

Psychiatry's civil war

- Updated 18:18 11 December 2009 by [Peter Aldhous](#)
- Magazine issue [2738](#). [Subscribe](#) and get 4 free issues.
- For similar stories, visit the [Mental Health](#) Topic Guide

Editorial: [Psychiatry's bible: Its time has passed](#)

Since this article was first posted, the American Psychiatric Association has announced that the [publication of DSM-V will be delayed](#) until May 2013. "Extending the timeline will allow more time for public review, field trials and revisions," says APA president Alan Schatzberg.

When doctors disagree with each other, they usually couch their criticisms in careful, measured language. In the past few months, however, open conflict has broken out among the upper echelons of US psychiatry. The focus of discord is a volume called the [Diagnostic and Statistical Manual of Mental Disorders](#), or *DSM*, which psychiatrists turn to when diagnosing the distressed individuals who turn up at their offices seeking help. Regularly referred to as the profession's bible, the *DSM* is in the midst of a major rewrite, and feelings are running high.

Two eminent retired psychiatrists are warning that the revision process is fatally flawed. They say the new manual, to be known as *DSM-V*, will extend definitions of mental illnesses so broadly that tens of millions of people will be given unnecessary and risky drugs. Leaders of the American Psychiatric Association (APA), which publishes the manual, have shot back, accusing the pair of being motivated by their own financial interests - a charge they deny. The row is set to come to a head next month when the proposed changes will be published online. For a profession that exists to soothe human troubles, it's incendiary stuff.

Psychiatry suffers in comparison with other areas of medicine, as diseases of the mind are on the whole less well understood than those of the body. We have, as yet, only glimpses into the fundamental causes of the common mental illnesses, and there are no biological tests to diagnose them. This means conditions such as depression, schizophrenia and personality disorders remain difficult to diagnose with precision. Doctors can only question people about their state of mind and observe their behaviour, classifying illness according to the most obvious symptoms.

We have only glimpses into the causes of mental illnesses and there are no biological tests for them

First published in 1952, the *DSM* has its origins in a book used by the US military to determine if recruits were mentally fit for combat. The difficulty of separating mental disorders from normal variation in behaviour made it controversial from the start. Over the years, the book's influence has grown, and today it is used by doctors across the globe. The wording used in the *DSM* has a significance that goes far beyond questions of semantics. The diagnoses it enshrines affect what treatments people receive, and whether health insurers will fund them. They can also exacerbate social stigmas and may even be used to deem an individual such a grave danger to society that they are locked up. Some of the most acrimonious arguments stem from worries about the pharmaceutical industry's influence over psychiatry. This has led to the spotlight being turned on the financial ties of those in charge of revising the manual, and has made any diagnostic changes that could expand the use of drugs especially controversial. "I think the *DSM* represents a lightning rod for all kinds of groups," says David Kupfer of the University of

Pittsburgh, Pennsylvania, who heads the [task force](#) appointed by the APA to produce the revised manual.

Few would claim that the *DSM's* current version is perfect. With each revision, the number of conditions it defines has swelled, many surrounded by bewildering lists of symptoms that must be checked to assign a diagnosis. Using current *DSM* checklists, for example, 114 different combinations of symptoms can lead to a diagnosis of schizophrenia. At the same time, many patients prove hard to fit into the framework.

One aim of the work groups compiling *DSM-V* is to cut through this chaos. They are streamlining diagnoses by removing various subtypes of schizophrenia, for example, and intend to address the confusion created by the fact that many people with one condition meet criteria for other disorders as well. The *DSM-V* task force is expected to propose a series of "dimensions" to be considered with a patient's main diagnosis. So as well as deciding whether someone has, say, bipolar disorder, doctors would determine whether they are suffering from problems such as anxiety and sleeping disturbances, and assess them on a simple scale of severity.

Grandiose claims

This is widely seen as a first step towards a future in which psychiatric diagnosis has a more scientific base, where sprawling checklists of symptoms are replaced by sliding-scale measurements of the underlying determinants of mental health. Yet critics worry that even a limited embrace of this "dimensional" approach is running ahead of the science. Until we understand more about the biological basis of psychiatric disease, this approach will not be helpful, they say.

Some of the harshest criticisms have come from those who led previous revisions of the *DSM*, in 1980 and 1994. In July, Robert Spitzer and Allen Frances, both now retired, wrote a stinging [letter](#) to the APA, accusing it of planning unworkable changes and making grandiose claims. In a separate [editorial in the magazine *Psychiatric Times*](#), Frances complained that most of the authors are university-based researchers who are cut off from typical doctors and patients.

