spiked

HELENE GULDBERG

'This manual is, frankly, a disaster for children'

Christopher Lane talks to ***spiked*** about the new edition of the bible of psychiatry – 'a legal document facilitating the medication of millions'.

7 JUNE 2013

On 22 May, the American Psychiatric Association (APA) published *DSM-5*, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, after months, perhaps even years, of speculation about its contents.

Its critics warned that *DSM-5* would lead to the further overdiagnosis of children and adults. *The Economist* reported that 11 per cent of American school-age children have been diagnosed with attention-deficit/hyperactivity disorder (ADHD) and that *DSM-5* would likely lead to even more ADHD diagnoses. Considering the majority of those diagnosed are on prescription drugs, this is a worrying development. So worrying, in fact, that Dr Allen Frances, Professor Emeritus at Duke University and former Chair of the task force that developed *DSM-IV*, writes: 'If people make the mistake of following *DSM-5*, pretty soon all of us may be labelled mad.'

Many years before the publication of *DSM-5*, Chicago-based professor Christopher Lane raised serious concerns about overdiagnosis and overmedicalisation in his book *Shyness: How Normal Behaviour Became a Sickness*.

'Our quirks and eccentricities – the normal emotional range of adolescence and adulthood – have become problems we fear and expect drugs to fix', Lane wrote in 2008. 'We are no longer citizens justifiably concerned about our world, who sometimes need to be alone. Our afflictions are chronic anxiety, personality or mood disorders; our solitude is a marker for mild psychosis; our dissent, a symptom of oppositional defiant disorder; our worries, chemical imbalance that drugs must cure.'

In *Shyness*, Lane charted how the *Diagnostic and Statistical Manual* was transformed – by a handful of psychiatrists behind closed doors – from the thin handbook it was in the 1970s into the hefty tome it is today, with hundreds of new, poorly specified and poorly researched syndromes being added. I asked Lane whether he would make the same criticisms of *DSM-5* as he did of *DSM-IV* – both in terms of the process and the outcome of the revisions.

Christopher Lane: I would, yes. The outcome this time is painfully similar to that of earlier editions. But there were notable differences in the process, including the sheer number of people working on the new edition.

The *DSM-5* task force made all kinds of announcements before publication about having made an effort to be more transparent and responsive to the concerns of mental health professionals, many of whom had been troubled by the low thresholds given a litany of psychiatric disorders. And, true enough, the APA did offer a brief window for commentary on proposed changes and did abandon its initial support for psychosis risk syndrome, a proposal so poorly defined it actually would have been dangerous in its implications. The APA also set a cap on honoraria that participants could accept from the drug companies ($10,000 each year). Previously, there had been no cap – and no

conflict-of-interest forms distributed or signed.

But the new edition introduces so many new problems – including its dramatically lowered thresholds – that it is arguably a lot more hazardous than earlier editions. The latest one also approves such controversial additions as disruptive mood dysregulation in children and, for the appendix, internet addiction. Given how poorly these conditions were rated by the APA's own field trials, which were flashing warning signs about unreliability, that they went ahead with them really is a serious concern.

DSM-5 is also, frankly, a disaster for children assigned behavioural disorders. It sets the threshold for such disorders far too low, as it does for many other, poorly defined conditions such as generalised anxiety disorder, with which it's now even easier to be diagnosed and thus, by extension, medicated.

Helene Guldberg: You wrote in your *Psychology Today* blog last year: 'Although the APA can't officially accept an ounce of responsibility for the 40-fold increase in diagnoses of bipolar disorder in children, shortly after *DSM-IV* eliminated 'mania' as a required symptom for bipolar disorder type 2, the organisation does fortunately seek to remedy the diagnostic crisis. The problem is it has taken entirely the wrong action, devising a new disorder to conceal problems in the framing and real-world application of previously defined ones.' You warned that *DSM-5* was certain to 'include highly controversial changes'. So did this turn out to be the case?

CL: Unfortunately yes. Children exhibiting prolonged temper tantrums can now be diagnosed with disruptive mood dysregulation disorder. That's along with ADHD, oppositional defiant disorder, and bipolar disorder, which are already in the manual and share a great deal of overlap. And the elimination of the bereavement exclusion clause will mean that depression can now be diagnosed among the recently bereaved after just two weeks. David Kupfer, chair of the *DSM-5* task force, told the *New York Times* that psychiatrists and GPs would just need to exercise 'good solid clinical judgment' in distinguishing between mourning and depression, when at 14 days both share a large number of symptoms, including insomnia, loss of appetite, listlessness, and intense mood swings.

The knock-on effect of these decisions—the unintended consequences that are frustratingly obvious and easy to predict - are truly what concern me. Because even when there's an uproar - and there *was* this time over the decision to delete the bereavement exclusion clause, with the *Lancet* calling the proposal 'dangerously simplistic' and 'flawed' - the APA showed that it is largely impervious to even such expert medical concern.

