

Prognosis Negative

Psychiatry and the Foibles of the Diagnostic and Statistical Manual V (DSM-V)

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SPENT TOO MUCH MONEY ON PRADA LOAFERS OR Gucci handbags? Still upset over not getting to play starting quarterback for the big game your senior year? Maybe you're overcome by the desire to surf the web, which your boss refuses to acknowledge is disabling. If so, you may qualify as mentally ill, stricken by a psychiatric disorder as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (AKA, the DSM, or "The Psychiatrist's Bible") when the new (5th) edition (DSM-V) is released in 2013.

The DSM-V will officially sanction suffering and dysfunction like never before, with new disorders such as "Post Traumatic Embitterment Disorder," "Compulsive Shopping," and "Internet Addiction Disorder," all being considered for addition to the official list of psychiatric disturbances. The folks writing the new DSM-V are even considering a new classification of "prodromal" disorders, which means you may qualify for diagnosis of a mental disorder just based on the hunch of your psychiatrist. No one knows how many disorders will be added yet, but if history is any indication (the number of psychiatric diagnosis has nearly doubled with each edition of the DSM), you may qualify for a newly acknowledged disorder and maybe 3rd party payers will reimburse me, a psychiatrist. How did we get to this stage?

The Origin of the DSM

The first edition of *The Diagnostic and Statistical Manual* was released in 1952. The manual was 130 pages long and listed 106 mental disorders.¹ It was grounded in psychodynamic psychiatry, which relied heavily upon the writings of Freud and others, as did the 2nd edition published in 1968. Unlike today, symptoms were not specified in detail for each disorder. Psychic anxiety and the analytic concept of neurosis were critical in conceptualizing almost all psychopathology. Until the mid-1970s, a model informed by psychoanalysis, sociological thinking, and limited biological knowledge was the organizing paradigm for American psychiatry. How-

ever, this model did not clearly lend itself in helping define who was "sick" in the collective eyes of psychiatry. In part this failure led to a crisis in the legitimacy of psychiatry by the 1970s.²

Adding to this failure was the famous experiment exposing the subjectivity of psychiatric evaluations conducted by the psychologist David Rosenhan and his colleagues, reported in the journal *Science*.³ Eight experimenters, including a psychology graduate student, three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife were instructed to attempt to gain psychiatric hospital admission by feigning symptoms during psychiatric assessment. Each claimed to be hearing voices that were often unclear but which seemed to say the words "hollow," "empty," and "thud." No other psychiatric symptoms were claimed and apart from giving false names and employment particulars, further biographical details were truthfully reported. If admitted, the pseudopatients were asked to "act normally" and report that they felt fine and no longer heard voices. None had a history of mental illness.

All eight of Rosenhan's subjects were admitted, seven with a diagnosis of schizophrenia and the last with manic-depression. Once admitted and diagnosed, the pseudopatients were not able to obtain their release until they agreed with the psychiatrists that they were mentally ill and took antipsychotic medications. Rosenhan's article exploded in controversy that ultimately led to the publication of the *DSM-III* in 1980. With it, the essential focus of psychiatric nosology changed to a research-based atheoretical descriptive model. A new paradigm was born.

Scientific Psychiatry?

Robert Spitzer may be the second most influential psychiatrist of all time. Regardless, I do not recall ever hearing his name mentioned even once during all my training. Unlike Freud, Jung, or Kernberg who brought interesting but arguably dubious, speculative

