A new chapter for psychiatrists' bible

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Controversy dogs the revision of the manual used to diagnose mental illness, writes Amy Corderoy.

Allen Frances sees the future. In it, a young man wakes up early next year to discover he has a mental disorder.

James is easily distracted. At work and with friends he is always the loudest. He hates waiting for answers, finishes other people's sentences, and often feels restless.

James has always been this way, but now he meets the criteria required for a diagnosis of attention deficit/hyperactivity disorder because of a change in the way mental disorders are defined.

Madness is being redesigned. *The Diagnostic and Statistical Manual of Mental Disorders (DSM)* will be updated this year, meaning what counts as a psychiatric disorder will change.

Frances, one of the architects of the current manual, *DSM-IV*, published in 1994, knows the results of his changes to the definitions of mental illness.

“We were definitely modest, conservative and non-ambitious in our approach to *DSM-IV*,” he says. “Yet we had three epidemics on our watch.”

The making of illness

First published in 1952, the manual was initially a 130-page collection of disorders, often listed with no symptoms and heavily influenced by Freudian, psychodynamic theories.

It wasn't until its third revision, in 1980, that it really took off. Credited with saving the psychiatric profession from vague diagnoses that often varied wildly from doctor to doctor, hospital to hospital, and country to country, it added much-needed reliability to the profession.

Today, it runs to nearly 900 pages and it is estimated it could earn its owner, the American Psychiatric Association, $US100 million.

Seemingly small changes to the DSM, often referred to as the psychiatrists' bible, can have a massive impact on patients the world over, because access to treatment depends on its definitions.

Drug companies rely on the *DSM* too: if criteria for a disorder are loosened, vastly more people become candidates for medication.

Nearly 70 per cent of the *DSM-5* taskforce have declared they have ties to the pharmaceutical industry.

Frances says the changes being proposed by the *DSM-5* taskforce will see people throughout the world waking up with a mental disorder.

When his taskforce reduced the number of symptoms needed to qualify a person as having ADHD, they thought the prevalence of the disorder might increase by 15 per cent among children.

Instead, it increased by 200 per cent. At the same time, autism diagnoses increased by 2000 per cent. Frances believes the problem will get worse this time around.

"They [the taskforce] were told in the beginning to be innovative, and the only way to be innovative is to expand," the professor emeritus at Duke University, in Durham, North Carolina, says.

Rare disorders will stay relatively rare but the more mild disorders will increase.

"And the strategy for drug companies is to target these disorders because if they want to expand their market the only places they can go are kids and people who weren't previously thought of as sick," he says.

In *DSM-5* the new diagnoses are even more contentious because they concern a group least equipped to fight off the ever-reaching hands of drug company marketing: children.

Child-specific diagnoses are losing their own category in the manual and instead being integrated into adult diagnoses. The reason is that at the moment a child can be diagnosed with a childhood condition but simply by virtue of turning 18 their diagnosis might change.

For Frances, the risk is that more children will be given antipsychotic medications.

"The huge weight gain associated with anti-psychotics means you are literally shortening people's lives and I just couldn't stand by and do nothing," he says.

These drugs are the biggest selling class of prescription medications in the US, with more than $US14 billion in sales in 2008.

The most obese country in the world spends more on anti-psychotics than on cholesterol medication.

But in some cases, such as ADHD, adult symptoms are also being explicitly inserted into conditions thought of more commonly as childhood disorders.

While a child will need six of 13 hyperactive and impulsive symptoms or six of nine inattentive symptoms to be diagnosed, adults will need only four symptoms from either category.

Who does the prescribing?

This change means we should prepare for a significant increase in adult ADHD, says Melissa Raven, a psychiatric epidemiologist and policy analyst in the school of public health at Flinders University, in Adelaide.

“Requiring only four out of the 13 hyperactivity/impulsivity criteria means that someone who is essentially just rude could qualify,” Raven says. “They are lowering the diagnostic threshold so more and more people will actually qualify for a diagnosis but also more and more people will be close [to qualifying].”

Doctors diagnosing too easily, or people exaggerating symptoms, will then further increase the numbers diagnosed.

Raven says the “single worst thing” about the changes to the *DSM* is that the field trials, which test the new diagnoses in the real world, do not include GPs.

The vast majority of Australian patients seek help from their GP. They come with suffering that is as much caused by life circumstances or social differences as problems with their brain, yet often leave with only a prescription.

“GPs are not specialists, and they are in a hurry and might not even like dealing with psychiatric diagnoses,” Raven says. “GPs are extremely ill-equipped for dealing with these types of problems. They have to diagnose across a very wide range of areas so of course they can't have the in-depth knowledge”.

In Australia, about 85 per cent of prescriptions for psychiatric drugs are written by GPs, and less than 10 per cent by psychiatrists.

There were over 22 million government-subsidised prescriptions for mental health-related medications in 2009, accounting for 11 per cent of all subsidised prescriptions.

Between 2005 and 2010 the average rate of psychiatric drugs prescribed in the community increased by about 2 per cent each year, national prescribing figures show.

Is the *DSM* to blame?

Gavin Andrews, a professor of psychiatry at the University of NSW and a member of the DSM-5 anxiety working group, says the *DSM* should not be blamed for pharmaceutical companies' excesses.

“It's like saying no one should have a motor vehicle because they kill; it's the same argument,” Andrews says.