Spitzer and Frances also criticise the fact that members of the various *DSM-V* work groups have had to sign confidentiality agreements. "The main problem is that we don't know what they're doing," says Spitzer. The APA says the confidentiality agreements are to stop the manual's authors writing their own diagnostic handbooks alongside the official manual. Kupfer points out that discussion does go on: work groups proposing major changes debate their ideas in papers and at meetings. "We've done everything we can to encourage it," he says.

Another focus for Spitzer and Frances's concern is the suggestion that *DSM-V* could include new categories to capture milder forms of illnesses such as schizophrenia, depression and dementia. "The result would be a wholesale... medicalization of normality that will lead to a deluge of unneeded medication," Frances said in his editorial.

For example, one work group is considering whether it is possible to catch people in the early stages of schizophrenia or other psychotic illnesses before they have their first full-blown psychotic episode ([Schizophrenia Bulletin](#), vol 35, p 841). Some doctors prescribe antipsychotic drugs at this early stage in the hope of stopping the illness from progressing.

Libido loss

These medicines can have serious side effects, such as loss of libido, weight gain and distressing tremors and spasms, so no one would want to take them without good reason. Yet it's hard to separate distressed people who will go on to develop a psychotic disorder from the "false positives" - those who will recover or develop a different illness. The available evidence suggests that only about 30 per cent of people identified as being at risk of psychosis will go on to develop it within two years.

These medicines can have serious side effects so no one wants to take them without good reason

Nevertheless, William Carpenter, a psychiatrist at the University of Maryland in Baltimore who chairs the *DSM-V* work group on psychosis, believes the needs of the "true positives" are so great that adding a diagnostic category to cover "psychosis risk" would, on balance, be a good thing. Frances brands this proposed diagnosis as "the most worrisome suggestion entertained".

Given the controversy, psychosis risk may not make it into the *DSM* proper, and may instead appear in the appendix, as a condition needing more research. But even that designation might boost prescribing.

Frances and Spitzer are not the only ones with concerns, and there are other flashpoints (see "[Hebephilia](#)", "[Transgendered](#)" and "[Bereavement](#)"). In March, [Jane Costello of Duke University in Durham, North Carolina, resigned](#) from the work group on disorders in childhood and adolescence, worried about what she saw as a lack of scientific rigour across the whole *DSM* revision. "I felt that there was not enough empirical work being achieved or planned," she says.

The disputes are getting ugly. Senior APA figures have even suggested that Spitzer and Frances are motivated by a desire to safeguard their flow of royalties from clinical guides linked to the current *DSM*. "The fact that Dr. Frances was informed... that subsequent editions of his *DSM-IV* associated products would cease when the new edition is finalized, should be considered when evaluating his critique," leading APA figures said in a response to Frances's editorial.

Spitzer and Frances reject this charge. "To suggest that I have no concern other than the royalties is a little absurd," says Spitzer. "My annual royalties from *DSM-IV* related books are \$10,000 per year," notes Frances. "These have nothing to do with concerns I expressed."

Attention has also turned to the financial interests of those working on *DSM-V*. The APA has ruled that members of the task force and work groups may not receive more than \$10,000 per year from industry while working on *DSM-V*, and must keep their stock holdings below \$50,000. This doesn't satisfy Lisa Cosgrove of the University of Massachusetts, Boston, who studies financial conflicts in psychiatry ([New Scientist](#), 29 April 2006, p 14). She notes that the APA's ruling places no limit on industry research grants, and has found that the proportion of *DSM-V* panel members who have industry links is exactly the same as it was for *DSM-IV*, at 56 per cent ([The New England Journal of Medicine](#), vol 360, p 2035).

The final version of *DSM-V* is scheduled to be published in 2012, but given the level of controversy and the need to test whether psychiatrists can reliably use the proposed diagnoses, that date seems certain to slip.

For now, there is an uneasy ceasefire, but next month the work groups will post their proposed changes on the APA's website. Stand by for renewed hostilities.

Editorial: [Psychiatry's bible: Its time has passed](#)

Hebephilia

How young is too young?

You may have never heard of "hebephilia", but this obscure diagnosis has huge significance in the courts. If it becomes accepted it could lead to hundreds of sex offenders who have served their jail time being locked up indefinitely - on grounds that some say are spurious.

Hebephilia refers to when adults are sexually fixated on teenagers around the time of puberty. This sets it apart from paedophilia, which refers to a focus on pre-pubescent children. The *DSM-V* work group on sexual disorders is likely to call for paedophilia to be renamed paedophephilia, and include a hebephilic subtype.

