

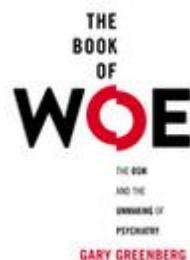
DSM-5: The Perfect Storm

A Review of

Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life

by Allen Frances

New York, NY: Morrow, 2013. 314 pp. ISBN 978-0-06-222925-0. \$27.99



The Book of Woe: The DSM and the Unmaking of Psychiatry

by Gary Greenberg

New York, NY: Blue Rider Press/Penguin Group, 2013. 403 pp. ISBN 978-0-399-15853-7. \$28.95



Our Necessary Shadow: The Nature and Meaning of Psychiatry

by Tom Burns

London, England: Allen Lane/Penguin Group UK, 2013. 333 pp. ISBN 978-1-846-14465-3. \$27.95

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Reviewed by

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The first national nomenclature, the *Diagnostic and Statistical Manual of Mental Disorders (DSM-I; American Psychiatric Association, 1952)*, gave U.S. clinicians a valuable, though limited, common vocabulary of disorders. The nomenclature was disparaged for its sketchy syndrome descriptions and resultant unreliable diagnoses, its heavy reliance on psychoanalytic terms and concepts to structure many of its diagnoses, and its exclusive dependence on the diagnostic expertise of a select group of prestigious male psychiatrists. No empirical data informed the process.

The second edition (*DSM-II; American Psychiatric Association, 1968*) was censured for similar reasons, even though its developers made modest efforts to respond to concerns about *DSM-I*, including the influence of psychoanalytic theory on diagnostic terms.

DSM-III (American Psychiatric Association, 1980) revolutionized the diagnostic process by introducing operational criteria that were much more extensive and carefully wrought than were the few diagnostic cues for each syndrome sketched out in the first two

nomenclatures. The operational criteria, along with the decision-tree models by which they were to be applied, successfully enhanced diagnostic reliability.

Some of the operational criteria were informed by empirical data from limited field trials, also a first. A multiaxial system designed to increase the usefulness of the diagnostic process was also introduced. The *DSM-III* Task Force included a few women and people of color, as well as one psychologist, thereby modestly broadening the range of professional representation brought to the nomenclature. Notwithstanding these improvements, *DSM-III* also generated heated controversy over a two-fold increase in the number of diagnostic labels (from 106 in *DSM-I* to 265 in *DSM-III*), including an even greater increase in the number of diagnoses for children and adolescents; for “sacrificing validity on the altar of reliability” (Vaillant & McCullough, 1998, p. 140); and for what many felt was an effort, largely unsupported by research, to highlight psychopharmacological treatments and emerging neuroscience findings in an attempt to reinforce psychiatry’s stature as a medical discipline.

The *DSM-IV* Task Force, led by Allen Frances, author of *Saving Normal*, sponsored an extensive series of field trials that examined a wide range of alternative operational criteria; the results were reported in a set of volumes that captured the workings of the developmental process. The composition of the Task Force and work groups was even more diverse than for *DSM-III*. Moreover, leaders of the *DSM-IV* process worked hard to restrain new diagnoses and limit the scope of existing diagnoses in response to persistent concerns that *DSM-III* had imposed diagnoses on many persons who were not mentally ill. Despite these advances, *DSM-IV* (American Psychiatric Association, 1994) was condemned for many of the same shortcomings for which *DSM-III* had been criticized.

Saving Normal: An Insider’s Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life

The title of Allen Frances’s book says a great deal. Above all, it confirms that he wrote the book to document why he rejected many of the decisions made by the leadership of both American psychiatry and the *DSM-5* revision process. He did so in hopes of heading off an avalanche of new and broadened diagnostic terms and a subsequent explosion in the numbers of persons unjustifiably diagnosed with mental illness. Because diagnosis is “out of control,” *saving normal*—reducing the number of new patients with unnecessary diagnostic labels—has become virtually impossible.

Frances’s *DSM-IV* experiences figure importantly in his reaction to *DSM-5* (also reviewed in *PsycCRITIQUES*: Millon, 2013; Neimeyer, 2013).

