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ESSAY REVIEW

The Troubles with Psychiatry

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: William Morrow (HarperCollins), 2013. 314 pp. $27.99 (hardcover). ISBN 978-0-062229-26-7.

The Book of Woe: The DSM and the Unmaking of Psychiatry by Gary Greenberg. New York: Blue Rider Press (Penguin), 2013. 403 pp. $28.95 (hardcover). ISBN 978-0-399158-53-7.

The mind–body problem has puzzled thinking humans as far back as we have knowledge of human thought, yet we still cannot claim to understand cause and effect in the interactions of the brain's material electrochemistry and the mind's intangible mental processes.

Psychiatry and clinical psychology seek to deal with undesired mental processes even as cause and effect in mind–body interactions remain mysterious. Even the definition of mental illness is arbitrary, determined by what is taken as normal or acceptable in a particular social context. With physical illnesses, patients and society agree that illness is present, but society will often label someone as mentally ill who does not agree that he is ill; and individual psychiatrists all too often reach different diagnoses of any given prospective patient.

In the early part of the 20th Century in the Western world, Freudian concepts were mainstream: Mental processes were seen as autonomous.[1] Although Freud himself was a medical doctor, his acolytes—psychoanalysts—needed training only in psychoanalysis, not in medicine. In the second half of the 20th Century, psychiatry sought to capture for itself the treatment of mental disorders as a medical specialty. To exclude psychoanalysts and clinical psychologists, the biological basis of mental illness was emphasized, since only medically qualified individuals could prescribe drugs. A required corollary was the definition of distinct mental illnesses, a need filled by successive editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

In practice, however, psychiatry long continued to rely heavily on talk therapy, augmented as seemed appropriate by drugs as well as to a decreasing extent by other physical–biological approaches: insulin-shock or electric-shock therapy or lobotomy. As more substances ("psychotropics") were found to affect mental processes, drug treatment increasingly began to predominate, and different classes of drugs came to be regarded as appropriate treatment for some of the distinct conditions described in the *DSM*: thus anti-anxiety pills, anti-depressants, anti-psychotics, atypical anti-psychotics, mood stabilizers, selective serotonin re-uptake inhibitors (SSRIs) . . . .

Incredible as it may seem, these descriptive names are unwarranted and misleading: the drugs do not have the specific effects implied by those names. They are no more specific than shock therapy or lobotomy. They disturb or disrupt mental functioning, with a great variety of possible consequences—thus some individuals sometimes react to "anti-depressants" (or other mind-altering drugs) by committing suicide; "anti-anxiety" pills in some countries are "anti-depressants" elsewhere.

For chapter and verse supporting these seemingly extreme assertions, see a representative (but far from exhaustive) bibliography that is updated periodically (Bauer 2014). For a summary of the main points, see my Essay Review of one of those books (Bauer 2011).

The *DSM* labels for distinct mental disorders are no more justified than are the names for the purported classes of drugs. Defining a mental disorder requires specifying symptoms that distinguish "normal" from "not normal," but all the symptoms are matters of degree. *DSM*s are replete with loose criteria that comprise satisfying several of some number of symptoms, for more than some specified period of time, and to degrees that are judged excessive. Decisions are then inescapably subjective and arbitrary.

A system has evolved in which *DSM* labels and drugs for mental illness stand to the benefit of powerful vested interests: not only the pharmaceutical industry but also healthcare and health-insurance corporations, psychiatrists and clinical psychologists and their professional organizations, the National Institute for Mental Health, the World Health Organization, charities and patient-advocate and activist groups. . . . In the absence of established science connecting symptoms of mental illness to proven causes or proven treatments, what happens under this system reflects power relations. The devastating consequences are exposed passionately in these books by Greenberg, a clinical psychologist, and Frances, a psychiatrist. They know one another. Greenberg is barely mentioned in Frances' book, but Frances features prominently in Greenberg's—unavoidably, because Frances led the writing of *DSM-IV* and remains a fierce public critic of *DSM-5*; in

Greenberg's account, he and Frances have a passionate friend–antagonist relationship about foundational matters as well as about *DSM*s.

