Projected Disorders: How Psychiatry Diagnoses Its Own Anxieties

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Psychiatry presents itself as the scientific interpreter of mental suffering. Through manuals like the *DSM-5-TR*, it categorizes thoughts, behaviors, and identities into disorders, shaping how society responds to everything from grief and belief to gender and sexuality. But what if many of these diagnoses don't merely reflect the patient's condition—but the profession's own unresolved fears? This paper argues that psychiatry has, at key points in its history, projected its institutional anxieties onto the very people it aims to treat. Homosexuality was pathologized not solely due to public prejudice, but because psychiatry itself feared what it could not reconcile with its normative frameworks. Religious experiences that lie outside conventional forms are labeled delusional not necessarily because they are unreal, but because they defy the profession's secular assumptions. Gender identity debates are often managed through sanitized diagnostic language—not to promote clarity, but to avoid confronting the deeper instability of psychiatry's own sexual and social paradigms. By exploring these diagnostic territories—where professional discomfort masquerades as medical authority—we propose a new way to read the DSM: not just as a map of mental illness, but as a mirror reflecting the hidden neuroses of the institution itself.

Keywords: psychiatry, DSM-5-TR, projection, homosexuality, religion, gender identity, pathologization, medical ethics, psychiatric history, secular bias, diagnostic politics, anxiety, social control, mental health narratives, institutional psychology.

1. Introduction

Projection as a Psychological and Institutional Mechanism

In classical psychoanalytic theory, *projection* is a defense mechanism whereby an individual attributes their own unacceptable thoughts, feelings, or fears to someone else. While commonly discussed in interpersonal contexts—such as a person accusing others of dishonesty to avoid confronting their own—projection also operates at the institutional level. Systems of authority, especially those claiming scientific neutrality, are uniquely prone to projecting their anxieties outward in the form of official classifications, warnings, and controls.

Psychiatry, as the gatekeeper of mental health in the modern era, is particularly vulnerable to this dynamic. The very act of diagnosis depends on a distinction between the "normal" and the "disordered." But who defines these boundaries—and with what unconscious motivations? When an institution claims the power to define reality for others, it must constantly guard against importing its own internal conflicts into the very frameworks it uses to assess the world. Diagnosis, in this view, is not just clinical—it is confessional.

Psychiatry's Cultural Power and Authority Through Diagnosis

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is not simply a medical reference; it is a cultural artifact with far-reaching implications. A DSM label can determine whether a person receives care or coercion, medication or marginalization. The APA's diagnostic language filters into schools, courts, prisons, and insurance systems. It shapes how families speak about suffering, how the media frames deviance, and how entire communities are disciplined or defended.

This power gives psychiatry an aura of objectivity, but it also grants it subtle authority to pathologize what it does not understand, or worse, what it unconsciously fears. As this paper will explore, the most controversial categories in the DSM's history—homosexuality, religious belief, gender identity—often reveal less about those labeled and more about the institution doing the labeling. When psychiatry declares a condition disordered, it also reveals what it finds disturbing.

2. Homosexuality and the Fear of Desire

From "Sexual Deviation" to "Ego-Dystonic Homosexuality"

The psychiatric classification of homosexuality has undergone a dramatic—and revealing—evolution. In the *DSM-I* (1952), homosexuality was grouped under "sociopathic personality disturbances," placing same-sex attraction in the company of criminality and moral failure. By *DSM-II* (1968), it was slightly reframed as a "sexual deviation," but still listed alongside pedophilia and fetishism, reinforcing the assumption that non-heterosexual desire was inherently disordered.

The major turning point came in 1973, when the American Psychiatric Association (APA) voted to remove homosexuality as a standalone disorder. However, this was not a clean break. To appease internal dissent, the *DSM-III* (1980) introduced a compromise: "Ego-Dystonic Homosexuality." This diagnosis applied when individuals experienced distress over their same-sex desires and wished to change them. On the surface, it respected patient distress. But in practice, it preserved the idea that homosexuality could still be treated—*if the patient hated it enough*.

This transitional label served as a kind of institutional hedging—a way for psychiatry to retreat from overt condemnation while still retaining control over nonconforming identities. It also allowed reparative therapy to continue under the guise of patient-centered care.

