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How Psychiatry's Discontents Became a Sea Of Disdain, Controversy & Confusion

A review of DSM a History of Psychiatry's Bible

Abstract

The issue of DSM-111 (the little blue book) in 1980 changed the face of psychiatry. It was intended to put the discipline on a scientific footing, ensure reliability of diagnoses and provided the basis to elucidate the scientific causes of such disorders.

It has however failed in almost every task set out, with succeeding iterations leading to even more controversy, culminating in DSM-5 in 2013.

DSM has had enormous success in terms of distribution and income for the APA but led to great controversy as evidenced by the growing number of critical articles and books.

This review of Allan Horwitz's book looks at the background to the controversy and the ongoing crisis for psychiatry.

Keywords

Allan Horwitz, DSM, Psychiatry Classification, Robert Spitzer, Pharmaceutical companies, Health Insurance

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Psychiatry, the medical discipline that treats disorders of the mind, has ever been a source of controversy. The mind, after all, is simply the modern term for what used to be considered the soul, usually the territory colonised by theologians or philosophers. Originally the province of the mad doctors, in the last two hundred years disturbances of the mind have crept and clawed their way into the ranks of mainstream medicine, providing the scientific and establishment status it needed.

If the vicissitudes of psychiatry over the following decades that came and went – and there were many –were the equivalent of perigean tides, this was nothing compared to the present state of desuetude which can be best compared to the debris left after a tsunami.

There are many causes of this state but a central issue, the veritable epicentre of the quake, can be attributed to a neat little blue pocket book – cerulean shades of Mao's *Little Red Book* – entitled the *Diagnostic & Statistical Manual* of the American Psychiatric Association (always known as DSM). Among the great books that have changed the course of history, its *verbrente* critics regard it as the *Mein Kampf* of the discipline. Perhaps the only equivalent is *Psychopathia Sexualis* by Richard von Krafft-Ebing, the first medical book to attain pornographic status.

The issue at stake goes to the beating heart of psychiatric epistemology: making sense of psychiatric illness – madness, if you will. Just as Carl Linnaeus classified all of nature, so was the intention to categorise the disorders of the mind which would render them accessible to scientific study from which treatment would hopefully emerge.

The process started with Philippe Pinel – the figure who largely defined the discipline as we know it[1] – and his epigone Jean-Étienne Esquirol – whose lasting contribution was the diagnosis of monomania[2] – passing on to the Germans where the giant figures of Kraepelin and Bleuler established a robust structure that was to last a century before it began creaking alarmingly at the edges.[3]

World War 11 recast the issues of the earlier Great War. Psychiatric casualties were huge and the treatment was psychological, not physical.[4] Leading figures in the US military were psychoanalysts Roy Grinker and William Menninger whose influence on American psychiatry continued in post-war years.

When the conflict ended, psychoanalysis ruled supreme in America and this led to the first two DSMs (1952 and 1968): short, cheap and entirely based on the psychological basis of psychiatric disorders. No one paid attention; for pscychoanalytic psychiatry, a productive future lay ahead.

This illusion was not to last. It was started by the counter-culture environment of the Sixties. The anti-psychiatry movement started by Szasz, Laing, Goffman and others kicked into high gear.[5] The movie *One Flew Over the Cuckoo's Nest* played its part in persuading the public to see psychiatry as inherently oppressive. Michael Foucault, the French intellectual superstar, based on his rather dubious historical research, said that asylums represented the punitive arm of society.

If that weren't enough, then along came David Rosenhan. In 1973 the psychiatric profession was deeply shaken by a paper published in *Science*, purporting to show that psychiatric diagnosis was effectively useless.[6] "On Being Sane in Insane Places" by Stanford psychologist David Rosenhan described a unique experiment: Eight volunteer "pseudopatients" presented themselves at mental hospitals under fake names, complaining that they heard voices and were duly admitted.[7] The question asked was psychiatric diagnosis scientifically valid or merely a random, subjective and erratic process? Arguably the most influential psychological paper published in the last half-century, Rosenhan became a star and it is still one of the most cited social science papers, as well as prescribed reading in psychology and social work courses.

Rosenhan's findings, taken at face value, were very difficult to refute.[8] One motivation for the experiment not considered was one of the oldest: turf war. Psychologists, especially then, were excluded from many activities on which psychiatrists had a monopoly. Discrediting their practice would expand the opportunities for all mental health workers.