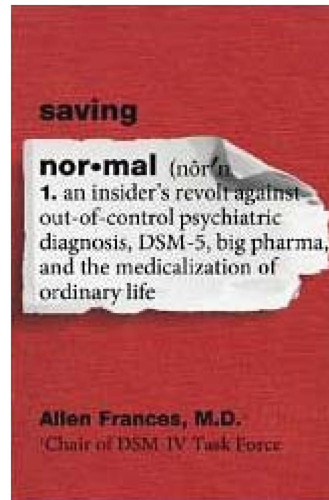
The main theme of Frances's *Saving Normal* is that taking *DSM* criteria and definitions literally has led to an epidemic of *mis*-labeling and over-prescribing. Human beliefs and behavior are hugely diverse, and labels of mental illness should be reserved for conditions where the individual is incapable of functioning without outside help, or feels so disturbed as to seek help; or, with reservations because of obvious political pitfalls, when society regards an individual's behavior or beliefs as "crazy" or "insane."

But Frances takes on an impossible task: attempting to defend the labeling inherent in *DSM*s while acknowledging that there is no factual basis for it. At times he seems self-serving in defending his *DSM-IV*, but overall he makes pointed and largely documented criticisms of the excesses that follow from taking *DSM* labels literally; and he is devastating about the role played by the pharmaceutical industry, enabled by being allowed—since the 1990s in the USA—to advertise directly to consumers, which is not permitted in any other developed country besides New Zealand.

In essence, Frances wants everyone to understand that psychiatry, like medicine in general, should deal with every individual as unique, having recourse to diagnostic labels of convenience and to drugs only after each client's whole circumstances have been understood as fully as possible. He criticizes the formulaic labeling and prescribing that has become standard under bureaucratic, commercial, and legal pressures: General practitioners (GPs)—without understanding what they are doing—write prescriptions for 50% of all anti-psychotics, 65% of stimulants, 80% of anti-depressants, and 90% of anti-anxiety pills (p. 101). Chapter 9 recounts hair-raising cases of damage to particular individuals.

One must surely agree with Frances that all psychiatrists should practice as Frances recommends—and, one suspects, as he himself practiced. But how to achieve that is far from clear, and *Saving Normal* is no help in that respect. Its main attempt, in Chapters 7 and 8, is no more than wishful, for instance in suggesting that commercial enterprises behave other than commercial enterprises naturally do; as well as impractical in outlining how individuals should actively participate in their own diagnosis and treatment. Much of *Saving Normal* is properly sourced and documented, but at times it reads like a "just-so" story, and there are regrettably many citations from *Wikipedia*, a totally unreliable source on anything that isn't 100% cut-and-dried.

Nevertheless, Frances's book deserves the widest possible readership, for here is one of the foremost psychiatrists of his generation explaining how and why his profession has gone astray and deserves to lose the respect



of its clientele. Frances's utter sincerity is beyond question; he did not undertake his campaign lightly, understanding among other things that "it was bad form to comment on the work of my successors" (p. xvii).

Chapter 4 has informative summaries of psychiatric-type fads of past and not-so-past fads, including demonic possession, hysteria, multiple personality disorder, and witchhunts about alleged sexual abuse in daycare centers. Still-current fads include naming drugs as though they were specific when they are really not and ascribing mental illnesses to "chemical imbalance" of neurotransmitters without a shred of actual evidence; and (Chapter 5) attention-deficit disorder (ADD), childhood bipolar disorder, autism, bipolar II (adult), social phobia, post-traumatic stress disorder (PTSD), erectile disorder, and female sexual dysfunction—the "expectable sexual experience of almost one half of women" (p. 163). Potential fads and epidemics enabled by *DSM-5* include temper tantrums in children (Disruptive Mood Dysregulation Disorder, DMDD, pp. 177–179), the normal decline in memory and attention in older age (Mild Neurocognitive Disorder, MND or MNCD, pp. 179–182, and ADHD, pp. 184–186), gluttony (Binge Eating Disorder, pp. 182–184), grief (Major Depressive Disorder, MDD, pp. 186–188), and the labeling of passionate interests as addictions (pp. 188–192).

