understanding the process of othering further. In projective identification, things that are disavowed are not just projected on to others, but those others are then perceived as possessing those qualities that we have projected on to them. We thus do not just project *on* to others, we project *in* to them, and we identify with those projected parts of ourselves *in* others and experience those others as a threat. Thus, we come to fear those in to whom we have projected the "bad" parts of ourselves. The "others" come to represent that which we fear in ourselves. Furthermore, we may then try to manage this by attempting to control that which we have projected, by controlling those "others" and so keeping that which is "bad" separate to the "good" self. At a social level, who we project these unwanted "bad" parts of ourselves in to, and what these unwanted bad parts may be, depend on the ideologies and moral values that are dominant in the particular society or group.

Nussbaum (2004) argues that what is often projected is that which is experienced as disgusting or shameful. She draws on psychoanalytic theory to argue that primitive shame and disgust over one's bodily functions, bodily liquids and excretions, and our vulnerability and dependency are projected onto stigmatized groups who are then represented as the disgusting and the shameful. For example, she outlines how, particularly for heterosexual males, this is most fraught when it comes to same-sex relationships, where disgust and revulsion are often the reaction towards homosexuality and homosexual sex. Disgust is also often intertwined with racism. From a psychoanalytic perspective, white racists may project their own "animality" (Kovel, 1995, p. 217) and instinctual sexual desires onto African men and women who are then perceived as "other," as "animal-like," as "savage," and as having a wild and unrestrained sexuality (Fanon, 1967). Similarly, Marks (1999) draws on psychoanalytic theory to argue that able-bodied people may project our experiences of dependency, damage, and vulnerability on to people with disabilities, who are then perceived as damaged, even dangerous.

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Online Resources

The Centre for Studies in Otherness. http://www.otherness.dk/about/

Overdiagnosis

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Introduction

The overdiagnosis of mental disorder has been the subject of much scholarly examination and public debate over the past several decades. Since the introduction of fluoxetine in 1987, the "Decade of the Brain" (1990–1999), and the introduction of blockbuster atypical antipsychotics and "mood stabilizers" by the

pharmaceutical industry (1990s–present), the estimated prevalence of many mental disorders has skyrocketed. This led psychiatrist Allen Frances, chair of the DSM-IV Task Force, to summarize the issue of overdiagnosis by writing, "The NIMH estimates that, in any given year, twenty-five percent of the population (that's almost sixty million people) has a diagnosable mental disorder. A prospective study found that, by age thirty two, fifty percent of the general population had qualified for an anxiety disorder, forty percent for a depression, and thirty percent for alcohol abuse or dependence....In this brave new world of psychiatric overdiagnosis, will anyone get through life without a mental disorder?" (Frances, 2010).

Definition

Overdiagnosis has been identified as a problem in general medicine. The narrow definition of overdiagnosis within medicine is the diagnosis (and usually, treatment) of an asymptomatic disease which will not cause early mortality (Moynihan, Doust, & Henry, 2012). Concerns have been raised that the reflexive diagnosis and treatment of such patients may actually cause reduced quality of life (Healy, 2012). In broader terms, which is more relevant to psychiatric diagnosis (see below), overdiagnosis is defined as "...the related problems of overmedicalisation and subsequent overtreatment, diagnosis creep, shifting thresholds, and disease mongering, all processes helping to reclassify healthy people with mild problems or at low risk as sick" (Moynihan et al., 2012).

Overdiagnosis in general medicine is often generated through overuse of biological testing for disease (e.g., PSA testing for prostate cancer, blood tests for high cholesterol, or flowmeter tests for asthma). In contrast, there are no valid biological tests for mental disorders. Such diagnoses are made based on the clinical judgment of mental health providers, by performing clinical interviews while referring to the Diagnostic and Statistical Manual of Mental Disorders (DSM). There is no compelling research demonstrating that clinicians reliably diagnose mental disorders in routine practice (Kutchins & Kirk, 1997). It has been argued that this subjective process of diagnosis is shaped by bias, in terms of both the psychiatric definitions of mental disorder used and their clinical implementation. Many types of potential bias have been identified, ranging from sexism to pharmaceutical company influence (Caplan & Cosgrove, 2004) to pseudoscientific bioreductionism (Lacasse & Leo, 2006). Clearly, the most overarching type of bias in Western societies is the increasing trend towards labeling and classification of disturbed and disturbing behaviors as mental disorders (Kutchins & Kirk, 1997). In the absence of objective, reliable, and valid tests for mental disorder, this can lead to overdiagnosis.