The justification is the research of one work group member, Ray Blanchard of the University of Toronto in Canada. Working with sex offenders, Blanchard used a device that records blood flow in the penis to measure their arousal while they were listening to sexual material. He concluded that some men have a disorder that causes them to fixate on girls aged 11 to 14 ([Archives of Sexual Behavior, vol 38, p 335](#)).

The proposed diagnosis has been condemned by critics as dangerously blurring the boundary between paedophilia and normal male attraction to teenage girls - which isn't necessarily acted upon. Karen Franklin, a forensic psychologist in El Cerrito, California, argues that the diagnosis makes a disease out of preferences that have been shaped through human evolution. "People didn't used to live so long and mating started earlier," she says.

The work group is also considering whether some men are specifically turned on by rape - a proposed condition termed paraphilic coercive disorder. Again, the evidence is based largely on measurements of penile blood flow in response to sexual images and stories, and the validity of the condition is hotly contested.

The rows over hebephilia and paraphilic coercive disorder aren't academic, because 20 US states have passed laws that allow sex offenders who have served their sentences to be detained indefinitely in a secure hospital if they are deemed "sexual predators" ([New Scientist, 24 February 2007, p 6](#)). This can only be done if the offenders have a psychiatric disorder that increases their risk of reoffending - which few do, according to *DSM-IV*. Franklin says that if hebephilia and paraphilic coercive disorder make it into *DSM-V*, they will be seized upon to consign men to a lifetime of incarceration. This argument cuts little ice with Blanchard, however. "The clinical facts are what they are," he says.

Transgendered

We are who we say we are

Is history repeating itself? That's the question facing psychiatrists considering how gender identity should be defined in *DSM-V*. The APA has a legacy of uneasy relations with the lesbian, gay and transgender community, having included homosexuality in the *DSM's* list of psychiatric disorders until 1973. Some transgender activists want issues of gender identity kicked off the list of mental illnesses too.

These activists are up in arms over the membership of *DSM-V's* sexual and gender identity disorders work group, in particular the selection of Kenneth Zucker of the University of Toronto, Canada, as its chair. Zucker is reviled by some transgender activists for his work on therapy to reorient children who feel that they were born into the wrong

sex. An [online petition](#) objecting to the work group's composition has more than 9500 signatures.

The group is nevertheless likely to recommend changes that could actually ease tensions. One of these is a change in the name of a diagnosis that as currently phrased is inherently offensive to transgender people. "Gender identity disorder' falsely implies that the gender identities of gender variant people are in themselves disordered," says Kelley Winters, founder of [GID Reform Advocates](#).

The work group has not yet revealed its proposed name, but "disorder" will be dropped. "We're sensitive to issues of language," says Zucker. One possibility is "gender dysphoria", which focuses on the inherent distress of people living in a body that doesn't match their identity.

That would not satisfy those transgender activists who want issues of gender identity removed from the *DSM* altogether. But others argue for the retention of a renamed condition to make it easier for those distressed by the mismatch between their identity and their bodies to seek assistance, and also to help those who need sex-change surgery to get it paid for. Even now, many transgender people face problems when insurers refuse to recognise the treatment as a legitimate medical expense.

Bereavement

When does grief become an illness?

Losing a loved one is the most devastating event that most people ever experience, yet the official diagnosis of depression specifically excludes people who have recently been bereaved. Now there may be a major shift.

Not only is bereavement a known trigger for depressive symptoms, but bereaved people respond just as well to antidepressant treatment as others with similar symptoms, says Jan Fawcett of the University of New Mexico, Albuquerque, who heads the *DSM-V* work group on mood disorders. He thinks it may be time to class people who are severely distressed due to a recent bereavement as depressed.

For most people time proves at least a partial healer. But about 10 per cent of bereaved people are still debilitated by their loss more than six months later - and they can remain locked into this loop of grief for many years. Acknowledging their plight, the proposals for *DSM-V* are expected to include a new diagnosis of "complicated grief" or "prolonged grief syndrome".

The impetus for this comes from a team led by Holly Prigerson of Harvard Medical School in Boston, who has shown the condition can be reliably diagnosed ([PLoS Medicine, vol 6, p e1000121](#)). Katherine Shear, now at Columbia University in New York, has also found that the condition responds well to a form of psychotherapy designed to help bereaved people begin resuming their lives ([Journal of the American Medical Association, vol 293, p 2601](#)).