Frances is also insightful in pointing out that psychiatry's failings are no different in kind from those of present-day drug-obsessed and drug-industry–influenced medicine overall (p. xix)—including the fad for "screening" as a supposed tool for preventing illness, which instead leads to unnecessary treatment and even direct harm as healthy people are told that they are ill (p. 78 ff.). Then too there is the tendency for specialists to see only their pet condition and to be oblivious to the bigger picture (p. 83).

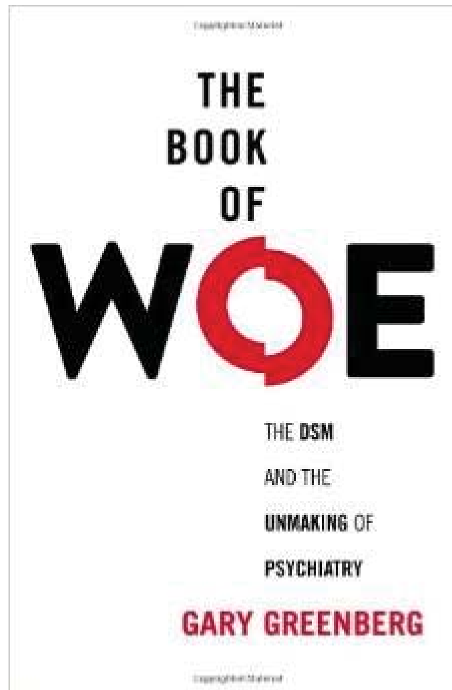
What everyone should know is that "placebo is the greatest broad-spectrum wonder drug ever invented—cheap, effective for almost all but the most severe of man's ills, and with very few side effects" (p. 97). Indeed, before antibiotics, just about all efficacy of medical practice resulted from placebo (Shapiro & Shapiro 1997). Nowadays, anti-depressant drugs appear to benefit about 10% of patients, whereas placebo is effective with 40% (Healy 2012).

Greenberg's *Book of Woe* brought me innumerable chortles as he demolishes the hypocrisy and incompetence displayed in the production of *DSM-5*. His task is far easier than Frances's: He can just cite self-important people saying absurd things and proposing absurd diagnoses, for instance Delusional Dominating Personality Disorder (DDPD): "a tendency to feel inordinately threatened by women who fail to disguise their intelligence" (p. 237). Having had much fun for 250 pages, Greenberg turns serious and uses a specific case history for a heartfelt plea that psychiatry should be foremost and only about each individual who needs help that is idiosyncratic, unique to that person (pp. 253–262).

The Book of Woe is explicit about the making of *DSM-5*, but the details enable Greenberg to emphasize over and again that there is simply no evidence-grounded definition of mental illnesses because their causes are mysterious and their symptoms are overlapping and thereby non-specific. Greenberg was a public thorn in the side of the American Psychiatric Association (APA) as *DSM-5* was being prepared. Especially but not only in Chapter 17, Greenberg's quarrels with the APA and with Frances are detailed; summarized polemically at p. 280. The APA bumbled long and incredibly, doubtless in some part because the Association's revenues depend so much on sales of *DSM*; but of course in some other part because, like Frances, they were attempting the impossible: constructing purportedly evidence-based labels and treatments in the absence of the needed evidence. Like Frances, Greenberg illustrates how the loose descriptions of psychiatric ailments allowed an enormous increase in the numbers of the supposedly mentally ill (p. 51 ff.). Elaborate schemes for diagnosing were supposed to be tested in "field trials"; the description of one such trial is uproarious and devastating (pp. 284–291). Trials confirmed that the diagnostic classifications are hugely unreliable (p. 311 ff.).

