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Making the DSM-5

Concepts and Controversies

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Editors
Joel Paris, MD
Jewish General Hospital
Department of Psychiatry
McGill University
Montreal, QC, Canada

James Phillips, MD
Department of Psychiatry
Yale School of Medicine
New Haven, CT, USA

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Preface

In 2013, the American Psychiatric Association is publishing the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This book examines some of the conceptual and pragmatic issues raised by the new manual.

DSM has sometimes been called "the bible of psychiatry." This seems a strange term to describe a manual that only classifies mental disorders, but does not explain them or guide their treatment. Yet while earlier editions of DSM had little impact on clinical practice, DSM-III, published in 1980, was a kind of "paradigm shift," reflecting the shift of focus in American psychiatry from psychodynamics to phenomenology and neuroscience. Moreover, DSM-III introduced algorithms for diagnosis that proved popular, even if they were not followed very strictly. This edition of the manual became influential all over the world, and also became a standard for almost all research.

The controversy over DSM-III eventually blew over. Biological psychiatry won the day, and was accepted as the primary paradigm for the field. DSM-IV, published in 1994, made only minor changes in the manual. Thirty odd years later, few could remember a psychiatry that did not follow the DSM. However flawed the system was, the pace of research was slow, and most mental disorders remained poorly understood.

Nonetheless, the American Psychiatric Association felt it was time for a revision. To this end, they appointed David Kupfer, a prominent biological researcher, and Darryl Regier, their own research director, to head a task force to prepare DSM-5. This process took quite a few years, with work groups of experts asked to propose revisions based on the most recent research findings. Originally, APA hoped to introduce another paradigm shift, in which psychiatric diagnosis would be in greater harmony with neuroscience. When it became clear the data supporting these changes was too fragmentary for radical changes, it backed off from major revisions.

The final document that constitutes DSM-5 is a compromise. It is not dramatically different from DSM-IV, but reflects a tendency to see mental disorders as lying on a continuum with normality, and supports the view that half of the population can be labeled as having some kind of mental disorder. It is hoped that this model will eventually be supported by the discovery of biological markers and endophenotypes.

The chapters in this book examine DSM-5 from the point of view of these conceptual principles, and also assess the implications of its approach for clinical practice.

Several chapters consider the problem of over-diagnosis and false positives. Psychiatry has long been criticized for medicalizing and pathologizing normal variations, and over-diagnosis means over-treatment, with all the attendant side-effects of psychopharmacological interventions. At the same time, some conditions listed in DSM-5 may be underdiagnosed. This "dialectic" can best be resolved by a combination of conservatism and pragmatism. Diagnostic epidemics could discredit psychiatry by claiming that there is no essential difference between mental disorder and normality, and by forcing clinicians to treat normal people with drugs that they do not need.

One must also consider the political and economic context in which over-diagnosis occurs. The history and politics of American psychiatry is marked by a need to stand equal to other medical specialties. The creation of the new manual is seen as an attempt to create a system that is consistent with neuroscience, but that goes beyond existing data. At the same time, psychiatry hopes to legitimate itself with a scientific diagnostic system. But in DSM-5, the overall definition of mental disorder in the manual is weak, failing to distinguish psychopathology from normality. Moreover, there are powerful interests, both corporate and, public, that could profit from a highly inclusive diagnostic system.

Finally, we have to address the question of whether the vision of psychiatry guiding DSM-5 is valid. Its scientific theory corresponds to a medical approach, but does not distinguish "disease" from "illness." Thus diagnoses in psychiatry may not be "natural kinds." DSM-5 raises both conceptual and pragmatic problems that will affect the future of psychiatry. In the years to come, it will be subjected to detailed empirical testing. At the same time, the diagnostic system needs to adopt a broader model that does not reduce all of psychopathology to neuroscience. These developments could eventually lead to a better system for DSM-6.