Despite our efforts to tame excessive diagnostic exuberance, *DSM-IV* has since been misused to blow up the diagnostic bubble. Even though we had been boringly modest in our goals, obsessively meticulous in our methods, and rigidly conservative in our product, we failed to predict or prevent three new false epidemics of mental disorder in children—autism, attention deficit, and childhood bipolar disorder. . . . If a cautious and generally well-done *DSM-IV* had probably resulted in more harm than good, what were the likely negative effects of a carelessly done *DSM-5*? (p. xiv)

Saving Normal's subtitle identifies two of the principal villains responsible for over-diagnosis: Big Pharma and psychiatrists who medicalize ordinary life. Here is Frances on Big Pharma:

Big Pharma is really big and incredibly successful. Worldwide sales exceed \$700 billion each year . . . and the profit margin, at a whopping 17 percent, is among the highest of any industry. Why so big and so successful? The companies justify their high prices and enormous returns by touting their research effort to advance medical science and improve patient care. This is mostly fluff. Pharma spends twice as much money (\$60 billion) on promotion as on research. (p. 90)

And on the medicalization of ordinary life:

In the early 1980s, about a third of Americans qualified for a lifetime diagnosis of mental disorder. Now about half do. . . . Some people think these are underestimates—more carefully done prospective studies actually double the lifetime prevalence. If you believe the results, our population is almost totally saturated with mental disorders. (p. 104)

These are substantial indictments. Frances expresses them forcefully, although without naming names. However, few readers can be unaware of whom Frances regards as the villains. For those few readers uncertain of their identity, there is Gary Greenberg's book, *The Book of Woe: The DSM and the Unmaking of Psychiatry* (which I discuss below); it focuses on who the perpetrators are, what they said or did, and how others responded to their actions.

There is even more. Frances indicts the unnamed leaders of *DSM-5* for "a cautionary tale of soaring ambition, poor execution, and a closed process" who "wildly overpromised, then failed to meet minimal performance standards" (pp. 170–171). Their failures included an astounding lack of oversight of the *DSM-5* developmental effort, poorly designed and inadequately monitored field trials that were not completed, and vain attempts to deliver on the promise of a substantial move from categorical to dimensional diagnosis. As well, and perhaps most damning,

the excessive *DSM-5* ambition to effect a paradigm shift in psychiatric diagnosis [included] the unrealistic goal of transforming psychiatric diagnosis by somehow basing it on the exciting findings of neuroscience. This would be wonderful were it possible, but the effort failed for the obvious reason that it is still a bridge too far. (p. 171)

Frances also identifies "several sure-fire fads of the future" (p. 176) in *DSM-5*. All were rigorously questioned when initially proposed, yet all made it into the published nomenclature. Frances's criticisms include a new diagnosis that he fears will dramatically and unjustifiably increase the rate of mental illness among children: *disruptive mood dysregulation disorder* (DMDD), which turns "temper tantrums into a mental disorder" (p. 177). He laments the introduction of *mild neurocognitive disorder* (MND), which he believes mislabels the minor cognitive changes of normal aging as a mental disorder.

Frances also questions the introduction of *binge eating disorder* (BED), “a very low threshold disorder” (p. 182) likely to capture at least 3 to 5 percent of the population (including Frances himself). Other concerns about changes in the nomenclature include easing of criteria for adult attention-deficit/hyperactivity disorder (ADHD; “Unchastened by the false ‘epidemic’ of ADHD already running rampant among kids, *DSM-5* has set the stage for creating a new epidemic of ADHD in adults”; p. 184), a similar easing of criteria “to diagnose major depressive disorder (MDD) among the bereaved . . . a stubbornly misguided decision in the face of universal opposition” (p. 186), and the addition of pathological gambling to *DSM-5*’s roster of substance-related addictions, which will set off a series of “false epidemics of [nonsubstance] addictions” (p. 189).

Frances’s criticisms of *DSM-5* differ markedly from the faultfinding of prior *DSM* editions. In the first place, the book appears after several years of blogs and op-ed pieces by Frances and others of escalating intensity published in prominent outlets. The book recapitulates its author’s many and varied concerns about the *DSM-5* process and substance, as well as rejoinders to them by American Psychiatric Association staff and *DSM-5* leaders. Frances describes his efforts to share these concerns—and his assessment of the consequences of doing so—as follows:

I have spoken to the APA [American Psychiatric Association] leadership; written four warning letters to the APA Trustees; posted countless blogs; published numerous editorials and papers; given talks at professional and public meetings and appeared on radio and television—all warning about the risks that *DSM-5* will mislabel normal people, promote diagnostic inflation, and encourage inappropriate medication use. I have not been alone in trying to save normal. . . . But overall we failed. (p. xviii)

Frances is an “insider,” a prominent psychiatrist who spent a term as chair of the Department of Psychiatry at Duke University and headed the *DSM-IV* Task Force; these positions give his opposition to *DSM-5* and organized psychiatry a good deal of credibility. No similarly prominent psychiatrist led such a sustained attack on any of the prior *DSMs*. Moreover, and importantly, Frances’s attacks on *DSM-5* raise substantial questions about the worth of continuing to use behavioral diagnosis and to further update the *DSM*.