It is not necessarily bad to see relatively common diagnoses of conditions such as depression, he says.

“When you end up going across all the disorders, I think the majority of people will meet criteria for a mental disorder in their lifetime and that doesn't fuss me much,” he says. “The majority of people will meet criteria for influenza in their lifetime, although many will claim they meet it most winters.”

He believes the modern *DSM* was probably the single greatest advance in mental health care last century, and its creators are conscious of the risk of false epidemics.

Andrews believes that, in a sense, the *DSM* is a victim of its own success; needing to be all things to all people. “There is a chronic tension between its use as a research manual, practice manual and a book of billing codes. It's hard to make that work”.

He says the people creating the manual are some of the best minds in psychiatry, and are very conscious of the risks of creating false epidemics.

Andrews, a pioneer in the development of promising online treatments for anxiety disorders, believes cheaper online care could lessen the need for prescription drugs. And structured online diagnostic tools would force doctors to diagnose according to strict rules, making them less responsive to pressure from patients and parents.

“Instead of just listening to Mum, they work out if the kid actually satisfies the criteria for the disorder,” he says.

All about politics

Gordon Parker, a scientia professor in the school of psychiatry at the University of NSW, says the *DSM* has always been about politics.

“The *DSM III* was far more a political document than it was a revolution in psychiatry,” Parker says.

Before that edition, he says, depression was considered either a lifetime affliction, called melancholia, or a neurotic response to life events that could just go away.

The third edition included the latter type of depression in its broader definition as a 'peace treaty' to keep the analysts - who didn't want to lose their lucrative neurotic patients - on side.

That decision massively expanded the numbers of people diagnosed with depression, and he believes it came at great cost to melancholic depressives because they require different treatments.

“Not a week goes by as a clinician that I don't see the consequences. It drives my frustration,” Parker says. “I see patients who have had anti-depressant after anti-depressant, an anti-psychotic and even ECT and it doesn't work because as a model it's wrong.”

What really worries him is what he calls 'psychiatric expansionism and diagnostic creep'.

“Defining conditions more and more progressively until they move into normal sorts of sadness and the vicissitudes of life, you are essentially pathologising human behaviour,” he says.

The DSM influences diagnosis more in the US than it does in this country, because Australia lacks the direct-to-consumer marketing of conditions and the drugs needed to treat them, and also more commonly use other diagnostic tools, such as the World Health Organisation International Classification of Diseases codes.

But Parker worries about trainee psychiatrists taught the 'paint by numbers' approach, where conditions can be diagnosed using only lists of symptoms.

Peter Parry, a consultant child and adolescent psychiatrist and senior lecturer at Flinders University, says using a *DSM* symptom list is inadequate for a full diagnosis.

“The best diagnosis is about three paragraphs at least,” Parry says. “When you bring it back to one- or three-word phrases as a label you lose so much information.”

He gives the example of a non-psychiatric patient who has torn their medial meniscus.

“Everyone knows what that is, but if you say you have got major depression it's completely different.”

Children diagnosed with ADHD who have trouble functioning at school could have a significant attention deficit but for others 'restrictive school environment disorder' might be a better description.

“The *DSM* is useful in making us use these terms so everybody knows what you are talking about and that's great but it should have stopped at that . . . being sort of like a dictionary,” he says. “People think you have got an explanation when what you have got is a label, more a starting than an end point.”

International response

It's not that the critics believe there is no value in psychiatric diagnosis. Frances is at pains to point out the last thing he wants is for people who need medications to go off them, or to decide not to seek help.

And it's not that he believes the committee creating the *DSM* is in the hands of the drug companies.

Instead, the psychiatrists and researchers involved are so caught up in their projects that they are proposing conditions before the evidence is there to back them up.

And it seems he might find some agreement in unlikely quarters.

In November the vice-chair of the *DSM-5* task force, Darrel Regier, told a US medical news site that the DSM was no more than "a set of scientific hypotheses that are intended to be tested and disproved if the evidence isn't found to support them".

While the *DSM-5* task force sees this process as a way to promote research into the conditions and ensure medical care for those who need it, Frances sees it as a potential disaster in the making.

"If something can be misused in a diagnostic setting it will be," he says. "What they are doing will lead to a feeding frenzy and create consequences they don't want."

A growing, and increasingly vocal, group of concerned psychiatrists, psychologists and members of the public is joining him.

A petition sponsored by the American Psychological Association, and supported by nearly 50 different psychological organisations in the US, Asia, and Europe, has gathered more than 11,000 signatures.

And the American Psychiatric Association's recent attempt to shut down a popular critical blog over trademark violations backfired. The blog re-opened under a new name, dxrevisionwatch, and with increased traffic.

But the manual's designers are pushing ahead with their plans despite the criticism.

"They are wedded to their ideas," Frances says. "This thing seems absolutely clear to me, but I can't convince the people in charge. I'm like Cassandra."

TIMELINE

1994 DSM IV published

1995 Development of DSM-5 white papers and research agenda begins

2006 DSM-5 chairs appointed

April 2010 first 'field trials' of DSM proposals begin in academic medical centres

October 2010 to Feb 2012 field trials in clinical practices

December 31, 2012 Final draft of manual due.

May 2013 DSM-5 released

DSM-IV AVAILABLE ONLINE

www.appi.org/PsychiatryOnline

DSM-IV diagnoses, codes, mental disorder descriptions online.