Montreal, QC, Canada Joel Paris

Contents

Contributors

Allen Frances Department of Psychiatry, Duke University, Durham, NC, USA

Allan V. Horwitz Department of Sociology and Institute for Health, Health Care Policy, and Aging Research, Rutgers University, New Brunswick, NJ, USA

Warren Kinghorn Department of Psychiatry and Behavioral Sciences, Duke University Medical Center and Duke Divinity School, Durham, NC, USA

Aaron L. Mishara Department of Clinical Psychology, Sofia University, Palo Alto, CA, USA

Joel Paris Jewish General Hospital, Department of Psychiatry, McGill University, Montreal, QC, Canada

James Phillips Department of Psychiatry, Yale School of Medicine, New Haven, CT, USA

Joseph M. Pierre Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine at UCLA, Los Angeles, CA, USA

VA Greater Los Angeles Healthcare System, Los Angeles, CA, USA

Douglas Porter Central City Behavioral Health Center, New Orleans, LA, USA

John Z. Sadler Department of Psychiatry, The University of Texas, Southwestern Medical Center, Dallas, TX, USA

Michael A. Schwartz Departments of Psychiatry and Humanities in Medicine Texas A & M Health Science Center College of Medicine, Round Rock, TX, USA

Edward Shorter Faculty of Medicine, University of Toronto, ON, Canada

Owen Whooley Department of Sociology, University of New Mexico, Albuquerque, NM, USA

Part I
Historical/Ideological Perspectives

Chapter 1
The History of DSM

Edward Shorter

> *At Ohio's Academy GP meeting one year, I gave a paper on the [new] drugs, and in the discussion afterwards, a man got up and said: 'Very erudite paper, but it isn't worth a damn to me, because when you say don't give this drug to an obsessive compulsive, this drug is good in an endogenous depression, you are talking way over my head. The doctor sitting next to me might be schizophrenic or he may have an endogenous depression, I wouldn't know this.*'
>
> —Frank Ayd, one of the pioneering psychopharmacologists, at the founding meeting of the American College of Neuropsychopharmacology, 1960 [1].

Psychiatric diagnosis turns out to be complicated, probably far more so than anyone thought 50 years ago in the heyday of psychoanalysis when diagnosis didn't really count. And the story of the Diagnostic and Statistical Manual of the American Psychiatric Association is, at one level, a tale of steady progress in getting things right. At another level, it is the story of a nosological process that has, to some extent, run off the rails. Despite enormous investments of time, thought, and academic firepower, the means of establishing a reliable nosology of psychiatric illness continues to slip from our grasp.

Psychiatry has always had a nosology, or roster of classifying diseases according to some basic principle. The motto of no treatment without diagnosis is as valid in psychiatry as in any other specialty. And modern systems of classification, detached from the humoralism of the Ancients, go back to such seminal writers as Philippe Pinel in Paris [2] and August Heinroth in Leipzig [3]. Yet how reluctant nature has

E. Shorter (✉)
Faculty of Medicine, University of Toronto, 150 College St, #83D, Toronto, ON M5S 3E2, Canada
e-mail: edwardshorter@gmail.com

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been to give up her secrets! In presenting the new diagnosis delirious mania—later seen as a form of malignant catatonia—to the profession in 1849, Luther V Bell, chief physician at the McLean Asylum for the Insane in a suburb of Boston, lamented the difficulty of digging a new disease entity "from the mass of rubbish—of confused, irregular conglomerations of amorphous appearance, to separate it from the encumbrance of incidental matters, and so present it, that others may be able to satisfy themselves of its genuine individuality" [4].

Anticipating DSM

As medicine established itself increasingly as a science rather than an art in the course of the nineteenth century, the demand became loud within psychiatry for a system of classification that went beyond the rough categories of Pinel and Heinroth. In 1851 Louis Delasiauve, a veteran psychiatrist at Bicêtre mental hospital in Paris, scorned his colleagues for their uninterest in diagnosis, leading to anarchy in treatment. "I have been preoccupied over almost the entire course of my career with ways of putting an end to this. And it seems to me that the comparative study of different kinds of types, and of the analogies they have in common as well as the differences that separate them, is calculated to lead to more satisfactory data on which a nomenclature might be based" [5]. But how to derive such data?

