COUNCIL FOR EVIDENCE-BASED PSYCHIATRY

Psychiatric diagnostic manuals such as the DSM and ICD (chapter 5) are not works of objective science, but rather works of culture since they have largely been developed through clinical consensus and voting. Their validity and clinical utility is therefore highly questionable, yet their influence has contributed to an expansive medicalisation of human experience.

The DSM (Diagnostic and Statistical Manual of Mental Disorders) is the book that lists and defines all of the mental disorders believed to exist. In May 2013 its 5th edition was published (entitled DSM-5), amid considerable controversy. Some central criticisms of DSM-5 were summarised in an online petition that went live in 2012, protesting its publication. It was endorsed by over 50 organisations, including The British Psychological Society, the Danish Psychological Society and the American Counseling Association. The arguments stated that DSM-5:

1. By lowering the diagnostic thresholds for warranting a diagnosis, may lead to more people being unnecessarily branded mentally ill.
2. By including many new disorders that appear to lack scientific justification, there will be more inappropriate medical treatment of vulnerable populations (children, veterans, the infirm and the elderly).
3. By deemphasizing the sociocultural causes of suffering, biological causes will continued to be wrongly privileged.

The petition concluded: 'In light of the growing empirical evidence that neurobiology does not fully account for the emergence of mental distress, as well as new longitudinal studies revealing long-term hazards of psychotropic treatment, we believe that these changes pose substantial risks to patients/clients, practitioners, and the mental health professions in general'.[1]

One of the more controversial changes in DSM-5 is that under certain circumstances grief can now be classified a symptom of mental disorder. While previous editions excluded bereaved people from being diagnosed with a major depressive disorder, DSM-5 has removed that exclusion. This means that as early as two weeks after the death of a loved one, if a person experiences deep sadness, loss, sleeplessness, crying, inability to concentrate, tiredness and low appetite, they can be diagnosed with depressive disorder. Critics argue that this will inevitably lead to many more thousands (perhaps even millions) of people be diagnosed and medicated unnecessarily. This pathologisation of grief has been strongly criticised by over 100,000 grievers worldwide,[2] in over 100 critical articles in the world press, in two eloquent pieces in The *Lancet* and in one in the *New England Journal of Medicine*.[3] Despite this widespread opposition, the DSM-5 decision stands.

Criticisms of the DSM are not just reserved for DSM-5. The entire DSM project (developed cumulatively over consecutive editions) is now under sustained attack. For example, we now know from extensive interviews with the creators of its previous editions (DSM-IV and DSM-III), that its construction was far less rigorous than many had assumed. For example, while DSM III listed 265 disorders (most of which still exist in DSM-5 largely unaltered), we also know that most these were established on the basis of scant and largely inconsistent research. As the Chairman of DSM III, Robert Spitzer, put it:

> *For many of the disorders that were added, there wasn't a tremendous amount of research, and certainly there wasn't research on the particular way that we defined these disorders.*[4]

As a key member of his taskforce, Theodore Millon, echoed:

> *There was very little systematic research, and much of the research that existed was really a hodgepodge – scattered, inconsistent, and ambiguous. I think the majority of*

> *us recognized that the amount of good, solid science upon which we were making our decisions was pretty modest.*[5]

Without solid data to guide them, they relied upon reaching consensus among themselves about whether to include new disorders and, if so, how they should be defined. As another taskforce member, Donald Klein, states:

> *We had very little in the way of data, so we were forced to rely on clinical consensus, which, admittedly, is a very poor way to do things. But it was better than anything else we had… If consensus were not reached, then the matter would be eventually decided by a vote*.[6]

The centrality of this voting or 'consensus method' has greatly undermined the manual's legitimacy, casting suspicion upon its vast expansion – from 106 disorders in 1950 to around 370 today (counting the appendix inclusions and subdivisions). Critics point out that this vast expansion could occur because it is easier to 'vote' new disorders into existence than it is to scientifically discover them.[7] Critics have also suggested that the DSM's rapid expansion, coupled with its lowering of thresholds as to what constitutes mental illness, has progressively and wrongly brought more and more human experience under psychiatric jurisdiction, creating the illusion of a psychiatric epidemic (if DSM-based estimates are to be believed, 1 in 4 of us suffer from a mental health disorder in any given year).[8]