What Psychiatry Feared: The Destabilization of Sexual Norms

Why was homosexuality pathologized in the first place? It wasn't just societal prejudice. Psychiatry, emerging in the 20th century as a "science of the mind," depended on a vision of mental health that assumed normative sexual roles, family structures, and moral codes. Homosexuality threatened these assumptions—not only because it was different, but because it *revealed the instability of desire itself*.

Homosexuality made visible the fact that desire does not follow rules—that it can be fluid, ambivalent, resistant to social engineering. For a profession seeking order in the psyche, this was deeply unsettling. The diagnostic apparatus responded not

with curiosity but with containment. It attempted to render same-sex attraction as either a developmental failure or a maladaptive preference—thus reducing a cultural and existential phenomenon to clinical misalignment.

In this way, the classification of homosexuality was not an act of neutral description. It was a response to psychiatry's own fear of ungovernable desire, a projection of the profession's need to impose boundaries on what could not be neatly defined.

Removal as a Political, Not Purely Scientific, Process

The 1973 removal of homosexuality from the DSM is often framed as a moment of scientific progress. In reality, it was the result of sustained political pressure, internal activism, and external protest—*not* a sudden influx of conclusive empirical data. Gay rights activists infiltrated APA meetings, disrupted panels, and forced the profession to confront its complicity in social harm.

This was not a scientific reckoning, but a moral and epistemological one. The profession did not suddenly discover that homosexuality was healthy; it could no longer defend the idea that it was sick. The shift reflected a loss of institutional confidence, not the triumph of new clinical evidence.

Moreover, the presence of "Ego-Dystonic Homosexuality" in *DSM-III*—seven years after the landmark vote—underscored the ambivalence of the profession. It was not ready to accept homosexuality as a natural variant of human expression. It could only tolerate it as long as it came attached to distress—and thus remained within the therapeutic fold.

Ultimately, the withdrawal of the diagnosis did not mark psychiatry's liberation from bias. It marked its first major concession to the reality that its categories are not immune to culture, power, and fear. The fear of desire had been displaced—not extinguished.

3. Religious Experience as a Threat to Rationalism

Hallucination vs. Revelation: Who Decides?

In psychiatry, a central diagnostic axis is the distinction between reality and delusion—a boundary whose arbiters are clinicians trained in secular frameworks. Yet religious traditions around the world are built upon claims of visions, voices, supernatural interventions, and mystical insight—phenomena that, if presented in a clinical setting, often meet criteria for psychosis. A patient who reports hearing the voice of God or seeing divine light may be diagnosed with schizophrenia, while a prophet, saint, or mystic in another context might be venerated for the same experience.

This dilemma reveals psychiatry's epistemological bias: it privileges materialist rationalism as the default worldview and treats departures from it as potential pathology. The moment religious content moves beyond metaphor and into phenomenological experience—especially when it involves communication with non-physical entities—psychiatry becomes uneasy. The problem is not necessarily the suffering involved, but the challenge to psychiatric sovereignty: who gets to define reality, and who must submit their experiences for clinical validation?

Religious experience, in this light, is threatening not because it is always delusional, but because it resists psychiatric control. It posits other sources of authority—divine, spiritual, communal—that do not answer to diagnostic criteria or peer-reviewed journals.

Scrupulosity and the Policing of Inner Morality

One of the few explicitly religious-themed pathologies recognized in the DSM framework is scrupulosity, a subtype of Obsessive-Compulsive Disorder (OCD) characterized by obsessive concerns over sin, moral failure, or divine punishment. While many sufferers benefit from therapeutic intervention, the concept of scrupulosity also reveals psychiatry's underlying stance toward religious thought: excessive piety becomes pathology when it interferes with normative functioning.

But who defines “excessive”? A devout person who prays five times a day or avoids all impure thoughts may be fulfilling religious obligations—or demonstrating symptoms of OCD—depending on the clinician’s own cultural framework. Psychiatry often lacks the tools to distinguish between authentic spiritual conviction and maladaptive compulsion, especially when both are expressed with fervor. In such cases, treatment often focuses not on the theology but on the behavior—eroding the complexity of lived religious life into a set of dysfunctional rituals.