Other prominent psychiatrists, including Thomas Insel, director of the National Institute of Mental Health (NIMH); Steven Hyman, a former NIMH director; and Eric Kandel, a Nobel laureate, have also questioned continued reliance on diagnosis based on symptoms in favor of diagnosis based on neurobiological markers. Unfortunately, almost no biomarkers have yet been identified, and their widespread use appears likely to be well into the future.

No Role for Psychology in *Saving Normal*

It is surprising—and disappointing—that, in a 314-page book devoted to *DSM-5*, almost nothing is written about psychology’s contributions to assessment and diagnosis. Given the vitriol Frances expresses about his colleagues in psychiatry, that omission is probably just as well, especially because both of his mentions of psychology in *Saving Normal* are denigrating. In asking, “Can Psychology Ride to the Rescue?” (p. 12) of behavioral diagnosis, Frances answers, “Sadly no” (p. 12) because psychological tests have not and cannot set the boundary between who is normal and who is not. Psychologists have studied and debated this matter for years; Frances dismisses it with a few words.

To the question “Which discipline does diagnosis best?”, Frances concludes unsurprisingly that, among a list of psychiatrists, psychologists, psychiatric nurse-practitioners, social workers, counselors, and psychiatric occupational therapists, he thinks the training and skills of psychiatrists are preeminent—followed by those of psychologists. Aside from the fact that the question is frivolous, one has to ask about the basis for the author’s judgment because he cites no data.

Overall, I missed meaningful and informed discussion of the role of all members of the traditional mental health team in a book devoted to the diagnostic process. Admittedly, Frances’s focus is on the shortcomings of his disciplinary colleagues, but there is a good deal he might have written about psychologists and other nonpsychiatrists who have played important roles in diagnostic systems.

Final Word

Frances strongly believes that the new nomenclature has taken a step—or more—backward, judged by the failures of the *DSM-5* Task Force to restrain further overdiagnosis and unnecessary drug treatment, to deliver on promises of openness and transparency, to complete a credible and useful set of field trials, to implement dimensions in the diagnosis of the personality disorders, to make good on completion timetables, to identify diagnostic biomarkers, and to avoid giving in to the lure of new diagnoses for which justification appears to be lacking.

The Book of Woe: The DSM and the Unmaking of Psychiatry

Much of what Greenberg writes about the making of *DSM-5* in *The Book of Woe* echoes Allen Frances’s views; the substance of their concerns is very much the same. What is different is the manner in which those concerns are expressed. Frances largely avoids naming those who he thinks are responsible for the failures of the American Psychiatric Association and *DSM-5*. By contrast, Greenberg, a journalist and practicing psychotherapist, wrote his book largely from interviews with an impressive array of *DSM-5* critics and supporters whom he names.

Frances does identify in his book those who in his opinion have worked through the years to mitigate the historic shortcomings of the *DSMs*. Robert Spitzer, Frances’s supervisor and colleague at Columbia University and a longtime friend, is mentioned frequently and admiringly. Notably, at Spitzer’s retirement dinner, Frances referred to him as “one of the most important psychiatrists who had ever lived, placing him in the company of Freud and Kraepelin” (Greenberg, p. 168).

Like Frances, Greenberg praises Spitzer’s contributions to enhanced and systematized diagnosis, even while he shares interview material that highlights Frances’s and Spitzer’s complicated relationship. To this end, although Frances was apparently quite concerned that his criticisms of the *DSM* might detract from Spitzer’s earlier contributions, he nonetheless strongly criticized Spitzer’s role in the proliferation of *DSM-III-R* (American Psychiatric Association, 1987) diagnoses: “Bob couldn’t resist playing with it. He couldn’t resist the

committee meetings, all the new diagnoses, all the excitement" (p. 44). As a result, *DSM-III-R* added to the overdiagnosis of which both *DSM-III* and *DSM-5* were accused.

However, Greenberg adds, Frances clearly learned the hazards of "mission creep": "When the *DSM-IV* was released, it was nearly four hundred pages longer than the *DSM-III-R*, but most of the expansion was in the explanatory sections. Only a few new diagnoses had crossed Frances's threshold" (p. 48).