Keywords

Overdiagnosis; medicalization; deviance; pharmaceutical; psychiatric diagnosis; psychiatric medication; pediatric bipolar; attention-deficit hyperactivity disorder; antipsychotic

Scholarly Debates Regarding Overdiagnosis

While it is argued that many different mental disorders are overdiagnosed, given the lack of objective tests, there is often no rigorous way to settle the issue. A consistent theme is found in the literature and public debate: One camp argues that a normative human experience or behavior is being medicalized and labeled as mental disorder, resulting in higher rates of diagnosis and potential harm from overtreatment; the other camp argues that vigilant screening and destigmatization efforts have been successful at identifying and treating a previously underrecognized mental disorder, leading to better outcomes for those so diagnosed. Debates regarding overdiagnosis thus usually revolve around dramatic increases in the estimate prevalence of mental disorders. Frances (2010) argues that pediatric bipolar disorder, attention-deficit

hyperactivity disorder (ADHD), and autism are now overdiagnosed at epidemic levels.

Psychiatrist David Healy notes that the estimated prevalence of classic manic depression was ten patients per million people but that DSM-defined bipolar disorder now "...supposedly affects up to 50,000 per million" (Healy, 2012, p. 37). He argues that pharmaceutical companies have effectively "captured" evidence-based treatment guidelines in order to sell "mood-stabilizing" drugs, which has an impact on diagnostic practice. Many mental health clients now diagnosed as bipolar would have received a less severe diagnosis (e.g., unipolar depression) in a different context, raising the question of overdiagnosis and overtreatment. The most dramatic rise in bipolar diagnosis, though, is among children. Application of the pediatric bipolar label to disruptive and disturbing children increased 4,000 % from 1994 to 2003 (Moreno et al., 2007). Such an astonishing increase in such a short period of time clearly raises the question of overdiagnosis. This is of great importance because children labeled as bipolar are often prescribed antipsychotic medication with known iatrogenic effects. In the cases of both child and adult bipolar disorder, the influence of the pharmaceutical industry is a key factor: The popularity of these diagnoses coincides with aggressive efforts by drug companies to market on-patent drugs prescribed for these disorders.

However, putting pharmaceutical industry marketing aside, overdiagnosis can result from other factors. The empirical limitations of the DSM can lead to overdiagnosis. For example, over time, the DSM-defined diagnostic criteria for ADHD have become less restrictive, making it more likely that a child would qualify for a diagnosis of ADHD. Using the DSM-IV ADHD criteria, Kirk (2004) examined the false-negative (underdiagnosis) and false-positive (overdiagnosis) rates for a theoretical sample of 1,000 children with a 5 % prevalence of ADHD. Assuming a sensitivity of 91 % and a specificity of 61 % (derived from field trial data), in this sample of 1,000 children, 371 children would be receive false-positive labels for ADHD, while only five children were false-negative (underdiagnosis) cases. The overdiagnosis rate for ADHD was thus 37 % in this study, illustrating the point that the DSM criteria are biased towards overdiagnosis of ADHD. It is unknown whether clinicians are aware of this diagnostic inaccuracy embedded within the ADHD definition or whether parents are informed of this when their children are assessed.

The DSM-5 was released in May of 2013, and Frances (2010) has cautioned that several categories may lead to overdiagnosis: Binge eating, hypersexuality, minor neurocognitive disorder, and mixed anxiety/depression are all arguably "normal" experiences which may be medicalized by their inclusion in the DSM-5. Similarly, the bereavement exclusion will be removed from DSM-5. This means that in contrast to the DSM-IV, recently bereaved clients will be eligible for a diagnosis of Major Depression if they have clinical symptoms more than 2 weeks after the death of a loved one. Thus, it is likely that the overdiagnosis of mental disorder will increase in the DSM-5 era.

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