not usually upheld by such extreme penalties, it leaves fewer means of escape, penetrating much more deeply into the details of life, and enslaving the soul itself."[26] If you're really looking for a code that captures life's fine points, try the symptom lists in the *DSM*, from ADHD to Female Sexual Interest/Arousal Disorder. The cognizance of the *DSM*, knowing no limits, extends to the last details of private life, beyond anything Mill imagined possible. And it's the limitlessness of the *DSM* that stamps it as a utopian—which is not to say harmless—project.

DSM and the Propagation of Illness

That project began with the historic third edition of the *DSM* in 1980, which contained 265 diagnoses, about a third more than its predecessor. A well-researched article on the creation of the new diagnostic system in the 1970s finds that it represents a "collective fantasy" and was inspired by a "utopian vision."[27] Ironically enough, the goal uniting the framers was to rid psychiatry of speculation—Freudian speculation in particular—and place it on a solidly empirical foundation. Precisely in defining mental disorders by their symptoms while abstaining from theorizing about their cause, *DSM-III* marked a revolution in psychiatry. The immediate losers were those of the Freudian school, who thought little of the niceties of diagnosis, whose practices were not data-driven, and whose inferences regarding the causes of presented symptoms were idiosyncratic and unverifiable. Both Spitzer and Frances trained as psychoanalysts, only to abandon the Freudian tradition in favor of more useful and less dogmatic forms of inquiry.

The framers of *DSM-III* hoped that its symptom-based taxonomy would bring different observers to reliably similar diagnostic conclusions, as psychosocial theories conspicuously failed to do. It may seem odd that a diagnostic system designed for reliability (that is, standardization of findings) has become a vehicle of utopianism. However, as long as various observers tabulate the same symptoms—whether the symptoms be low mood, dread of public speaking, or misplaced commas—the *DSM* is satisfied; and time has already shown that the list of problems that can be recast as symptoms has no bounds. In addition, once Freud was deposed a major obstacle to utopianism was out of the way.

[26]John Stuart Mill, *On Liberty*, ed. David Spitz (1859; New York: W.W. Norton & Company, 1975), 6.

[27]Alix Spiegel, "The Dictionary of Disorder," Annals of Medicine, *New Yorker*, January 3, 2005, http://www.newyorker.com/magazine/2005/01/03/the-dictionary-of-disorder.

Conveying a felt sense of the intractability of human nature, Freud's thought clashes fundamentally with the managerial ethos informing the *DSM* project.

Wrote Freud in *Civilization and Its Discontents*: "We may expect to carry through such alterations in our civilization as will better satisfy our needs….But perhaps we may also familiarize ourselves with the idea that there are difficulties attaching to the nature of civilization which will not yield to any attempt at reform."[28] The world is unreformable because we ourselves are. Lionel Trilling once said of *Civilization and Its Discontents*, a work he prized, that it "may be thought to stand like a lion in the path of all hopes of achieving happiness through the radical revision of social life."[29] A comprehensive survey of utopianism in the West concludes, "In many ways Freud's was the most trenchant and devastating attack on utopian illusions—what he called the lullabies of heaven—that had ever been delivered."[30] Whatever the actual scientific merit of Freud's theories and pronouncements, the undoing of his authority and the end of psychoanalytic dominance meant that utopianism would meet less resistance. The challenge to Freud in the name of a scientific psychiatry that existed more in aspiration than in reality may have been powered to begin with by a utopian spirit that carried over from the 1960s.

As Stephen Toulmin observes, "In Europe and North America, notably in countries with a Puritan culture, individual human beings were expected to execute their life projects without letting themselves be 'carried away' by their feelings or turning for help to priests or doctors or anyone else….For the generation of the 1960s, that undervaluation of the emotions was at an end."[31] The same upheaval fueled the transformation of the *DSM* from an obscure to an illustrious document. In the *DSM* era, the very courts turn to psychiatry for help, as in the *Guckenberger* decision with its citations of the *DSM* itself. Judge Saris commiserated with the plaintiffs, describing them as "confused and upset," "devastated," "frantic," as if their emotionalism gave weight to their arguments.[32]

It was on the rubble of traditional norms of self-restraint that the *DSM* diagnostic system, invoked in *Guckenberger*, was built. And with codes of

[28] *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, ed. and trans. James Strachey, vol. 21, *Future of an Illusion, Civilization and Its Discontents, and Other Works (1927–1931)* (London: Hogarth Press, 1961), 115.

[29] Lionel Trilling, *Sincerity and Authenticity* (Cambridge, MA: Harvard University Press, 1972), 151.

[30] Frank Manuel and Fritzie Manuel, *Utopian Thought in the Western World* (Cambridge, MA: Harvard University Press, 1979), 788.

[31] Stephen Toulmin, *Cosmopolis: The Hidden Agenda of Modernity* (Chicago: University of Chicago Press, 1990), 163.