Rosenhan, however, did not get away unchallenged. Most of the criticism he could dismiss, but Robert Spitzer, a professor of psychiatry at Columbia – destined to be the leading figure behind DSM-111 – was of a different calibre.[9] Writing that "Some foods taste delicious but leave a bad aftertaste," he described the paper as pseudoscience presented as science and its conclusion a diagnosis of 'logic in remission.'

The Rosenhan paper led to a typhoon of discussion about the practice of psychiatry. It fed into the deinstitionalization movement, an agenda driven by governments, radicals, the counter-culture and others. Although not intended, the results of closing the hospital wards to discharge the patients were catastrophic. Community services never came close to meeting the needs of the discharged patients and the vacuum was filled by the streets and prisons, creating the depressing inner-city scenes so familiar today.

The American Psychiatric Association (APA), all too aware of the problems, decided that something had to be done: the result was the epochal DSM-111 in 1980. Its midwife was Robert Spitzer who had gone into psychiatric life with a Reichian analysis.[10] To what extent we can blame this for what followed is an interesting but unanswered question. Spitzer had a clear mandate: a disease classification that eschewed etiology (or, more correctly, etiological speculation), but instead open a path finding the scientific basis for the illnesses.[11]

The intentions of the DSM committee could not be faulted. Operational diagnoses provided a list of required symptoms, as well those that had to be excluded. For the first time diagnoses were categorised with listed symptoms, free of etiological presumptions, notably psychoanalytic. Disorders were established by a "tick-the-boxes" approach.

The little blue book, as it became known, was regarded as the most important psychiatric book of all time, making Spitzer one of the most influential psychiatrists of the twentieth century. The response to its publication was huge. Such a nodal point was it in the development of psychiatry that it is possible to consider events as anti- or post-DSM-111. And all this over a book that could fit in any pocket.

It was a Kuhnian paradigm shifter and the profession could now go on to a scientific footing that would hold its own in the academy, the clinic and the court. It took off like wildfire and was soon used in every country round the world with a few hold-offs like the French (to no surprise). It was eagerly adopted by government health departments, psychiatric hospitals, insurance companies and courts.

For the flailing psychoanalytic community, DSM-111 was the final nail in the coffin. Neurosis, the condition the analysts treated in their offices, was officially gone. Its death throes had taken a while, but it was now dead. As a consolation (or, rather, pay-off) they were left with *dysthymia*, a synonym for chronic depression, and several types of personality disorder: *borderline, narcissistic and masochistic*. This was very thin gruel indeed and a grim future lay ahead in dealing with health insurance companies that wanted everything neatly boxed and defined with evidence-based quantifiable treatment. For companies required to pay for psychiatric illness that can have a prolonged and difficult course, massive savings can be made by insisting on quantifiable sessions that can be judged against the far shorter number required for CBT treatments. The old saw that personal analysis was something restricted to the rich in cities like New York – think Woody Allen – was now a reality.

In all the hoopla, there were a few dissident voices but they were lost in the excitement. DSM rules OK! was the mantra and things could only get better in future. It had certainly brought an unprecedented benefit. In a triumph of medical marketing, the APA

had created a brand that may be as well known as *Apple* or *Coca Cola*. The APA made many millions of dollars and the rivers of gold will keep flowing with future editions.

But megabucks alone was not the solution. Had DSM solved the problems, not least epistemological, that beset psychiatric diagnoses?

If only.

The DSM-111 revolution actually reversed its intended goals. By providing a tick-box list for every disorder, it made instant diagnosis a reality for anyone who wanted to get into the mental health business. So much for the lengthy and careful psychiatric examination that had been refined over the years. If the APA had intended to use DSM to protect their domain, it in fact raised the portcullis for psychologists, social workers and therapists of multiple persuasions to get in on the act.

The squabbling over methodology and classification in succeeding years steadily escalated with parties becoming more antagonistic, akin to those theological disputes about angels dancing on the head of a pin.