Greenberg doesn't hide his admiration for Frances and Spitzer, whom he considers the heroes of the *DSM* story. Another hero, albeit of somewhat lesser magnitude, is Michael First, a psychiatrist who served as text editor for *DSM-IV* and editor of the *DSM-IV-TR* (American Psychiatric Association, 2000). In those roles, First played an essential role in ensuring the accessibility of these instruments to mental health professionals. Inexplicably, First was shut out of the *DSM-5* process until a time and performance crunch forced the *DSM-5* Task Force again to call upon him to text edit.

Greenberg also gives credit to psychologist Tom Widiger, an authority on dimensional approaches to the personality disorders. Although Widiger had made a number of substantial contributions to *DSM-IV*, without explanation he, too, was left out of the *DSM-5* process.

David Kupfer and Darrel Regier, leaders of the *DSM-5* Task Force, are the principal villains in *The Book of Woe*. Greenberg clearly cherishes both Frances's attacks and his own on Regier's and Kupfer's decisions and performance throughout the process. He also delights in sharing the reactions to these criticisms by Regier and other *DSM-5* and American Psychiatric Association leaders.

For example, Greenberg quotes Regier as remarking, of Frances, as early as 2010, "His major critique [was that] nothing has changed in the scientific world since his revision and hence no substantive revision is possible" and "that his judgment on the pragmatic consequences of revisions should take precedence over any of the experts" (p. 138). In other words, according to Greenberg's understanding of Regier's comments, Frances was

trumping up his personal grievance into a broadside against the institution he once served and in the bargain calling into question the credibility of the APA. . . . Blinded by pride, he had become his own kind of antipsychiatrist and, even worse, a turncoat. (p. 138)

Frances has always been his own most severe critic. So it is not surprising that he should assess the impact of his three-year battle with the leaders of *DSM-5* and American psychiatry as an unmitigated disaster:

The controversy stirred by my critique of *DSM-5* is a terrible moment in the history of psychiatry. This is the worst thing to happen to the field's credibility since Rosenhan—and psychiatry is a field that especially requires credibility to be effective. I know I have done great harm. (as quoted by Greenberg, p. 329)

Greenberg's comments on the fallout from criticisms of *DSM-5* in a recent *New Yorker* blog are no less hyperbolic:

But never has the [DSM revision] process provoked warfare so brutal, with attacks coming from *within the profession* as well as from *psychiatry's usual opponents*. Indeed, it's possible that no book has been subject to such scrutiny in the course of being written. (Greenberg, 2013, para. 1)

Final Word

If you have time to read only one book critical of *DSM-5*, I suggest you read Frances's *Saving Normal*. Reading Greenberg's *The Book of Woe* will not add much to what you know of *DSM-5*'s shortcomings. What you will learn is what Greenberg quotes his interviewees—many of them principal players in the conflict—as thinking and saying about others involved in the conflict. Much of this material is fascinating. I am entertained by all of it. Greenberg writes very well.

Our Necessary Shadow: The Nature and Meaning of Psychiatry

After the Sturm und Drang of *Saving Normal* and *The Book of Woe*, reading *Our Necessary Shadow: The Nature and Meaning of Psychiatry* is a bit like leaving behind the clamor and confusion of metropolitan London for a leisurely walk through the quiet streets of a Cotswold village, accompanied by a wise, erudite friend. Tom Burns, chair of the Social Psychiatry Department in the medical school of the University of Oxford, has written a concise history of psychiatry and shares his views on important psychiatric matters in this book. Burns projects a humane, tempered view of the issues with which psychiatrists and nonpsychiatrists alike have long been concerned, including many of those debated in the pages of the books by Frances and Greenberg.

Perhaps of greatest interest to readers of this review is the material in four chapters in the section of *Our Necessary Shadow* titled *The Questions Psychiatry Asks About Us and the Questions We Ask of It*. Space constraints permit only brief excerpts from Burns's thoughtful answers to these substantial questions.