[32] Guckenberger herself was awarded $5000 for emotional distress; another plaintiff was awarded $10,000.

restraint crumbling, maybe it was only to be expected that more and more disorders would come into existence under successive iterations of the *DSM* system. But disorders haven't just multiplied on paper; they have been promulgated in the marketplace, entered into our common lexicon—think of PTSD and ADHD, both children of *DSM-III*—and been taken up in the minds and bodies of millions. This inflationary process is so entrenched that in 1998, the year of the coda of the *Guckenberger* ruling, it could be confidently predicted that "there will be a significant increase" in the number of students claiming ADHD and demanding accommodations accordingly.[33] No doubt this bold prophecy has been realized.

It's unclear, to say the least, how the process of propagating illness enhances human welfare. For all the idealism that has gone into serial revisions of the *DSM*, it would be hard to argue that the medicalization of human life as a whole has made us happier and healthier. Even if treatments are available, the anticipated benefits may or may not materialize; thus, a comparison of large surveys conducted in Britain in 1993 and 2000 showed that "widespread increased prescribing of psychotropic medication"—led by antidepressants—"has not improved the mental health of the nation."[34]

What if faulty writing were widely recognized as a disorder and affected students were exempted from English 101 just as students with a foreign language disability were already excused from coursework at our most prestigious universities, our trendsetters, at the time of *Guckenberger*? How coding faulty writing as a medical problem will help cure it remains obscure. Yet the diagnosis of some kind of deep-seated cognitive disorder on the basis of a student's writing could be counter-therapeutic in itself. As a result of what's known as "diagnosis threat," people whose attention is called to cognitive deficits supposedly, but not actually, associated with mild head injury perform worse on various tests than people with the same history not cued to do poorly.[35] Similarly, someone diagnosed with SLD-WE because he meets its trivial diagnostic criteria could build up an expectation of failure that proves self-realizing, if only because someone convinced of failure is less likely to invest in a practice in the first place. Expectation appears to be a key mechanism

[33]Ranseen, "Lawyers with ADHD," 457.

[34]Traolach S. Brugha et al., "Trends in Service Use and Treatment for Mental Disorders in Adults throughout Great Britain," *British Journal of Psychiatry* 185 (2004): 383, http://bjp.rcpsych.org/content/bjprcpsych/185/5/378.full.pdf.

[35]Julie Suhr and John Gunstad, "'Diagnosis Threat': The Effect of Negative Expectations on Cognitive Performance in Head Injury," *Journal of Clinical and Experimental Neuropsychology* 24, no. 4 (June 2002): 448–57.

of the placebo effect.[36] Despite the comparative neglect of the power of the nocebo in the medical literature, we have every reason to believe that negative expectations also mediate outcomes.[37]

In that the diagnostic category, Specific Learning Disorder, offers what sounds like a convincing explanation of the symptoms in question (despite being only a name given to them), the label sends the message that misused commas and faulty exposition are more than just problems of commas and exposition. In fact, according to *DSM-V*, they are ultimately matters of biology; and as we know, biology is destiny. Much as the neurotransmitter theory of depression absolves the patient by making the disorder a "fault of chemistry,"[38] the unspecified biological origin of SLD seems intended to lift the burden of failure from the diagnosed person. The rub is that disorders attributed to a cause can become more credible, vivid, and real for the affected person precisely for that reason, even if the cause is theorized or fictitious. The medically suspect Chronic Fatigue Syndrome became a sort of epidemic when the idea caught on that it was produced by "an unknown, disease-causing agent."[39] Similarly, in a mass psychogenic incident, illness with no detectable origin breaks out among "a group of people with shared beliefs about the cause of the symptoms"—a mysterious gas, for example.[40] If people with experience of mild head injury show cognitive deficits upon prompting, it's because they believe the injury causes such deficits. Even a spurious cause can be potent, it seems. Causes verify disorders and their constituent symptoms not only to courts and insurers but our own imaginations. Along with the mass marketing of antidepressants went the popularization of the idea that depression is caused by a chemical imbalance or neurotransmitter deficiency, despite the dubious evidence in favor of this believable theory.[41] The notion of cause speaks strongly to us, appealing to ancient habits of attribution (there are pages of discussion of causes in Burton's *Anatomy of Melancholy*) as well as reverence for modern discoveries,

[36]Fabrizio Benedetti, *Placebo Effects: Understanding the Mechanisms in Health and Disease* (Oxford: Oxford University Press, 2009).

[37]See my study of the power of the nocebo, *The Nocebo Effect: Overdiagnosis and Its Costs* (New York: Palgrave Macmillan, 2015).

[38]See the billboard pictured on the jacket of Horwitz and Wakefield, *Loss of Sadness*.

[39]Elaine Showalter, *Hystories: Hysterical Epidemics and Modern Media* (New York: Columbia University Press, 1997), 127.

[40]Timothy F. Jones et al., "Mass Psychogenic Illness Attributed to Toxic Exposure at a High School," *New England Journal of Medicine* 342, no. 2 (2000): 99.

[41]See Joanna Moncrieff, *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* (New York: Palgrave Macmillan, 2009) and Irving Kirsch, *The Emperor's New Drugs: Exploding the Antidepressant Myth* (New York: Basic Books, 2010).

such as the world-transforming discovery that specific bacilli are responsible for specific diseases.