The result has not been pretty. By the time of the next iterations, *DSM–III–R* (1987) and *DSM–IV* (1994), concerns were rising and knowledge of how the classifications were decided was not a good look. The resignation of Spitzer did not help either, another case of the revolution consuming its own. Allan Francis, his successor, left on equally disillusioned terms.[12]

The DSM-5 version, released in 2013, dragged credibility to its lowest point. Conditions that were determined by 150 years of careful psychiatric observation were put through a political and bureaucratic grinder that killed off well-established and understood conditions like paraphrenia and Asperger's syndrome, seriously messed up depression[13] and inflicted such etymological gallimaufries as Late Luteal Phase Dysphoria Disorder (*aka* premenstrual syndrome).[14]

Critics of the system made two points. Pathologizing normal experience stigmatized those so diagnosed, resulting in unnecessary and often harmful treatment. Furthermore, treating non-disordered conditions took resources away from those in genuine need.

The most profound failure of the DSM enterprise was the way it played into the hands of the pharmaceutical and insurance industry. By providing a diagnosis unmoored from clinical reality but defined by operational criteria, a specific drug could be manufactured and marketed – the index example is Prozac for Major Depressive Disorder, followed by Paxil (Aropax or paroxetine) for Social Anxiety Disorder and then many others.

A new product, it seems, is launched on the market every day, judging by the journal ads, the glossy flyers in the mail and the bevvies of pert and perky sales reps who come calling with their latest brochures. The problem is that the new drugs are all variations on a theme. Antidepressants, antipsychotics and sedatives have not changed for decades; the only real difference is in the side effects.

A particularly egregious practice is the use of the so-called "atypical antipsychotics" as a kind of psychiatric penicillin. They are prescribed now for just about any disorder, regardless what other drugs are used. Their effect is to produce an emotional flattening. If this is considered an improvement, it is hardly a cure. Add to this the most spectacular side effect is weight gain, turning skeletal figures into Michelin men and women in a few weeks. Journals are now full of articles about the metabolic syndrome produced by these drugs.

More egregious however, is the medicalising of normal distress by making normal grief segue into Complex Prolonged Bereavement Disorder, effectively a clone of Major Depressive Disorder. This arises from the widespread misconception that "normal grief" just lasts a year. This is a ludicrous assumption. The process of grief varies with circumstances (for example, sudden or unexpected death) and individuals, so it can last from several years without necessarily assuming pathological features.

Allan Horwitz, who writes excellent books on the history of psychiatry, has provided what will turn out to be the definitive account of the DSM, one that will set the guidelines for future studies, although the extent to which it will quell the acrimonious debate is another matter. The DSM story, in all its perturbations, is carefully unveiled in a highly readable account that accomplishes its task in a lucid fashion without being too wordy or overloaded with footnotes.

The first point Horwitz makes is that DSM was an entirely American endeavour, shaped by the local approach to mental illness and deeply shaped by the local culture. That it would play such a significant role in other psychiatric domains was not considered but, in view of its huge influence, must make it the refulgent arm of US psychiatric imperialism.

Horwitz starts in the post-war fifties, the high days of psychoanalysis in the US. The focus was on neurosis, which arose from unconscious conflicts in early development. Even psychosis, which Freud thought to be untreatable, according to Freda Fromm-Reichman and John Rosen, was accessible to the couch.[15] Nitpicking about different categories therefore meant little and nothing changed with the first two DSM versions.

In order to get the project going, Spitzer had to deal with a major obstruction: the classification of homosexuality as an illness. This he accomplished in the face of much squealing by the conservative rear-guard, not least the analysts, but the issue was firmly consigned to history. Paradoxically, the LGTB community was later to lobby to retain the gender dysphoria category in order to have reassignment surgery funded.

He reveals the astonishing amount of money the little book[16] brought to the APA: DSM-111 earned $9.3 million; DSM-IV was still producing $5 million a year more than a decade and a half after its publication; and DSM-5 sold $20 million worth of copies in its first year.[17]

While previously revealed by Edward Shorter and Hannah Decker *inter alia*[18], Horwitz aptly shows how decisions were reached by the DSM committees. Clinical opinions and political deal-making between vested interests was the modus operandi with Spitzer tapping away at his typewriter while astutely juggling the committee factions. Once haggling was completed, the final wording was determined by the unscientific means of a vote, reminding some of the old saw that a camel is a horse constructed by a committee. Added to this was the elephant in the room. Some committee members (Horwitz lists 70%) were shown to be tucked into the purses of pharmaceutical companies while others had well-known political agendas.