This is not mere symptom-checking. It is moral adjudication masquerading as clinical objectivity. It reveals the way psychiatry polices the boundary between “healthy belief” and “mental illness,” often using the therapist’s worldview as the hidden ruler.

Z-Codes and the Refusal to Name Spiritual Harm

In the *DSM-5-TR*, the only category that explicitly acknowledges religious struggle is Z65.8 — “Religious or Spiritual Problem”. This is not a disorder, but a “condition that may be the focus of clinical attention.” It covers crises of faith, conflicts between belief and behavior, or distress around spiritual identity. On the surface, this seems like a respectful nod to the complexity of religious life. In practice, it functions more like a bureaucratic escape hatch—a way to acknowledge spiritual content without granting it full diagnostic legitimacy.

Notably absent is any formal recognition of religious trauma, despite growing literature on the psychological effects of spiritual abuse, authoritarian sects, excommunication, purity culture, and apocalyptic fear conditioning. Patients who leave high-control religious environments often report symptoms indistinguishable from Complex PTSD—yet their experiences must be filtered through generic trauma labels, stripped of their religious specificity.

By relegating spiritual conflict to a non-disorder status, psychiatry avoids confronting the role of religion as a source of psychological harm. It also avoids the more uncomfortable possibility: that mental health can deteriorate not

because religion is present, but because it is misused, weaponized, or enforced without conscience.

In refusing to name these dynamics, psychiatry reveals its own discomfort with confronting belief systems that claim authority beyond the self—and its fear of adjudicating between liberating faith and psychic colonization.

4. Gender Identity and the Evasion of Ontological Crisis

Sanitized Language: "Dysphoria" Without Ideology

In the DSM-5-TR, *Gender Identity Disorder* has been replaced by *Gender Dysphoria*, a shift widely hailed as a move away from pathologizing transgender identity. The new terminology emphasizes distress rather than identity—locating the problem not in being transgender, but in the suffering caused by incongruence between one's experienced gender and assigned sex.

On the surface, this change appears humane and progressive. Yet beneath the revision lies a careful evasion of the deeper ontological crisis: What is gender, and who gets to define it? Is it biological, social, spiritual, mutable, fixed? Psychiatry steps away from this terrain by treating gender as a personal reality, but it avoids grappling with what it means ontologically for sexed bodies to become optional, interchangeable, or fluid within a framework that once anchored diagnoses in material facts.

By choosing the term "dysphoria," the DSM couches an enormously complex metaphysical and sociopolitical question in psychological language stripped of ideological content. This sanitization allows the profession to appear supportive while avoiding any substantive stance on the nature of embodiment, sexual dimorphism, or the boundaries of identity formation. It is a diagnostic strategy of neutrality—but one that often obscures more than it clarifies.

Detransition, Regret, and the Profession's Blind Spots

While the dominant clinical narrative affirms transition as a path to psychological well-being, an increasing number of individuals have come forward describing experiences of detransition and regret. Their stories often include pressure to medicalize rapidly, lack of thorough psychological assessment, and dismissal of underlying trauma, comorbidities, or social confusion.

Despite growing testimony, the DSM-5-TR makes no formal mention of detransition. There is no category or sub-specifier for "resolved dysphoria" or "identity realignment." This omission is not merely a gap in coverage—it is a blind spot maintained by institutional anxiety. To fully acknowledge detransition would require psychiatry to revisit its own fast-tracking tendencies, its reliance on affirmative models without diagnostic rigor, and its vulnerability to cultural contagion within identity formation.

The profession's silence on detransition reflects a fear of reopening a diagnostic battleground that it hoped to close with terminological revisions. But in ignoring the full arc of gender experience, psychiatry risks becoming a gatekeeper for ideological conformity rather than a witness to human complexity.

The Risk of Re-Pathologizing Nonconformity Under New Terms

In its effort to de-pathologize transgender identity, psychiatry may inadvertently be re-pathologizing gender nonconformity in a new guise. By requiring a diagnosis of dysphoria to access medical transition, the profession medicalizes access to autonomy—turning subjective discomfort into a prerequisite for bodily change. This system forces individuals to frame their identities in terms of distress and dysfunction, even when their actual goal is self-actualization or social alignment.