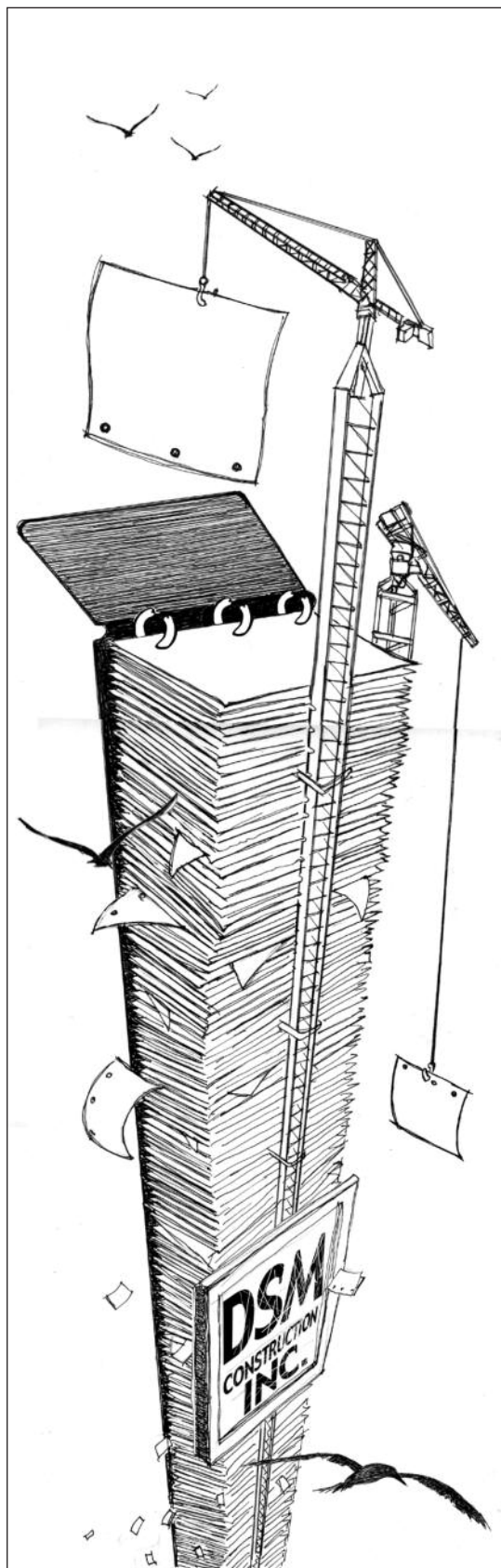
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philosophical models to psychiatry, it was Spitzer who was mostly responsible for the *DSM-III*, and it was he who brought claims of scientific credibility to the field. Spitzer rightly identified that part of what ailed psychiatry was its unscientific nature. To him, the first problem that needed to be addressed was the unreliability of diagnosis. One psychiatrist might identify a patient as being a raging narcissist, another as suffering from a run of the mill depressive neurosis. If the manual could not help psychiatrists reliably identify people as having the same disorder how could it be scientifically valid?

The primary goal of the *DSM-III* was to increase reliability by standardizing definitions. What disorder people had was all that really mattered. Why you had the disorder was another matter altogether. After the publication of the new *DSM*, Spitzer made it clear that psychiatry's new classification scheme stood on solid scientific ground, and in the words of the late Gerald Klerman, a prominent psychiatrist, "the reliability problem has been solved." The *DSM-III* was described as a "watershed document," "a stunning achievement," and "a scientific revolution" by those in the field.⁴

Not everyone was so thrilled. Stuart Kirk, a professor of public policy at U.C.L.A., and Herb Kitchens, a professor emeritus of social work at California State University, Sacramento, studied the creation of the modern *DSM*. They convincingly argued that its financial and academic success could not be attributed to its scientific credibility. In their words, "if one looks intensively at what was identified as the core scientific problem of diagnosis in the 1970s, unreliability, one discovers that the scientific data used to claim success and great improvement simply do not support the claim."⁵ In other words, the rhetoric of science—rather than scientific data—was used by the developers of *DSM-III* to promote their goal, and the science did not support claims made by Spitzer and his new brand of psychiatry.

Reliable or not, it did not matter too much to the people purchasing it. The *DSM-III* and the *DSM-III-R* (Revised) together flew off the shelves. Almost immediately the book became of great importance, not only in psychiatry but in psychology, social work, and in the courtroom. It was translated into 13 languages. Insurance companies, which expanded their coverage to the treatment of mental disorders, welcomed the *DSM-III* as a standard for determining payment. In other words, if you are a working psychiatrist you aren't going to get paid from your clients' insurance companies unless your diagnoses are in the *DSM-III*. The book's influence



in producing an almost complete paradigm shift in American psychiatry is hard to overstate, as has been its impact on a broad range of cultural practices and how we look at and speak about human suffering, disability, and deviance.

So, here's a brief history of psychiatric diagnosis: In 1917, the American Psychiatric Association together with the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the *Statistical Manual for the Use of Institutions for the Insane*. There were 22 diagnoses. In 1994, *DSM-IV* was published, listing 297 disorders in its 886 pages. This would reasonably lead one to the conclusion that in the past century there has been explosive growth in the basic science that supports the effective identification of those with mental disorders. Right?

Let's See If She Floats

In 1486, a treatise entitled *The Malleus Maleficarum* (*The Hammer Against Witches*) was written to assist in the detection and persecution of witches. It specified rules of evidence and the procedures by which suspected witches were to be identified, tortured, and put to death. The *Malleus* remained in use for 300 years. Between 1487 and 1520, the manual went through 13 editions. It is estimated that in Europe it contributed to the identification and execution of as many as 60,000 "witches," most of them woman.^{6,7} The parallels with the *DSM* are eerie.