There are three approaches to creating a nosology: reliance on authority, on consensus, or, the third, by identifying a disease by the "medical model," a well-defined process that depends on more than "consensus" in opinion or symptoms alone. At the origins of twentieth-century classifications of psychiatric illness was the principle of authority, namely the authority of Emil Kraepelin, the great German nosologist who taught in Heidelberg and in Munich. Kraepelin simply sat in the quiet of his study, deliberated, then communicated to the profession his views about disease classifications, which thereupon were almost universally adopted. (He was, of course, a very active clinician as well.) This process began with the first edition of Kraepelin's textbook in 1883 [6] and reached its maximum influence with the massive eighth edition, the last one he was to create himself [7]. The innovative aspect of the Kraepelinian system was its intention of predicting prognosis. Not the phenomenology as such determined illness classification, but "how things are going to progress," as Kraepelin's colleague Robert Gaupp put it in 1926, the year Kraepelin died. "The prognosis is the touchstone of all of our science" [8]. In an epoch that lacked effective treatments, the ability to foretell a patient's future was the very rationale of nosology.

With the sixth edition in 1899, Kraepelin made several distinctions that are still with us. He had already originated in earlier editions the diagnosis dementia praecox, which became schizophrenia in 1908 under Eugen Bleuler's pen [9]. But in 1899 Kraepelin erected a firewall between the psychosis of dementia praecox and the affective troubles of manic-depressive illness [10]. Thus the two great illnesses of psychiatry became schizophrenia and "MDI," as different from each other as chalk and cheese and, for the most part, never destined to meet, or converge.

Yet authoritarian as he was in imposing his own concepts, in a sense, on the entire world, Kraepelin was also quite thoughtful about the requirements of successful nosology: the purpose was, as he explained in 1894, to create small, homogeneous groups of patients whose illnesses had "the same etiology, course, duration, and outcome." (He gave the presentation verbally in 1892 at a psychiatric meeting but the abstract was published only in 1894 [11].) Indeed, this is the holy grail of nosology, with differential responsiveness to medication added in today.

At an international level, the tradition of determining nosology by eminent experts rather than committees continued with Aubrey Lewis, professor of psychiatry at the Maudsley Hospital after the Second World War. Lewis angled towards the view that it was not useful to distinguish between "endogenous" and "exogenous" forms of depressive illness [12]. Yet Lewis never wrote a textbook and failed to have the same comprehensive impact on nosology that Kraepelin did. In these years the continent fell silent as a source of innovative thought because of war and the Holocaust (with a few exceptions [13]), and the baton passed across the ocean to the United States and the DSM series of the American Psychiatric Association.

The DSM series began with a document much in the tradition of authoritarian pronunciamentos rather than consensus. On October 19, 1945, psychoanalyst William Menninger, in charge of psychiatric services for the US Army during World War II, promulgated on his own a diagnostic roster, called Technical Medical Bulletin no. 203, which became the immediate ancestor of the DSM series [14]. (One recalls that in these years Army psychiatry was permeated with psychoanalysis. Max Fink describes attending the Army School of Military Neuropsychiatry at Fort Sam Houston in 1946, where the curriculum was one third general psychiatry, one third neurology, and one third psychoanalysis [15].) "Medical 203," as Menninger's creation came to be called, bore an immediate Freudian flavor, dwelling at length upon "psychoneurotic disorders... resulting from the exclusion from the consciousness (i.e., repression) of powerful emotional charges, usually attached to certain infantile and childhood developmental experiences." Chief of these disorders was "anxiety," always the vaulting stone of the Freudian edifice. Menninger spoke of "anxiety reactions... unconsciously and automatically controlled by the utilization of various psychological defense mechanisms (repression, conversion, displacement, etc.)" [14].

Yet Medical 203 also bore the Kraepelinian imprint that would spill over 7 years later into the DSM series. "Psychotic disorders," meaning serious illness, constituted a separate category. And they were separated into watertight compartments: First were "schizophrenic disorders," also called, in the tradition of Adolf Meyer at Johns Hopkins University, "reactions." Kraepelin's three schizophrenic subtypes—hebephrenic, catatonic, and paranoid—were in attendance, and chronic "paranoia," without deterioration of the personality, was, as in the Kraepelinian system, singled out as separate. Then came "affective disorders," led by "manic-depressive reaction" and quite distinct from schizophrenia. This was the firewall.

Menninger distinguished among manic-depressive illness, psychotic depression, and Kraepelin's involutional melancholia. (Curious that Menninger should have retained involutional melancholia, the serious depression of midlife, after Kraepelin himself had rejected the diagnosis and made it part of MDI.) All these nosological decisions would shortly reappear in DSM-I.