Furthermore, by maintaining rigid categories such as *Gender Dysphoria*, psychiatry may still impose binary thinking under a therapeutic veneer. A person may be told they are "really" a man or woman based on their sense of self, but this framework still assumes a stable gender essence—now located in the psyche rather than the body. The apparatus of classification remains intact; only its content has shifted.

This raises a troubling possibility: in seeking to respect identity, psychiatry may be reinforcing identity essentialism—treating gendered feelings as diagnostic facts rather than fluid, negotiated, and socially embedded experiences. Rather than dismantling the old gatekeeping mechanisms, the new language risks entrenching them under progressive branding.

5. Institutional Anxiety and Diagnostic Control

Projection as a Defense Against Professional Uncertainty

Psychiatry is a field perpetually struggling to define its epistemic foundation. Unlike other branches of medicine, it lacks definitive biomarkers for most diagnoses, objective tests for confirmation, and universally accepted etiologies for its conditions. In this vacuum, psychiatric practice is vulnerable to uncertainty—not only about what mental illness is, but about what constitutes reality, normalcy, and autonomy.

Faced with this ambiguity, psychiatry often falls back on projection as a defense—*not at the individual level, but institutionally*. The classification of disorders can become a way for the profession to externalize its own discomfort: to project what it does not understand, what it cannot measure, or what it finds ideologically or emotionally dissonant onto the patient.

In this way, the DSM serves not only as a clinical tool but as a psychological mirror. Conditions that threaten psychiatry's internal coherence—like ambiguous identities, metaphysical experiences, or non-normative desires—are more likely to be pathologized or sanitized. The profession projects its own need for clarity, containment, and categorical control onto the very people it purports to help.

Pharma Influence, Overdiagnosis, and the Illusion of Clarity

One of the most powerful sources of diagnostic inflation has been the pharmaceutical industry. The tight coupling between DSM revisions and drug development pipelines has created incentives for broadening categories, lowering diagnostic thresholds, and multiplying specifiers. This has led to a world where ordinary distress is routinely reclassified as disorder—grief becomes depression, attention fluctuation becomes ADHD, and existential dread becomes a clinical anxiety spectrum.

These expansions serve institutional needs. They provide a sense of scientific authority, allow for standardization of care, and create billing pathways for insurance reimbursement. But beneath the surface, they mask uncertainty with the appearance of precision. A complex human struggle becomes a checkbox of symptoms matched to an FDA-approved treatment.

This illusion of clarity—conferred by a diagnosis, a billing code, a prescription—defends psychiatry from having to admit how little it sometimes knows. It offers order where there is ambiguity, and treatment pathways where there may be no definitive cure. In doing so, it displaces uncertainty from the profession onto the patient, who is now rendered legible and manageable, even if not truly understood.

What Psychiatry Avoids Because It Cannot Contain

Perhaps the most telling feature of psychiatric authority is what it refuses to include: entire dimensions of human experience that resist containment. The DSM does not address spiritual emergence, creative madness, philosophical despair, or socially induced breakdowns unless these experiences can be reframed in pathologizing language. There is no diagnostic space for the person undergoing a crisis of meaning that is not reducible to mood disorder, or for the individual shattered by structural injustice rather than neurochemical imbalance.

Psychiatry avoids these because it cannot contain them—because their inclusion would exceed the boundaries of clinical control and undermine the fantasy of

diagnostic sovereignty. To name these realities as legitimate would require psychiatry to admit that not all suffering is disordered, and not all healing is clinical.

This avoidance is not a failure of science—it is a failure of imagination. It reveals a profession constrained not by lack of tools, but by fear of losing its grip on definitional power. Psychiatry, in this light, is less an objective science of the mind than a regulatory apparatus of the permissible self. It manages what society permits us to be—so long as we remain legible, treatable, and contained.

6. A Mirror, Not a Map: Rethinking Diagnostic Authority

Toward Humility in Psychiatric Practice

If psychiatry is to move beyond its legacy of projection, it must adopt a posture of diagnostic humility. This does not mean abandoning diagnostic frameworks entirely, nor denying the reality of mental suffering. It means acknowledging that diagnostic language is not a mirror of objective reality but a culturally embedded system of interpretation, shaped by historical contingencies, professional anxieties, and power relations.