The *DSM* as a scientific text and almost every diagnosis found within it suffer from the same sort of problem as the concept of someone actually being a witch: Validity. Even if we accept the *DSM* as 100% reliable, which of course it is not, that does not make it valid. Let's say I see all those of Asian descent as being part of a group who are pathologic and inferior to all Caucasians based on appearance, speech, and diet. I have a method of identification that is 100% reliable. This does not mean that my congruent ideas or model of pathology are valid, any more than the *Malleus's* reliability in identifying women as witches means that they were actually witches.

In this sense, psychiatric disorders such as "Major Depression" and "Schizophrenia" are constructs. Or course, it would be solipsistic to say that people do not get depressed, and as a psychiatrist I have certainly observed people who present themselves as completely unhinged from concrete reality who we would describe as psychotic. The important question is if the constructs we create to describe such behaviors and experiences are consistent in

their ability to differentiate themselves from other pathological constructs, and if they provide a theoretical framework for both prediction and specific intervention.

The practice of medicine is filled with constructs. Parkinson's disease is a good construct because it is grounded in a consistent and specific group of neurologic symptoms, including tremor, rigidity, and bradykinesia associated with the concrete pathology of deterioration of neurons in the region of the brain known as the Substantia Nigra. The collection of observed symptoms is assembled into a construct called "Parkinson's disease." The corporeal pathology, however, is not the symptom group but the deterioration of specific neurons within the brain. The same symptoms can be created by anti-psychotic medications, so we need not interpret those symptoms as part of a unique, universally valid, and nearly completely reliable construct. The construct also lends itself to specific interventions targeted to address the lower levels of dopamine that lead to the clinical symptoms without direct measurement of such levels in patients. Key in all of this is that the neuropathology is consistently correlated with the construct and is part of an understood model that guides treatment.

By contrast, the diagnosis of fibromyalgia is problematic in the way psychiatric diagnoses are. It is a loose collection of non-specific complaints, including diffuse muscle pain, fatigue, and often insomnia mostly diagnosed in middle aged, overweight woman. It is not consistently correlated with any known or understood pathology in the body. Many doctors, including Dr. Frederick Wolfe, rheumatologist and lead author on the paper that defined the diagnostic guidelines for fibromyalgia in 1990, do not even buy into the idea that it is a disease or a valid construct. He now considers it a response to stress, depression, and economic and social anxiety, and he believes that the diagnosis simply causes patients to obsess over aches and catalogue pains that others usually tolerate.⁸ Regardless of such qualifications, many physicians treat people for "fibromyalgia," and ads for the drug Lyrica made by Pfizer and approved by the FDA declare it a "real disease" to TV viewers. Eli Lilly and Forest Labs have asked the FDA to let them market drugs for fibromyalgia.

Like fibromyalgia, almost every major psychiatric construct is seen as being of questionable validity by a vocal group within the field itself or outside it. This includes post traumatic stress disorder, bipolar disorder, and even schizophrenia.^{9,10,11}

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sexual dysfunction and paraphilias such as exhibitionism, fetishism, and sadomasochism are a particularly contentious area, with some researchers calling for their complete removal from the *DSM*. Robert Spitzer conceded that a significant reason that certain diagnoses are not removed from the *DSM* is because “it would be a public relations disaster for psychiatry.”^{12,13}

According to an APA press release, “Hundreds of clinical and neuroscience researchers, clinicians, and health care consumers from a variety of psychiatric specialties and backgrounds are working together to develop the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders*.” Dismay over including patients in formulating a textbook of pathology has been expressed, but response from the APA is that “Patients and families are the obvious experts in the experience of mental illnesses. Accordingly, the process of refining psychiatric diagnoses should take this unique perspective into account.”^{14,15}

I wonder if Joseph Lister consulted with a group of the infected before he introduced anti-septic technique? No branch of medicine manifests such consistent misgivings and criticism about its nosology both from within and without. Psychiatry, and none but psychiatry would include “consumers” to elicit feedback in defining pathology. The fact that this continues to be passionately disputed underscores that changes in the *DSM* must be viewed as at least in part political in nature. The way medical classification of disease evolves is messy and inconsistent and often has to do with politics and not just compelling scientific fact. It’s just much worse in psychiatry.

What is In a Name?

