Unabridged:
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Prescriptions for Trouble

There are many changes afoot – but they don't really advance psychiatry or our understanding of mental illness. Worse, some are prescriptions for trouble.

Last week, the American Psychiatric Association unveiled the much-awaited blueprint of the next edition of its official handbook of diagnoses, *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, or D.S.M.- V.

Outlets from the *New York Times* to *Hindustan Times* heralded its arrival. ABC News announced, "Big changes for DSM, the psychiatrists' bible."

Such fanfare makes sense. The DSM is as much a cultural institution as a clinical one. As arbiter of what is normal and what is not, the manual also plays an important role in insurance and disability determinations; in the courtroom it can bear on criminal culpability.

Scores of revisions, big and small, have been proposed by nearly 200 experts under the supervision of D.S.M.-V Task Force, which will release a final version of D.S.M.-V in 2013 – nineteen years after the publication of the DSM IV.

The problem is that the changes don't really advance psychiatry. Worse, some are prescriptions for trouble. One of the most controversial is the creation of a diagnosis called "psychosis risk syndrome."

Granted, the motivation is laudable: to identify adolescents or young adults who are at risk for developing serious mental illnesses marked by hallucinations and delusions. And what doctor wouldn't want to intervene early to ward off an affliction like schizophrenia?

But psychiatry is different. A diagnosis that is believed to foreshadow a full blown psychotic illness has the potential to be highly stigmatizing. This is lamentable, but true. It is especially unfortunate if the labeled individual does not even go on to develop such an illness – and the chances of that are estimated at seventy percent or more.[1]

To complicate matters further, treatment is not especially effective in forestalling psychotic illness in the minority who are destined to develop it. And since we don't

know who they will be, otherwise healthy kids will be exposed to potent anti-psychotic medications and their side effects such as diabetes and weight gain.

Thus, until the science of prevention becomes more advanced, it is better to keep psychotic risk syndrome out of the official diagnostic compendium.

This is just one suggestion (mine). By the time the public comment period ends on April 20th, the APA's inbox will be overflowing. Indeed, within moments of the task force's posting the draft on the Internet, vigilant psychiatry-watchers sprung into action.

Some with Asperger's Disorder ("Aspies," as they often call themselves) decried the proposed elimination of their category, which would be subsumed under a new diagnosis called Autism Spectrum Disorder. They resist being lumped with individuals who have lower IQ's and language delays. The task force's rationale for decommissioning Asperger's is that is really a milder form of autism.

Among the "transgendered," one camp urged the existing diagnosis of Gender Identity Disorder be removed because it implies they are mentally ill while the other wanted it left in so that insurers will pay for sex-change transition treatments and surgeries.

Psychiatrists too weighed in. "The DSM V would dramatically raise the rates of mental disorder in the general population," said Allen Frances M.D., head of the team that revised the fourth edition of the manual. "Some of the new diagnoses would be extremely common and pharmaceutical marketing would amplify the risk of their being found. This means, of course, that a lot of otherwise normal people will be medicated."

And on it will go for the next few weeks.

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So, yes, there is a lot to critique, and a few things to cheer, in the draft of DSM V. But the larger question is whether these changes help us better understand mental disorders?

For perspective, let's go back to 1980 when the revolutionary third edition of the handbook, the D.S.M. III, was published. In a radical break from earlier editions, which were based largely on Freudian concepts of unconscious conflict and stunted sexual development, the D.S.M. III categorized illnesses based on symptoms. A patient was said to have a condition if he or she had a certain number of the classic symptoms.

Such an approach promoted "inter-rater reliability" — the odds that two examiners would agree on what diagnosis to assign a patient. This enabled

clinicians to communicate better (when Dr. X said a patient had major depressive disorder, Dr. Y would know what he meant). It also meant that different research teams could work on new treatments for the same problems as well as compare, and confirm each others' work.

Yet just because two examiners concur that a person qualifies for a particular diagnosis does not mean that he has an authentic mental illness. How do we know, for example, that a person diagnosed with major depressive disorder (the D.S.M.'s formal designation for pathological depression) is not actually suffering from a bout of natural if intense sadness brought on by a shattering loss, a grave disappointment, or a scathing betrayal?

The manual will not help us here. In fact, a number of changes proposed for the D.S.M. V (e.g., new diagnoses for binge eating, hoarding, and hypersexuality) will likely exacerbate that confusion by inadvertently placing large swaths of normal human variation under the umbrella of pathology.

The other problem that confounds psychiatry is how to draw boundaries around diagnostic categories, given that we rarely know the cause of mental illness at the neural level. The simplest scenario would posit an errant gene behind the pathology, but that is not how psychiatric conditions work.

Instead, mental illnesses are the product of numerous genes that interact with one another, with the environment, and also with experience. A recent study by the National
Institute of Mental Health found that eighty genes could be associated with bipolar disorder, eight of which influence how the brain responds to neurotransmitters such as dopamine.

Add to this the miasma of social and personal encounters that impinge upon the genetically vulnerable individual -- stress, impoverishment, family instability, drug or alcohol use, and so forth -- and the causal mechanisms of mental illness becomes staggeringly complex and elusive.

No wonder many of my colleagues rightly wonder whether psychiatry has come far enough to warrant an overhaul of its master document.

Thus, despite efforts at clarification, patient profiles range widely. “You can have three patients with schizophrenia, but all that really means is that their symptoms fit a particular pattern,” says Columbia University psychiatrist Michael B. First. “They may not have the same pathophysiology and, as a result, they may not require the same treatment.”

Moreover, the "psychopathological pie," as a colleague calls it, is rarely divided up as tidily as the manual implies.” Patients often have symptoms that sprawl across several diagnostic categories at once. For example,

50 percent of kids who receive the trendy diagnosis of bipolar disorder also have ADHD.

The upshot is that, with some important exceptions, drug treatment is often guided more by symptoms than by diagnosis. In fact, good psychiatrists do not rely too heavily on the D.S.M. when they care for patients. There is simply no substitute for clinical judgment; for observing the patient, listening to his story, and fine-tuning his treatments – psychological and pharmacological– as needed.

The framers of the D.S.M. III knew this well. They cautioned against manual users taking too literally the sharp boundaries drawn between disorders and between disorder and mental health.

"This version," they wrote in the preface, "is only one still frame in the ongoing process of attempting to better understand mental disorders." Thirty years later, despite undeniable progress in brain science, we are saying much the same thing.

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[1] Yung A Yuen H Berger G Francey S Hung T-C Nelson B et al Declining transition rate in ultra-high risk (prodromal) services: Dilution or reduction of risk? Schizoph Bull 2007:33(3)7:675-82.

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