Critics further point out that this expansion has helped provide sanction and impetus to vaulting psychotropic prescription rates; rates amplified by decades of pharmaceutical industry marketing, physician and departmental funding, as well as research and regulatory 'capture'.[9]

In April 2013 Thomas Insel, the president of the National Institute for Mental Health (NIMH), the largest funding body for mental health research globally, stepped up the criticism of DSM by declaring that the 'NIMH will be re-orienting its research away from DSM categories…[because the DSM's] weakness is its lack of validity'. As he continued:

> *Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever*.[10]

Insel proposes we replace the DSM with a system that he hopes will someday be better grounded in biological research. Whether Insel's solution is viable or not, his central point is nevertheless important: the NIMH is moving away from the DSM because it was not founded on any solid research base.

The DSM vs ICD in the UK

Chapter 5 of the ICD (International Classification of Diseases) is the WHO's alternative to the DSM. Many British psychiatrists have argued that as we use the ICD in Britain, British psychiatry is largely exempt from these criticisms. This position is flawed for two reasons.

Firstly, the DSM has been highly influential in British psychiatry – both clinically and in terms of guiding research. In fact, the DSM has guided nearly all psychiatric research into mental disorders in Britain. Furthermore, the NICE guidelines in the UK dedicate as much time to the DSM as the ICD and actually recommend the use of the DSM over the ICD for particular conditions including depression.[11] In short, the DSM has significantly influenced British research and practice.

Secondly, the argument that 'we use the ICD therefore we are exempt', seems to assume that the ICD is a superior manual. The facts suggest it is not. Firstly, it contains almost as many disorders as the DSM, including those such as female orgasmic disorder, caffeine related disorders, stammering, stuttering,

reading disorder, transexualism, oppositional defiance disorder, non-compliance with treatment, and so on. Furthermore, the ICD's research base is no more solid than the DSM's. After all, the ICD was constructed via the very same voting and consensus system dominating the DSM. Finally, both ICD and DSM teams worked closely to cohere both manuals to safeguarded against there being two radically different diagnostic manuals within psychiatry.

CEP supports an independent review into the utility and validity of manuals such as the ICD (Chapter 5) and DSM. We believe both manuals have led to the unnecessary medicalization of people on a comprehensive scale, which has led, in turn, to more people needlessly suffering the stigma of being labeled mentally ill, and to more being unnecessarily prescribed potentially harmful psychiatric drugs. CEP believes such widespread and unjustified medicalisation, and thus medicating, of human experience is creating more human and societal problems than it is solving.

To contact us or for more information please visit cepuk.org.

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[1] See: http://www.ipetitions.com/petition/dsm5/

[2] See the Lancet: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60248-7/fulltext

[3] See: http://www.psychologytoday.com/blog/dsm5-in-distress/201203/turning-point-dsm-5

[4] Davies, J., 2013, Cracked: why psychiatry is doing more harm than good (London: Icon Books)

5 Quoted in: Angell, M, 2009, Drug Companies & Doctors: A Story of Corruption, *The New York Review of Books,* January 15

[6] Davies, J., 2013, Cracked: why psychiatry is doing more harm than good (London: Icon Books)

[7] Greenberg, G., 2013, The Book of Woe: the DSM and the unmaking of psychiatry (New York: Scribe)

[8] Horwitz A. V. & Wakefield J. C., 2012, The Loss of Sadness (New York: Oxford University Press); Caplan P, J., 1995, They Say You're Crazy (New York: DaCapo Press)

[9] Davies, J., 2013, Cracked: why psychiatry is doing more harm than good (London: Icon Books); Kutchins, H., Kirk, S. A., 1997 Making us Crazy (New York: Free Press)

[10] http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml

[11] http://www.nice.org.uk/nicemedia/pdf/cg90niceguideline.pdf