Humility in psychiatric practice begins by admitting the limits of certainty. It requires clinicians to resist the impulse to rush from ambiguity to classification, from distress to disorder. It calls for a slower, more dialogical mode of care—one in which the psychiatrist listens not only for symptoms, but for context, values, meaning, and dissent. Humility means accepting that some phenomena—grief, awakening, identity transformation—may not belong in the language of pathology at all.

This reform is not only technical; it is ethical. The stakes of psychiatric authority are not abstract. A diagnosis can justify forced medication, disqualify testimony, shape legal outcomes, and determine the boundaries of personal legitimacy. If psychiatry cannot wield this power with self-awareness and caution, it risks becoming an instrument of conformity rather than healing.

Recognizing Belief Systems, Not Just Symptom Clusters

To practice with humility, psychiatry must also learn to recognize belief systems, not just symptom clusters. Every patient arrives not as a collection of behaviors or brain states, but as a person embedded in cultural, religious, philosophical, and existential frameworks. These frameworks may be coherent or chaotic, liberating or constraining—but they are never irrelevant.

The DSM, in its current form, often treats belief as *background noise*—a set of cultural considerations to be filtered out in the diagnostic process. But belief systems are central to meaning-making, and they often shape what counts as suffering, what counts as healing, and what counts as real. To ignore them is to reduce the patient to an object of analysis rather than a subject in crisis.

Moreover, psychiatry must examine its own belief system—its default secularism, its allegiance to materialist ontology, its commitment to individualism and linear developmental models. These too are not neutral. They form a paradigm that can obscure as much as it reveals. To transcend projection, psychiatry must become self-aware as a cultural actor, not just a clinical science.

Psychiatry After Projection: Ethical and Epistemological Reform

A psychiatry after projection would no longer see itself as the master cartographer of the mind. It would relinquish the fantasy of mapping all internal states into stable coordinates. Instead, it would see the DSM not as a definitive atlas of mental illness, but as a mirror—reflecting not only the lives of patients, but the worldview of the profession itself.

Ethically, this means rejecting coercion masquerading as care, and recognizing that diagnosis is always a form of power. Epistemologically, it requires dismantling the illusion that mental phenomena can be cleanly divided into “normal” and “disordered” without reference to cultural values, metaphysical commitments, or political consequences.

This does not make psychiatry useless—it makes it more honest, more precise in its scope, and more respectful of the human beings it serves. Psychiatry after projection would no longer be an enforcer of normative identities or a tool of social legibility. It would become what it was meant to be: a companion to suffering, not its sovereign.

7. Conclusion

The DSM as Both Scripture and Confession

The *Diagnostic and Statistical Manual of Mental Disorders* is often treated as psychiatry's scripture: authoritative, prescriptive, and continuously revised by a council of experts. It provides the canon of mental illness, defining what may be named, what may be treated, and what must be corrected. In practice, it serves not only clinicians but also institutions—schools, courts, hospitals, insurers—as a theological manual of the modern self.

Yet the DSM is also a confession. Its history tells a story of shifting fears, political accommodations, scientific uncertainty, and the struggle to maintain control over what cannot be fully understood. It confesses, in subtle ways, the profession's ambivalence toward ambiguity, its fear of the irrational, its discomfort with spiritual and sexual nonconformity, and its vulnerability to ideological capture. In every revision, what is left out reveals as much as what is included.

To read the DSM as both scripture and confession is to recognize that it contains not only truths about human suffering—but also unexamined truths about psychiatry itself.

What We Learn When We Ask: Who Really Owns the Diagnosis?

Throughout this paper, we have asked a deceptively simple question: who owns the diagnosis? Is it the patient, whose experience of distress demands to be named? The clinician, whose training authorizes them to name it? The institution, which demands categorization for funding, liability, and control? Or the culture at

large, which projects its anxieties onto the “mentally ill” in order to preserve the illusion of normalcy?

In reality, diagnosis sits at the intersection of all these forces—and is never neutral. It is a tool of care and a mechanism of social regulation. It can liberate and pathologize, protect and punish, validate and erase.

To ask who owns the diagnosis is to expose its fragility. It is to admit that labeling is not always an act of understanding—but sometimes a displacement of uncertainty, a performance of authority, or a projection of institutional anxiety. And it is to recognize that true healing may begin only when the system itself becomes transparent to its own projections.

