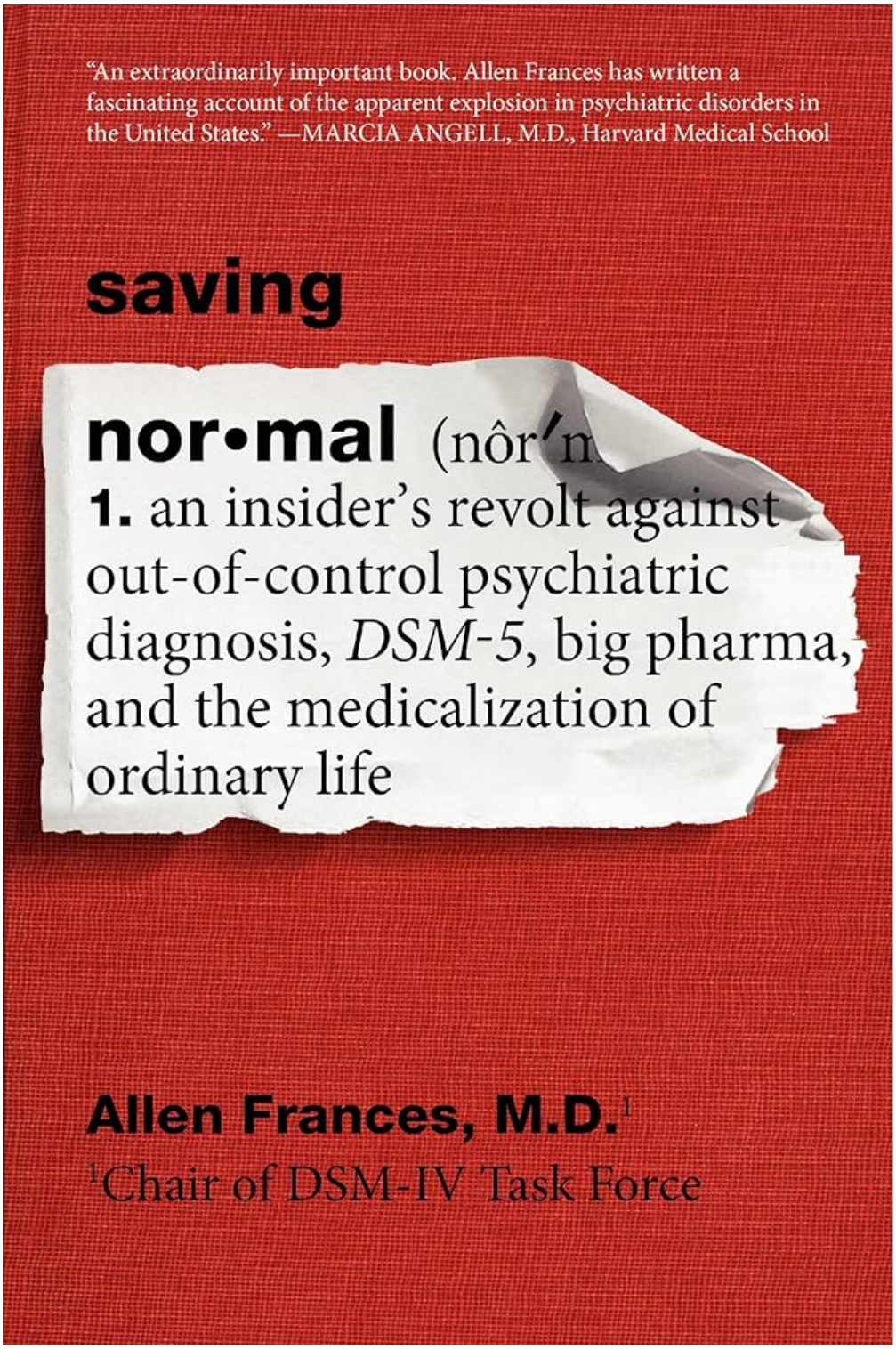
Saving Normal: An Insider's Revolt Against Out-Of-Control Psychiatric Diagnosis, *DSM-5*, Big Pharma, And The Medicalization Of Ordinary Life (2013) - Allen Frances, MD