"Is Mental Illness Real? Psychiatry's Legitimacy"

This new group [of antipsychiatrists] are, as it were, *evidence-based anti-psychiatrists*. They may share a deep suspicion of the fundamental legitimacy of psychiatry and psychiatric diagnoses; most undoubtedly do. However, their arguments are generally that psychiatry is too full of itself, or is corrupted by pharmaceutical companies, or that it makes endless mistakes. It is the *damage* done by psychiatry and psychiatrists that they warn against. (p. 182)

"Is Psychiatry Trustworthy? Psychiatry's Sins and Abuses"

Few professions have not made mistakes. . . . On balance I find little evidence that [psychiatry] has been uniquely evil . . . psychiatry labours under a unique double-standard. Limitations in efficacy and unwanted consequences that we quite readily

accept in general medicine and surgery become damning indictments in psychiatry. One of the main aims of this book is to provide enough background to put these things in perspective. (p. 208)

"Is Bad Behaviour Any of Our Business? Psychiatry and the Law"

The relationship between the law and psychiatry is often uncomfortable. We certainly do have different ways of thinking. On the whole, however, the adversarial nature of courtroom interactions has sharpened thinking on both sides to mutual benefit. . . . For all its limitations, psychiatry's contributions to legal decision making has probably been a significant force for good. (p. 223)

The fourth chapter in this section, titled "A Diagnosis for Everything and the Medicalization of Everyday Life," considers some of the concerns about diagnosis that led to the inclusion of this book in this multibook review.

"A Diagnosis for Everything and the Medicalization of Everyday Life"

First, Burns raises the familiar issue of the medicalization of everyday life by acknowledging the remarkable increase in both heft and number of diagnoses in every edition of the *DSM* from 1952 (130 pages, 106 disorders) to *DSM-IV* (886 pages, 297 disorders). But he also observes that "the threshold for diagnosis and treatment has been steadily lowering in all branches of medicine, accompanied by an ever lengthening list of diseases." In fact, "the number of diagnoses has increased by about 20 percent per decade in both psychiatry and general medicine" (p. 226). In this context, Burns reminds us of psychiatry's special problems with diagnoses, including their subjectivity, expansion into "an ever-wider range of human problems" (p. 226), adoption of the *DSM's* "criterion-based diagnoses," and the role of the pharmaceutical industry in overdiagnoses.

All of these issues are also considered—and most are severely criticized—in Frances's and Greenberg's books. Burns, a social psychiatrist by training and experience, reaches a very different conclusion:

A psychiatric diagnosis may be the only passport to the warmth, shelter, attention, and affection previously available from families. For those with severe emotional problems, professional services may be their only chance, and for this their problems have to be "medicalized" in some form or other. (p. 230)

Burns next addresses another familiar question, "Are addictions mental illnesses?" (p. 234). Early in this discussion he admits that "the benefits of considering addictions as diseases are several" (p. 234) and then lists them. But the downsides of addictions being categorized as mental illness outweigh the benefits. Above all,

if we consider the addictions as basically harmful habits then both the responsibility for them and the ability to change them lie primarily with the addict. This is not so with mental illnesses. . . . [This] does not mean that mental illnesses are serious and addictions are not. Far from it, addictions are very serious. (p. 235)

Presumably, Burns would have the addictions deleted from *DSM-5* and *ICD-11*.

Burns also raises another long-standing issue, that of the personality disorders, asking whether they are the same as mental illnesses and whether treatment for them works. To the second question, he gives a definite “no.” Nonetheless, given the ubiquity of some of the personality disorders, Burns believes that psychiatrists should be trained to identify and work with persons who present with them and that these categories are important, largely because of their co-occurrence with so many other psychiatric disorders.

Finally, Burns takes up the issue of *criterion-based diagnoses*, first introduced by Spitzer in *DSM-III*. In “A Case in Point,” quoting from Blazer (2005), he contrasts the criterion-based diagnosis of major depressive disorder, recurrent, in a 46-year-old woman with anxiety and depression in 2003 with a traditional diagnostic formulation given in 1963 that recognized her many symptoms of anxiety and depression, including loss of sleep, subjective anxiety, and loss of appetite, and that took into consideration her life circumstances, which included a divorce three years in the past. Not surprisingly, Burns finds the older diagnostic approach more helpful than the contemporary one, ultimately recommending a hybrid approach to diagnosis that retains the potential of traditional diagnosis for enhanced diagnostic validity but adds to it the increased reliability of criterion-based diagnosis.

Final Word

Burns accords a number of the incendiary issues stemming from the *DSM-5* process a more reasoned perspective, which reflects a bracing admixture of lessons from psychiatry’s history and equal doses of humanity and common sense. His book was written just as many of the controversies arising from *DSM-5* reached their boiling points, as recounted in *Saving Normal* and *The Book of Woe*. Burns’s book reminds us that psychiatry and the other mental health professions, sources of so much conflict, also represent some of modern life’s most humane aspirations.

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Footnotes

Disclosure: Peter E. Nathan was psychology's representative to the *DSM-III* process and a member of both the *DSM-IV* Task Force and its Substance Use Disorders Work Group. He had no involvement in the making of *DSM-5*.