Horwitz describes the enormous damage done to paediatric psychiatry. The most rebarbative example is the diagnosis of bipolar disorder in children as young as infants who are put on powerful drugs with heavy side effects. Another storm arose from the decision to eliminate Asperger's syndrome and collapse autism, Rett syndrome and childhood disintegrative disorders into Autism Spectrum Disorder. Asperger parents did not wish to have their children classified with the lower functioning autistics and families panicked because some would not be eligible for benefits.

This was followed by the massive increase in cases of Attention-Deficit Hyperactive Disorder (aka ADHD, another user-friendly acronym that says as much as its hides), a problem with huge clinical, financial, social and even political ramifications, which has led to the widespread use of stimulant drugs to control behaviour in children. Add to that all the adult ADHD cases that have since emerged and you get some idea of the mess.

Personality disorder classification was driven by researchers, rather than clinicians. There was a widespread belief that dimensions rather than categories would be the best approach, but this was overturned because it would prevent patients from being eligible for insurance payments.

Nothing sums up the problem more than the epidemic (or should that be pseudo-epidemic?) of post-traumatic stress disorder (*aka* PTSD, the most enticing acronym of them all).[19] In 1980 the US Vietnam Veterans Association, through intense lobbying, persuaded DSM to give it the slick moniker

and, in the process, a user-friendly acronym. After heavy lobbying by the vested interests, Spitzer only adopted the definition after modifying the original proposal for a "post-Vietnam syndrome".

A condition previously found in survivors of battle, concentration camps or life-threatening accidents has become the gold standard for the victim culture, rapidly becoming the commonest injury in compensation claims. In subsequent DSM revisions, Horwitz writes, the criteria for traumatic exposure were so expansive that they encompassed virtually everyone. PTSD is now said to be found in someone having an argument at work, watching footage of terrorist attacks[20] or, vicariously, from treating patients with PTSD![21]

PTSD is worn as a badge of pride. As Nancy Andreassen, former President of the APA, says, "It is rare to find a psychiatric diagnosis that anyone likes to have, but PTSD seems to be one of them."[22] Demonstrating the principles of free market economics, bracket creep (a concept of Richard McNally) is on the rise.

Horwitz concludes that the replacement of analytic concepts with theory neutrality, the recognition that intense social stressors can produce lasting mental disorders, the removal of homosexuality and the acknowledgment of autistic disorders—improved the manual in ways which few psychiatrists would object to. The profound failure of the DSM enterprise, however, is the focus on treating the disease and not the patient, in the process ignoring the role of social and cultural factors. As Horwitz pointedly states, the manual results from the dynamics and organization of the psychiatric profession and wider cultural, political, and economic currents. Fluctuations in the psychiatric politics, reimbursement for treatment, drug company marketing and the benefits patients, families, clinicians, and researchers receive from diagnoses shape the manual's uses.

And on it goes.

DSM has given the world an American-based classification of psychiatric 'disorders' (no one is allowed to have a disease or illness now) derived from in-house committees subject to intense political, social and personality processes. Add to this the appetite of a voracious legal profession for new "conditions" that could provide opportunities to litigate and, with one thing and another, we are where we are today. Despite all the subsequent versions, the endeavour has utterly failed to provide reliable diagnoses from which biological tests could be derived.

As third parties increasingly required DSM diagnoses to pay for treatment, patients and families saw them as valuable commodities, making it even more difficult to change problematic categories, of which there were many. Parent groups drove the huge expansion of mental disorders among children and adolescents.

If there was a knife that came close to the heart of the enterprise, it was the decision of the National Institute of Mental Health to cast aside DSM-5, recommending instead the Research Diagnostic Criteria.