And it's not as if these judgments were voices in the wilderness. Thomas Insel, director of the US National Institute of Mental Health, the world's largest funding agency for research into mental health, asserted just two weeks before *DSM-5*'s publication: 'The weakness [of *DSM-5*] is its lack of validity.' You couldn't get a blunter assessment than that, especially from an agency that had thrown its weight and considerable budget behind earlier editions. To let the APA save face, Insel walked back some of his criticism, but it was really a case of 'more truth than the system can bear'. Suddenly, many who'd been highly critical of the manual began implying, 'It's all we have, people, so it's time to mute concern about whether it's actually reliable and what it says is actually true'.

HG: Some are suggesting that the power and influence of the *DSM* has been exaggerated. Does what is in the *DSM* really matter? Will the revisions have an effect on people's lives?

CL: Yes, it does matter - and, quite definitely, the revisions *will* affect people's lives. In the UK and across Europe, there's been widespread concern among professional groups – including, most recently, the British Psychological Society's Division of Clinical Psychology (DCP) – about the extensive reach of the *DSM* and how it impacts definitions in the International Classification of Diseases, the system Britain technically follows. There's tremendous pressure to make the *DSM* and ICD synchronise, which raises well-founded fears about what the ICD would then be synchronising itself to.

HG: But Simon Wessely, professor of psychological medicine at the Institute of Psychiatry, King's College London, suggests the *DSM* has little effect in the UK, stating that 'in practice, most UK mental health professionals will

barely notice much difference'. Is this true?

CL: No, sadly, it's not. The *DSM* of course has less influence in Britain than in the US, but that's on a scale of saying that in the States the *DSM* is consulted daily across the nation's schools, courts and prisons, as well as in its consulting rooms and health-insurance agencies. Still, the manual also greatly influences the research agenda for psychiatry and related pharmaceuticals in the UK and around the world. And it doesn't just respond to changes in mental health (a standard, untrue defence by the APA); it also very much helps *set* those changes. Even minor revisions to the manual can thus have massive, unforeseen consequences, including for public-health diagnoses and worldwide prescription rates for drugs treating depression and anxiety, and the organisation has introduced dozens of new disorders since the *DSM*'s colossal expansion in the 1980s.

HG: One of the criticisms of the *DSM* is that it is part of a wider reshaping of our understanding of what it means to be human: the pathologising of everyday experiences. Do you agree? In this sense, is the *DSM* not part of a wider cultural problem – where humans are seen as excessively vulnerable and in need of protection from difficult emotions and experiences? Should we be directing all our ire at the *DSM*?

CL: When the penultimate chair of the *DSM* task force can write a book about the new one called *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis*, as he just has, you know there's more than a grain of truth to concern that psychiatry has spent the past three decades, in particular, turning significantly large numbers of human conditions into treatable disorders. Just follow the numbers: between them, the third and 'third revised' editions added 112 new disorders to the roster, almost doubling overnight the number of mental disorders said to exist. *DSM-IV*, from 1994, added 58 more. This is on a scale we see 'nowhere else in medicine', as David Healy put it in *The Antidepressant Era*. An unprecedented expansion, itself based on research that, as one consultant admitted to the *New Yorker* magazine, 'was really a hodgepodge – scattered, inconsistent, ambiguous'. So, what's in the *DSM* matters a lot, even though the manual plays an outsized role in defining mental health and illness.

HG: Is there a contradiction between criticising the pathologising of everyday emotions and a desire to help those with serious psychological difficulties who may benefit from drugs or other forms of therapy?

CL: No, I don't think so. The fundamental concern is human suffering and the ongoing effort to alleviate it. But the related problems here are several: the massive expansion of mild psychiatric disorders, with ever-lower thresholds, has taken resources and attention from the truly chronic ones. Biological psychiatry is now completely dominant in American psychiatry, and has been for several decades, but the results and reliability it promised have proven mostly elusive (the current success rate stands at three per cent of all defined mental disorders).

Rather than expanding their focus, to address environment factors and patient testament, researchers are now doubling-down on the need to pursue 'biomarkers' even more exclusively. Drug regimens also come with a litany of side effects, many of them serious, so it matters greatly that people do *not* receive treatments they don't in fact need. That's why the stakes are high. The *DSM* isn't just an interesting map, as Simon Wessely put it most inaccurately, as if it were purely descriptive, its effects broadly theoretical; it's also a legal document facilitating the medication of millions, often after just minutes of consultation. It's also a manual that's highly prescriptive in its adjustment of norms and shrinking of normalcy - witness the new possibility to diagnose depression among mourners after just 14 days.

That's why it's so necessary to show that the manual's power is unwarranted and misplaced. It's also why I try to underscore that there are excellent empirical studies demonstrating the powerful benefits of other forms of treatment and therapy besides medication.

Helene Guldberg is author of *Reclaiming Childhood: Freedom and Play in an Age of Fear*, published by Routledge. (Buy this book from Amazon(UK)) and *Just Another Ape?*, published by Imprint Academic. (Buy this book from

Amazon(UK).)

COMMENTS