DSM-5: A Manual Run Amok

It's time for psychiatry to drop its field guide and try to learn about mental ills

By PAUL MCHUGH

Psychiatry tops all other disciplines of medicine in captivating and confusing the public. It captivates because of the storied disturbances in human thought, emotion and behavior that psychiatrists describe. It confuses because, to the natural question, "What exactly are these disturbances?" psychiatrists today just provide a list of diagnoses, as if naming disorders explains them.

Jerome Groopman, in his informative 2007 book "How Doctors Think," confesses that "trying to assess how psychiatrists think was beyond my abilities." If this gifted physician finds psychiatry mystifying, how can we expect ordinary people who are seeking help to form suitable judgments?

Things will not improve with the American Psychiatric Association’s release this week of the fifth edition of its famed Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Like its predecessors, the massive new volume will shape what psychiatrists say and do with their patients. It is thus a perfect moment to consider how the DSM came about in the first place and why this new edition will do nothing to clear up the public's growing confusion.

From about 1940 to 1970, Sigmund Freud's theoretical concepts of mental life and its disorders dominated American psychiatry. The most enduring, problematic feature of Freudianism was its claim that the important facts about our mental life are disguised, buried in the "unconscious," stifled by convention and conformity.

Only a Freudian analyst instructed in the supposedly universal conflicts of human sexuality and domestic life (the Oedipal complex, etc.) could decode and disentangle them. By knowing these
secrets, the analyst could derive from the disguises "manifest" in dreams, slips of the tongue, symptoms and behaviors the "latent" truth provoking the different mental disorders.

Freud and his followers played down efforts at gathering such information as a patient's family background, educational and occupational course, intelligence, temperament, habits, medical condition and conscious assumptions. These factors were said to lack psychological depth.

In the 1960s, the authority of the Freudians began to wane in America, partly because their ineffectiveness with serious mental disorders became evident and partly because their treatments were costly, in both time and money. At the same time, the field began to make real progress with the discovery of medications, such as lithium, that were effective against specific and severe mental disorders. New psychological treatments such as Cognitive Behavioral Therapy also emerged and helped patients by addressing their conscious attitudes rather than conjectures about their unconscious minds.

Still, among many psychiatrists, the notion persisted that the true causes of mental disorders were unconscious. This belief opened the doors of psychiatry in the 1970s to many wild and conflicting suppositions about mental illnesses. Psychiatrists began acting like Sherlock Holmes, looking for various "dogs that didn't bark" to explain their patients' problems. This brought us fiascoes such as the multiple-personality craze and "repressed memories" of child abuse. Grotesque therapeutic programs "encounter groups," the use of hallucinogenic drugs such as LSD, primal-scream therapy also found their day, in the name of bringing "the hidden" to consciousness for treatment.

Ultimately, the profession could not tolerate the mounting turmoil. In 1980, the APA proposed simply setting aside the chaos of claims about the causes and mechanisms of mental disorders, including those of the Freudians. Were there not aspects of mental illnesses that everyone in the profession could recognize and agree upon?

With its third edition (DSM-III), the manual (which had existed since 1952) underwent a transformation. Its editors focused on codifying symptoms that seemed to distinguish one mental disorder from another. If psychiatrists would use these criteria consistently, they suggested, then perhaps researchers would be able to explain and differentiate disorders in terms of psychobiology.

This prescription for diagnostic peacemaking radically changed the psychiatric scene. No longer was it an unruly market of claims, counterclaims and "orientations." Psychiatric practices became centered on using the manual to identify disorders, much as a naturalist uses a field guide to identify birds or trees. The treatments derived from these diagnoses had no particular theory behind them. They were efforts, mostly pharmacological and rule-of-thumb, to provide relief from symptoms. Psychiatric thinking about patients and their disorders withered.

Today the public complains that psychiatrists seem ready to call every state of mental distress an illness. They see that any restless boy can receive a diagnosis of attention deficit disorder, that troubled veterans—whether exposed to combat or not—are routinely said to suffer from post-traumatic stress disorder, and that enormous numbers of discouraged, demoralized people are labeled victims of depression and have medications pressed upon them.
The public is not far wrong. A recent nationwide diagnostic census based on DSM claimed that the majority of Americans have or have had a mental disorder. As a result, an appalling number of young adults in schools and colleges are on one form or another of psychiatric medication.

The problem, though, is not only that psychiatrists have gone too far in naming mental states they surely have but that they have gone on too long with their field-guide checklists. They seem unable to do better. DSM-5 will be more of the same—a way to "know of" disorders without "knowing about" them, to draw a distinction made by William James.

With its new manual, the APA might instead have started taking steps toward a system of classification that, as in medicine, organizes disorders according to what we know about their natures and causes. Such knowledge, rather than checklists of symptoms, would then direct treatment and research.

Psychiatrists know, for instance, that depression and anxiety can derive from a number of different sources: cerebral diseases such as schizophrenia and bipolar disorder; alcoholism or drug addiction; experiences of loss, deprivation or trauma; and, more generally, a vulnerable temperament, characterized by introversion, shyness and emotional intensity.

Deciding which of these sources, alone or in combination, applies to a particular patient requires hours of evaluation. Prescribing an appropriate treatment involves not checking symptoms but determining who the patient is and what he or she has experienced and done.

DSM-5 displays none of this thinking. It remains a field guide organized by symptoms, clustered in categories that can expand without limit. Official, APA-approved psychiatry seems to lack the will to change. It justifies its stagnation not only by reminding its members of the chaos of the 1970s but by claiming that the U.S. health system would not pay psychiatrists if they tried to know their patients the way that they could and should.

DSM-5 is a missed opportunity to advance the discipline, instruct the public and encourage financial support for needed psychiatric services. Its editors seem willing to waste another decade before dispersing the mysteries of psychiatry and bringing practitioners and patients together in understanding what they are doing and why.

Dr. McHugh is University Distinguished Professor of Psychiatry at Johns Hopkins and former psychiatrist in chief at Johns Hopkins Hospital.