The hecatombs of criticism notwithstanding, can anything good be said about the DSM enterprise? Many of the categories are well defined and adjusted for recent developments. These include Organic and Neurocognitive Disorders and the Anxiety Disorders. Substance Use Disorders, having started off well with division into Abuse and Dependence, have now been collapsed into a single Substance Use Disorder category, the logic of which is difficult to penetrate. Added to this is the unresolved debate whether repetitive dysfunctional behaviours eg., compulsive gambling or internet addiction, to say nothing of the fashionable sex addiction, should be classified as disorders thus medicalizing human behaviour to an inordinate extent

Criticism of Social Anxiety Disorder (SAD, previously Social Phobia) that it is medicalising human shyness is overkill[23], a view that can only be held by someone who has never treated SAD cases (a problem with understanding all psychiatric illness). SAD is far more than just ordinary shyness, rather a pervasive anxiety under scrutiny with significant social, emotional, behavioural and occupational hazards. It is often poorly

recognised as most cases present with depression or alcoholism, secondary to the primary disorder. Just go to an AA meeting and ask those present to put up their hands if they went into life with severe social anxiety.

On the distaff side, the SAD classification led to the promotion of Paxil for treatment of SAD, another bank vault for pharma. This shows how easily the issues can be blurred. Most SAD patients present with depression and alcohol abuse which can respond to antidepressants. It is perfectly reasonable to put distressed and agitated SAD patients on such medications when they present. However, the correct treatment is psychological which can be done when they are no longer depressed or overwhelmed.

It cannot be said that the public image of psychiatry is in the ascent. The disclosure that some prominent researchers have their hands deeply in the drug companies' pockets is less than a good look. Add to this psychiatry's mandate – its exclusive control of illnesses of the mind – is fragmenting to an unprecedented degree. Turf wars with neurology and psychology were but kindergarten squabbles compared with the present situation. Witness the disparate agencies which have not just a foot, but an arm and leg, in promoting (and, in the process, facilitating) the raging epidemics of autism and ADHD. Future generations will not thank us for this unwanted legacy.

Less surprising is the passivity with which the profession as a whole deals with the situation. There is a good deal of posturing, leavened with oily dollops of political correctness, from the official bodies. Any steps to kick in on problems — notably rampant over-diagnosis of certain conditions and misuse of drugs — are timid and ineffective. All to often, when psychiatrists present in the media, it is evident they are pushing an ideological barrow, rather than representing the profession as a whole. A recent example: witness those rushing to pin diagnoses on Donald Trump in clear contravention of the Goldwater Rule (it is unethical for psychiatrists to make diagnoses of public figures).[24]

There are some chinks of light in the ever-deepening gloom. New drugs, such as ketamine, have genuine potential as antidepressants. The hallucinogens may revolutionise the management of obsessive-compulsive disorder and traumatic anxiety, if not alcoholism and drug abuse. Transcranial magnetic stimulation (TMS) is becoming a useful alternative to ECT. Vagal nerve stimulators may allow chronic depressives to come off medication. Deep brain stimulation is being seriously considered. Perhaps the most notable change is the use of cognitive behaviour therapy for a wide range of conditions, even psychotic delusions, something unthinkable a few decades ago. And after nearly a century of ignominy (thanks to Kraepelin including it under schizophrenia), catatonia has been recognised for the pervasive and treatable condition it is.

To those who care deeply about the profession and its history over 150 years of determination to classify and treat some of the most debilitating conditions known, for all the difficulties, missteps and mistakes en route – it is deeply dismaying, if not depressing. What is needed is nothing less than a thorough review of the framework in which psychiatry operates and a clear plan for the future.

Allan Horwitz is to be congratulated on a fine book that deserves to be read by everyone concerned about the state of psychiatry, especially trainees who will constitute the next generation of psychiatrists and have to deal with the consequences of DSM's trail of disaster and folly. This book should have as wide reading as possible in the hope that it will spur individuals and organisations to repair the growing catastrophe.

But don't hold your breath that this is going to happen soon.

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[1] The name Psychiatry came from Johan Reill in 1807.

[2] De Saussure R. The influence of the concept of monomania on French medico-legal psychiatry (from 1825 to 1840). J Hist Med Allied Sci. 1946 Jul;1:365-97.

[3] Bergsholm P. Is schizophrenia disappearing? The rise and fall of the diagnosis of functional psychoses: an essay. BMC Psychiatry. 2016 Nov 9;16(1):387.

[4] Despite the best efforts of some figures in the UK, like Malcolm Sargant and Eliot Slater.

[5] For a review of these issues, focussing on the Antipodean scene, see: Laffey P. Histories of Psychiatry after Deinstitutionalisation: Australia and New Zealand. *Health and History*, Vol. 5, No. 2, (2003), pp. 17-36.