The Book of Woe begins with an informative historical account of attempts at a classification of psychiatric diagnoses. The APA's shift over how to regard homosexuality illustrates that diagnosis is very much a matter of opinion and ideology (pp. 35–36).

In the 1970s, psychiatry faced a crisis as insurance companies and federal agencies cut reimbursements and funding because of a perceived lack of reliability in the diagnosis of mental illness (p. 35). The profession's response was *DSM-III* (1980), which "looks very scientific" (p. 41). The ambition to be scientific went arm-in-arm with postulating a biological basis for mental illness; correspondingly, the leader of the National Institute of Mental Health (NIMH) appointed in 1996 had a background in neurogenetics (p. 48). The profession also lobbied for legislation to mandate insurance reimbursement for mental illness at the same rate as for physical



illnesses (pp. 50–51, 55–56). In Greenberg's view, medicalizing mental illness has led to administering "mind-altering medications whose mechanism of action and long-term effects are as unknown as their capacity to blunt feeling is known" (p. 345). "Psychiatrists . . . are not treating the disorders they diagnose"; they prescribe "antidepressants to treat obsessions, antipsychotics to treat depression, mood stabilizers to treat anxiety, and so on" (p. 348). It is only symptoms that are being treated, not identified conditions, ailments, or mental illnesses.

A *New York Times* reviewer (Garner 2013) called both these books depressing and over-long. Depressing, yes; too long, *NO*. When practices accepted and approved by professional consensus and the usual "experts" are subjected to such sweeping attacks, the mainstream and the popular media are usually quick to cry "conspiracy theories," "denialism," "crackpots," and the like. To establish convincingly the radical fact that orthodox psychiatry is really not to be trusted nowadays requires such concentrated, repeated, documented critiques as appear in these books.

The merest glance at the *DSM-5* confirms that no one ought to take it seriously. The "Inattention" criteria for ADHD (p. 59 ff.) describe behavior quite typical of teenagers. Innumerable instances of "Binge Eating Disorder" (p. 350 ff.) can be seen any day of the week at any buffet restaurant. Erectile Disorder (p. 426 ff.) notes that "40%–50% of men older than 60–70 years complain of occasional problems with erections," but nowhere is this acknowledged to be *normal* rather than a "disorder." Political correctness features prominently, for example at p. 749: "*Race* is a culturally constructed category of identity . . . based on a variety of superficial physical traits"; perhaps the next editors of *DSM* would do well to read Ruth Benedict's *Race and Racism* (1942 and later editions), which distinguishes the biological reality of race—which has important proven

corollaries in medical matters—from the cultural reality of racism. But such clarity of thought and judgment may be beyond people who regard as worthwhile "Conditions for Further Study" such suggestions as "Caffeine Use Disorder" (p. 792) or "Internet Gaming Disorder" (p. 795).

Psychiatry would do well to heal itself of the *DSM*. Indeed, Frances argues that the American Psychiatric Association should not be left to organize and control the *DSM*: "Psychiatric diagnosis is too important to be left to the psychiatrists" (pp. 218–221). This truism parallels the better-known "war is too important to be left to the generals" and illustrates George Bernard Shaw's deeper insight that all professions constitute a conspiracy against the laity.[2]

Notes

[1] Wilhelm Reich, deviating from and breaking with Freud, insisted that thoughts and emotions are inextricably bound up with physiology and that "body work" should be a part of psychotherapy for many (but not all) patients. But Reich gained few acolytes and his approach never became mainstream.

[2] Preface to *The Doctor's Dilemma*, play first performed in 1906, first published in 1911. The Preface is as pertinent today as it was a century ago because it points to the conflicts of interest inherent in the medical profession: having a monopoly over diagnosis and treatment and over-setting the boundaries between health and illness at the same time as profiting financially from illness.

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