In order to define the abnormal, we must first determine that which constitutes ‘normal’.

This adage, in all its various iterations, is arguably the seminal ethos underpinning approaches to diagnostic practice in modern medicine. The very word ‘diagnosis’ has roots in Ancient Greek and means ‘to discern’ or ‘to know (apart from another)’. An elderly woman trips on a patch of uneven concrete and a jagged line on a black and white film confirms that she has broken her hip. A middle-aged man undergoes a routine blood test and is told that he is diabetic, despite not experiencing any symptoms at all.

We’ve come a long way since the Four Humours. We’ve learned so much, in fact, that we’ve chosen (perhaps wisely) to leave much of the diagnostic process to the machines that provide us with objective data, against which we can then also measure the perhaps equally elusive concepts of ‘progress’ and ‘cure’.

And therein lies the challenge. For, unlike other medical subspecialties in which pathology is grounded in a set of biological and serological markers, psychiatry seeks to define its diseases behaviourally and measures their severity against the yardstick of acceptable human nature.

It is unsurprising that the scope of diagnosable disorders has broadened to accommodate the novel things we have learned about the human condition. Between 2014 and 2017, the number of Australians with a mental or behavioural condition increased by 2.6%. The number with anxiety-related conditions increased similarly by 1.9% (ABS 2018). One in eight Australians takes antidepressant medication (ABS 2016).

This has prompted concerns of an epidemic of over-diagnosis (Bolton 2013, Doust & Glasziou 2013). As Dr Allen Frances (2010) remarks, ‘there is no particular reason to believe that life is any harder now than it always has been’; from this perspective, the rising incidence of mental illness is due, at least in part, to the pathologisation of normal behaviour by ‘fads’ within psychiatric practice (Paris 2013).

The clinician’s contribution to this phenomenon has been widely recognised since the release of the DSM-III in 1980 (Bolton 2013, Zimmerman 2016). What I hope to discuss today, however, is a more recent shift in the paradigm – the fads of society, rather than psychiatry. And it begins, as always, with the definition of mental ‘health’ before mental ‘illness’.

From wellness to greatness

According to the World Health Organisation (WHO, 2004), mental health is

‘... a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’.

This definition draws upon hedonic and eudaimonic traditions (Galderisi et al. 2015) in emphasising both the experience of happiness, as well as that of living a satisfying life. Of interest, the concepts behind it are also relatively modest; agency, resilience, aptitude.

If the booming self-help industry is anything to go by, however, the aspirations of our modern populace appear to be anything but conservative. A quick browse through the New York Times’ current ‘Advice, How-To & Miscellaneous’ Bestseller list reveals titles such as ‘Atomic Habits’, ‘You were born for this’, ‘You are a Badass (How to Stop Doubting Your Greatness and Live an Awesome Life)’ and, somewhat worryingly, ‘The 7-day Apple Cider Vinegar Cleanse’ (The New York Times, 2020).
There is nothing inherently problematic about engaging in self-help. A spot of wisdom can prove to be infinitely soothing in the simmering uncertainty of our collective economic, social, and political climates (Walker 2019). However, our reading habits betray the fact that we are no longer content with being just ‘normal’. The word ‘average’ is a stinging rebuke.

To diagnose is, therefore, not merely to pave a path towards ‘health’ (Elliott 2003). It is to provide a solution to an exasperating problem; namely, the question of lifting oneself from ‘well’ to ‘great’.

**Hammers and nails**

Self-improvement cannot occur without the recognition of some existing fault. A by-product of living in a culture that constantly spurs us to be ‘Better than Before’ (Rubin 2015) is that we begin to read more deeply into otherwise transient emotions; experiences of sadness or loneliness are commonly rejected for being ‘negative’ when they are also immutable characteristics of the human condition (Paris, 2015). The constant pressure to exude positivity creates unnecessary dichotomies by attaching value judgments to commonplace, everyday occurrences in a way that paradoxically reduces the potential for further personal growth (Parrott 2014).

The pathologisation of normal behaviour is also evident in the spiking diagnoses of several disorders, such as attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and autism, which were previously thought to occur rather infrequently (Paris, 2015). Children are increasingly likely to be diagnosed with ADHD for exhibiting ‘aberrant’ behaviour and are often medicated despite not fulfilling the DSM criteria (Angold et. al. 2000). Approximately 1.1 million children in the United States were misdiagnosed with ADHD and, of this, over 800,000 were incorrectly medicated for a relative (rather than absolute) immaturity (Evans et al. 2010). Indeed, a large body of research has shown that the younger members of a grade cohort at school are between 30-60% more likely to be diagnosed with ADHD compared to their slightly older peers (Elder 2010, Morrow 2012, Merten et al. 2017). As such, a diagnosis has not been made to correct any real disorder of behaviour; it has been made to provide an explanation for some perceived underperformance. The pressure to score well against increasingly unattainable academic outcomes is also partly responsible for the medicalization of childhood behaviours that are deemed to impede book learning (Timimi & Taylor 2004).

More so than ever, psychiatry is being relied upon to provide solutions for faults that we see within ourselves, regardless of whether these imperfections cause distress or impairment. And quite apparently, this is a process to which children are not immune.

**Conclusions: where to from here?**

For many years, psychiatry struggled to find its place between the social and biological sciences. This crisis translates remarkably into diagnostic dilemma. Our lives would be made easier if human nature was both consistent and predictable. However, we are social beings above all else and, 200,000 years later, still subject to the transformative forces of ongoing cultural evolutions. Our burgeoning ambitions have pushed ‘mental health’ past the goalpost of mere ‘wellness’, aided in part by a self-help industry that is all too happy to oblige. These changes may be clear to see; the way forward, however, is anything but. Perhaps, as with all areas of medicine, we must first learn to manage the expectations of our patients – both of themselves, and us.

And perhaps, rather than scrutinising what we know of mental health, we should be constantly re-evaluating what our patients see as ‘normal’ (or, importantly, whether normality is even their end goal). Only then can we keep this elusive yardstick firmly within our grasp.