[6] Rosenhan DL. On being sane in insane places. Science. 1973 Jan 19;179:250-8.

[7] Rosenhan DL. On being sane in insane places. ***Ibid***.

[8] But, as Susan Cahalan has now shown, it was one of the greatest scientific frauds of the century; see: Susannah Cahalan. *The Great Pretender: The Undercover Mission that Changed Our Understanding of Madness*. Canongate, 2020; and https://www.spectator.co.uk/2020/01/how-david-rosenhans-fraudulent-thud-experiment-set-back-psychiatry-for-decades/. Accessed 4 February 2020.
The damage however was done.

[9] Spitzer R L (1975). On pseudoscience in science, logic in remission, and psychiatric diagnosis: A critique of Rosenhan's "On being sane in insane places". Journal of Abnormal Psychology, 84(5), 442–452.
This may explain why Rosenhan never wrote again about the experiment and had to return the royalty payment for a book he was commissioned to write about it.

[10] Alix Spiegel. *The Dictionary of Disorder*. The New Yorker. Magazine.https://www.newyorker.com/magazine/2005/01/03/the-dictionary-of-disorder. Accessed 30/12/2021. Accessed 2/1/2021.

[11] Amidst the many articles discussing Spitzer's role in DSM-111, this article by Peter Tyrer is a useful summary: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6189982/. Accessed 28/12/2021.

[12] See: Frances, A. J. (2012b). "DSM-5 is a guide, not a bible—simply ignore its 10 worst changes." https://www.psychiatrictimes.com/alcohol-abuse/dsm-5-guide-not-biblesimply-ignore-its-10-worst-changes; and Alan Frances (2013) Saving Normal: An Insider's Revolt Against Out-of- Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalisation of Ordinary Life. William Morrow.

[13] Horwitz, A. V. (2015). "How did everyone get diagnosed with Major Depressive Disorder?" Perspectives in Biology and Medicine, 58, 105–19.

[14] Blumenthal, S., & Nadelson, C. (1988). Late luteal phase dysphoric disorder (premenstrual syndromes): Clinical implications. Journal of Clinical Psychiatry, 49, 469–74.

[15] For a review of the inanities, if not iniquities, involved in the psychoanalysis of schizophrenics, see Edward Dolnick. *Madness on the Couch. Blaming the Victim in the Heyday of Psychoanalysis*. Simon &. Schuster, 2007.

[16] It came in different sizes and versions, but the pocket edition was the big seller.

[17] It was decided to change from Greek to Roman numerals.

[18] Hannah Decker. *The Making of DSM-III. A Diagnostic Manual's Conquest of American Psychiatry*. Oxford University Press, 2013; and, Edward Shorter: *What Psychiatry Left Out of the DSM-5: Historical Mental Disorders Today*. New York: Routledge, Taylor & Francis Group, 2015; Edward Shorter (2015). *What psychiatry left out of the DSM. Historical Mental Disorders Today*. Taylor and Francis. Kindle Edition.

[19] Amidst many articles, see Wakefield, J. C. (2001). "The myth of DSM's invention of new categories of disorder: Houts's diagnostic discontinuity thesis disconfirmed." Behavior Research and Therapy, 39, 575–624.

[20] It was thus predicted that there would be massive cases of vicarious PTSD in New York after 9/11 when in fact it turned out to be quite the opposite.

[21] Rosen GM, Spitzer RL, McHugh PR. Problems with the post-traumatic stress disorder diagnosis and its future in DSM V. Br J Psychiatry. 2008 Jan;192(1):3-4; and Spitzer RL, First MB, Wakefield JC. Saving PTSD from itself in DSM-5. J Anxiety Disord. 2007;21(2):233-41.

[22] Quoted in: Allan V Horwitz. *PTSD (Johns Hopkins Biographies of Disease)* . Johns Hopkins University Press. Kindle Edition. Press. Kindle Edition.

[23] Lane, C. (2006). "How shyness became an illness: A brief history of social phobia." Common Knowledge, 12, 388–409. Lane, C. (2007).

[24] Robert M. Kaplan. Trumping the shrinks: The risks for psychiatry in diagnosing a public figure. Sydney Morning Herald. 12 January 2018.