If psychiatry is to evolve ethically and epistemologically, it must no longer mistake its categories for conclusions. It must learn to dwell in uncertainty, to listen more deeply, and to see in each diagnosis not a final answer—but a starting point for shared reflection.

Until then, the DSM will remain what it is: part scripture, part confession—and always, a mirror.

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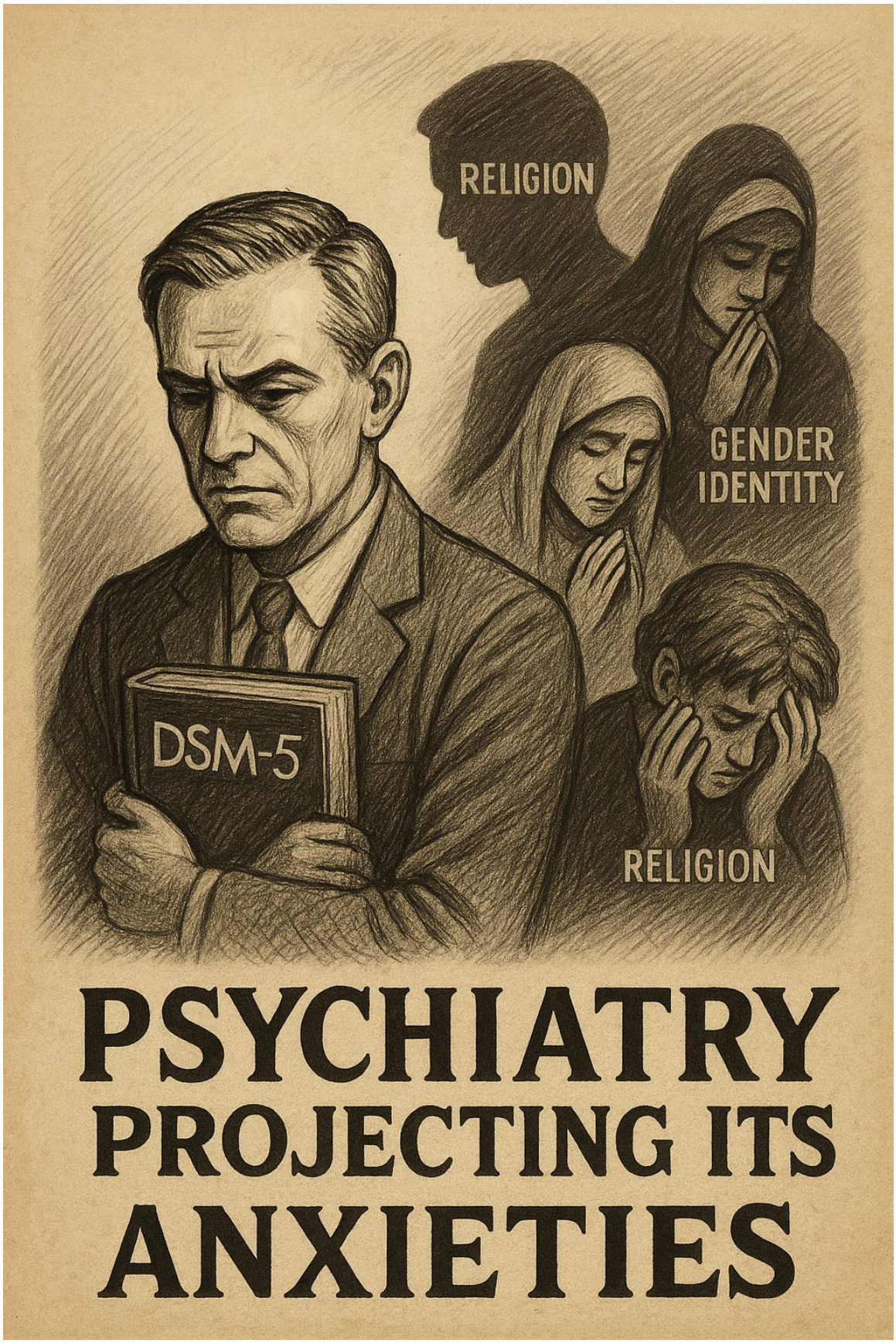
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