Controversy is already brewing over the forthcoming *DSM-V*. Some of the complaints are not new and center around the idea that many of the diagnoses are just examples of moral entrepreneurship. That is, they are not real descriptions of a natural disease process but just the moral objections of a group with the power and desire to medically pathologize another group for self-serving purposes. Maybe people with low sexual desire do not wish to be seen as disordered but as having made a healthy adaptation to changes in their lives and relationships.

A more compelling chronic complaint about the *DSM* is that it is a-theoretical and purely descriptive. Maybe we identify people who are “unwell” with it, but do those diagnosed with the same disorder actually have the same “pathology”? Major

depression, for instance, is defined as a disturbance of mood in which a person must have experienced at least five of nine symptoms that may include sleep and appetite changes for the same two weeks. So those symptoms equal a major depression, and what is a major depression? Those symptoms. Hence you go back and forth in a purely descriptive circular fashion. Description is not the same thing as explanation, and the *DSM* explains nothing. For example, does labeling someone with “major depression” really tell you anything more than just saying they are “very depressed”? Can major depression be objectively separated from the suffering of other depression such as grief, in a meaningful way? No, it can’t, at least not objectively. But such a diagnosis in the world of mental health is important because it is a loaded value-laden term implying that we know something objective about the person’s emotional state. (Like Parkinson’s disease allows us to know something about a patient’s neurological state.) It confers medical legitimacy on the description, suggesting that it is a distinct disease state separate and more severe. It also makes the condition no longer dependent on the events that may have caused it. We can objectively know nothing of the sort because the diagnosis is based on arbitrary symptom lists that are non-specific and almost always gleaned from self-report and pure speculation. We have no way of objectively validating anything. This is akin to saying a person has a diagnosis of a “major pain.”

This approach leads to people being regularly diagnosed with multiple disorders. Do 32% of adults with a “depressive disorder” have ADHD?¹⁶ The fact is, if you are trying to find “ADHD” in patients with “major depression” you can because patients with depression typically have symptoms such as distractibility, poor focus, and difficulty finishing tasks, none of which are specific to any psychiatric disorder. If they are chronically anxious and afraid of spiders, you could squeeze in a few more disorders in just the first visit alone. This approach also leads to rebranding old problems as new ones. Psychiatrists get paid for treating mental illness. There is a strong motivation for them to look at things they used to attribute to chronic personality, or just life, and see them as psychiatric illness. If you have an unstable personality disorder I am afraid psychiatry has little to offer, but if we call you bipolar or cyclothymic we treat you with antidepressants and mood stabilizers, and get paid to do so.

Bipolar disorders entered the *DSM* in 1980. At

the time, the criteria for Bipolar I Disorder involved an episode of hospitalization for mania. Since then, the diagnosis of Bipolar II Disorder, Bipolar Disorder NOS (not otherwise specified), and cyclothymia have emerged. With these additions, estimates for the prevalence of bipolar disorders have risen from 0.1% of the population having Bipolar I Disorder (involving an episode of hospitalization for mania), to 5% or more when the definition of bipolar disorders includes the aforementioned “community” disorders.^{16,17} In children, it has increased 4000% in the past decade alone.¹⁸

We know hardly anything more of real scientific significance about bipolar disorder than we did in 1980, but we sure have gotten good at diagnosing and medicating it along with lots of other things. There has been explosive growth in the diagnosis of mental illness and use of atypical antipsychotics and antidepressants, the two fastest growing categories of psychotropics, which are both used to treat almost every conceivable major psychiatric disorder, including bipolar disorder.^{19,20}

Follow the Money

This has led many, including Republican Senator Charles Grassley of Iowa, to seriously question the motivations of some of psychiatry’s most prolific researchers who shape how people get diagnosed, what disorder label they are given, and what drugs they are prescribed. An investigation has been ongoing to determine the full extent of industry fees paid to psychiatric researchers, and some of the biggest names in the business have been accused of misconduct. These include men like Charles Nemeroff, arguably the most influential biological psychiatrist in the world. He stepped down as Chairman of the Department of Psychiatry at Emory University after an investigation turned up more than \$800,000 in income from industry that Nemeroff failed to report to the university.²¹ The very father of “Childhood Bipolar Disorder” himself, Harvard child psychiatrist Joe Biederman, whose work has helped fuel an explosion in the use of antipsychotic medicines in children, has agreed to temporarily stop all work on industry activities, including clinical trials, until an investigation of his alleged failure to report industry payments is complete. He earned at least \$1.6 million in consulting fees from drug makers from 2000 to 2007, but for years did not report much of this income to university officials.²²