DSM-III broke with the Freudian style of theory and speculation by abstaining from guesswork about the underlying causes of disorders and confining diagnostic attention to presented symptoms. With Freudianism in retreat and a new way of doing psychiatric business firmly in charge, the makers of the *DSM* are free to install their own speculations about cause, speculations more congenial to biological psychiatry, such as the imputed origin of English 101 problems. But with theorizing about cause go troubling implications.

In the 1990s, around the time of *Guckenberger*, American medicine saw a surge of patients who insisted they were ill with strangely popular maladies such as repetitive stress, chronic Lyme's disease, and fibromyalgia as well as chronic fatigue—conditions whose troubling symptoms couldn't be traced to any identifiable abnormality. "The hyperbole, litigation, compensation, and self-interested advocacy surrounding [such disorders, known as functional somatic syndromes] can exacerbate and perpetuate symptoms, heighten fears and concerns, prolong disability, and reinforce the sick role."[42] An analogy with learning disorders suggests itself. And in both cases the affected persons have strong ideas about the cause of their problems. Like the *Guckenberger* plaintiffs, patients with the mystery disorders of the 1990s often displayed "a strong sense of assertiveness and embattled advocacy with respect to their etiological suppositions."[43] The theory of causation that bound them to the sick role also inspired them with a kind of moral energy. Presumed causes can be oddly powerful.

One factor among several that marked PTSD as a potential hot spot in the *DSM* system is that, contrary to the *DSM-III* policy of abstaining from causal attributions, it too played on etiological suppositions. As Spitzer and co-authors concerned with abuse of the PTSD diagnosis noted long after the publication of *DSM-III*, "Unlike other disorders in the DSM that were agnostic to aetiology, PTSD was defined as a disorder that arose after a specific set of traumatic stressors."[44] Because of the all-too-human practice of connecting symptoms and causes, people diagnosed or self-diagnosed with PTSD may identify normal responses *as* symptoms and trace their distress to events that didn't produce it or didn't take place as remembered. Such is the mystique of cause. The same mystique makes an entity called Specific Learning Disorder responsible for faulty writing and attributes SLD itself to biological factors. By framing

[42]Arthur Barsky and Jonathan Borus, "Functional Somatic Syndromes," *Annals of Internal Medicine* 130, no. 11 (June 1999): 916.

[43]Ibid., 910.

[44]Rosen, Spitzer, and McHugh, "Problems with Post-Traumatic Stress Diagnosis," 3.

commonplace "difficulties with written expression" as a disorder and grounding the disorder in biology, *DSM-V* plays to our leaning in favor of causal explanations even though nothing, in truth, is known about the biology of poor writing and nothing in the cabinet of biological psychiatry will improve the organization of paragraphs or the exposition of ideas.[45] But when student Jones learns that something or other having to do with his wiring is responsible for the state of his papers, he is truly primed for failure.

While the interpretation of faulty writing as evidence of a disorder and the invention of a cause for the disorder are humanely motivated, one has to ask what good would come of the medicalization of English 101. The diagnosed student might be spared a frustrating course, but if so, he would also be spared the best and only means of improving a deficient skill, which is to work at it. Students exempted from ordinary coursework on the basis of SLD-WE might be likened to patients who "withdraw from normal activity" after suffering what they think is whiplash (another of the mystery syndromes of the 1990s), only to see their symptoms worsen as a result of their own immobility.[46] In all, certification of poor writing as evidence of a disorder seems like dismal preparation for either further study or entry into an information economy. Law students may demand and receive accommodation on the bar exam, but it strains belief that anyone could actually practice law without being able to put together a paragraph.

Not only is the exercise of a skill the only way to improve it, but the same principles on which good exposition depends offer a defense against the wholesale redefinition of common problems as clinical disorders. Good exposition rules out the incantation of resonant but hollow terms like "chemical imbalance" and "biological origin," the ritual use of clinical brand names like "bipolar,"[47] and the deployment of empty constructs like a disorder that somehow accounts for the symptoms it consists of. Not the least measure of the influence of the *DSM* is its penetration of language itself. By the same token, though, to learn the use of language in clear and thoughtful ways is to acquire perhaps the one thing needful to counter the aggressive expansion of psychiatric territory.

[45]On over-investment in the notion that "learning disability is an immutable, brain-based disorder," see Ruth Shalit, "Defining Disability Down," *New Republic*, August 25, 1997, 16–22, esp. 21; available at http://media.hoover.org/sites/default/files/documents/0817928723_239.pdf.

[46]Robert Ferrari, "The Biopsychosocial Model—a Tool for Rheumatologists," *Best Practice & Research Clinical Rheumatology* 14, no. 4 (December 2000): 792. On this showing, the "common symptom pool" (789) from which the symptoms of chronic whiplash are drawn is equivalent to the common English 101 errors that substantiate the also questionable diagnosis of SLD.

[47]See Joanna Moncrieff, "The Medicalisation of 'Ups and Downs': The Marketing of the New Bipolar Disorder," *Transcultural Psychiatry* 51, no. 4 (August 2014): 581–98.