Aside from the financial motivations of psychiatric researchers, and the effect of these motives on

research that contributed to the creation of the *DSM* and the cataloging of millions as mentally ill, serious doubt has been expressed as to the real need for a revision of the *DSM*. The manner in which revision is taking place has been critiqued by Dr. Allen Frances, chairman of the committee that created the *DSM-IV*, who found himself purposely omitted from the new Task Force. The *DSM-V* web site (<http://www.psych.org/dsmv.asp>), explains the exclusions: “To encourage thinking beyond the current *DSM-IV* framework, many participants closely involved in the development of *DSM-IV* were not included.” Dr. Frances’ main criticism is that the *DSM-V* Task Force has been clear in proclaiming that their edition will revolutionize psychiatric diagnosis and produce no less than a “paradigm shift.” In a very open and public debate that has been described as a “brawl” on a prominent psychiatric blog,²³ Dr. Frances publicly stated that the process of writing the manual is less transparent and less inclusive than the process he oversaw when he chaired the *DSM-IV* committee.²⁴ For example, the members of the current task force had to sign a confidentiality agreement and are not permitted to keep written notes of their meetings on the new *DSM*. The American Psychiatric Association *DSM-V* Task Force has responded to the criticism by stating that Dr. Francis is just worried that he will stop making money from the sale of the old *DSM* and they are protecting their new intellectual property.

Aside from the infighting over money and openness, the more important criticism being aired is that the underlying science of psychiatry has not advanced enough to merit the kind of extreme makeover proposed. According to Dr. Francis, “There can be no dramatic improvements in psychiatric diagnosis until we make a fundamental leap in our understanding of what causes mental disorders. The incredible recent advances in neuroscience, molecular biology, and brain imaging that have taught us so much about normal brain functioning are still not relevant to the clinical practicalities of everyday psychiatric diagnosis. The clearest evidence supporting this disappointing fact is that not even one biological test is ready for inclusion in the criteria sets for *DSM-V*.”²⁵

Not Even Wrong

An apparently scientific argument is said to be “not even wrong” if it is based on assumptions that cannot possibly be falsified or used to predict anything. I am afraid after nearly 20 years in the belly of the beast of psychiatry I come to no other logical

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conclusion than that for the most part the *DSM* and the psychiatry behind it are “not even wrong.” The entire premise of artificially and endlessly cataloging every conceivable form of human suffering or perceived dysfunction is neither helpful nor sound. It is a confused attempt to apply the principles of the hard sciences like physics and chemistry to the softest of social sciences. The *DSM* takes great pains to be a-theoretical because it knows it must. The *DSM* jettisoned the flawed Freudian theory that held it together after the 2nd edition, but today it is just a big catalogue of symptom lists.

Because of this purely descriptive, medicalized approach untied to verifiable pathology, if I as a doctor want to see bipolar disorder as irritability and daily mood swings (as many do), than that to me is being “bipolar.” I can also look at it as a byproduct of a very challenging environment superimposed on temperament, but I cannot prove that it is or is not “bipolar disorder.” I can only prove that I choose to interpret some symptoms as diagnostic of that particular label. When the definition of the construct cannot escape subjective description or self report we cannot escape the arguments by certain groups with competing interests that we are either “under” or “over” diagnosing disorders.²⁶ Whether we are or are not depends on what kind of world you want to live in and how you want to conceptualize what people tell you.^{27,28}

An additional problem has arisen through the personal use of the Internet to check your own symptoms against published symptom lists. I run an in-patient psychiatric unit and I spend a good deal of time trying to explain to people that they may be suffering, but that this does not mean they have an illness a doctor can fix. Many do not like to be told this because they have adopted the medical model of psychiatry and are in search of an easy cure. To be sure, I also have seen some very unwell people made better by what psychiatry can offer, and these include acutely manic, psychotic, and catatonic patients, but that is a very small minority of the people who cross the path of the *DSM* and psychiatry. The rest I see are either getting no help or are being made worse by the *DSM* approach, and I tell them to stay as far away as possible from contemporary psychiatry.

Unless the APA takes a dramatic turn and decides to narrow the scope of what it considers pathology and worthy of research and medical treatment, it will be a step backwards for a field already circling the drain due to its poorly conceived cataloging and incoherent theoretical models. We are all taught the first day of medical school to “first do no harm.” I do not see the rampant diagnosis of mental illness that the *DSM-IV* produced as being within the spirit of that edict, so I ignore it, as I plan to do for the *DSM-V*. I suggest you do the same. **S**

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