About Dr. Allen Frances

Psychiatrist best known for chairing the American Psychiatric Association's DSM-IV Task Force and his later criticism of the diagnostic manual, particularly

the DSM-5, for its role in psychiatric overdiagnosis. Professor emeritus at Duke University and author, he advocates for a more cautious and less medicalised approach to mental health.

[What follows are quotes from the book above. These quotes stood out to psychotherapist Emil Barna in his reading of the book. They are not meant to be exhaustive nor representative of the entire book. All quotes are to be read in this context and must not replace medical and/or other professional advice. Note: Any typographical errors occured through the transcription process and do not reflect what may be found in the book.]

Blurb

Anyone living a full, rich life experiences ups and downs, stresses, disappointments, sorrows, and setbacks. These challenges are a normal part of being human, and they should not be treated as psychiatric disease. However, today millions of people who are really no more than "worried well" are being diagnosed as having a mental disorder and are receiving unnecessary treatment. In Saving Normal*, Allen Frances, one of the world's most influential psychiatrists, warns that mislabeling everyday problems as mental illness has shocking implications for individuals and society: stigmatizing a healthy person as mentally ill leads to unnecessary, harmful medications, the narrowing of horizons, misallocation of medical resources, and draining of the budgets of families and the nation. We also shift responsibility for our mental well-being away from our own naturally resilient and self-healing brains, which have kept us sane for hundreds of thousands of years, and into the hands of "Big Pharma," who are reaping multi-billion-dollar profits. Frances cautions that the new edition of the "bible of psychiatry," the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5), will turn our current diagnostic inflation into hyperinflation by converting millions of "normal" people into "mental patients." Alarmingly, in DSM-5, normal grief will become "Major Depressive Disorder"; the forgetting seen in old age is "Mild Neurocognitive Disorder"; temper tantrums are "Disruptive Mood Dysregulation Disorder; worrying about a medical illness is "Somatic Symptom Disorder"; gluttony is "Binge Eating Disorder"; and most of us will qualify for adult "Attention Deficit Disorder." What's more, all of these newly invented conditions will worsen the cruel paradox of the mental health industry: those who desperately need psychiatric help are left shamefully neglected, while the "worried well" are given the bulk of the treatment, often at their own detriment.*
Master fully charting the history of psychiatric fads throughout history, Frances argues that whenever we arbitrarily label another aspect of the human condition a "disease," we further chip away at our human adaptability and diversity, dulling the full palette of what is normal and losing something fundamental of ourselves in the process. Saving Normal *is a call to all of us to reclaim the full measure of our humanity.*

Preface

“One out of every five U.S. adults uses at least one drug for a psychiatric problem; 11 percent of all adults took an antidepressant in 2010; nearly 4 percent of our children are on a stimulant and 4 percent of our teenagers are taking an antidepressant; 25 percent of nursing home residents are given antipsychotics. [...] Loose diagnosis is causing a national drug overdose of medication. [...] Since 2005 there has been a remarkable eightfold increase in psychiatric prescriptions among our active duty troops. [...] Eighty percent of prescriptions are written by primary-care physicians with little training in their proper use, under intense pressure from drug salespeople and misled patients, after rushed seven-minute appointments, with no systematic auditing.”

Part I: Normality Under Siege

Chapter 1 - What Normal and What’s Not?

“The guiding assumptions are that "normal" has no universal meaning and can never be defined with precision by the spinning wheels of philosophical deduction—it is very much in the eye of the beholder and is changeable over time, place, and cultures.”

“in the wrong hands, utilitarianism can be blind to good values and twisted by bad ones, it still remains the best or only philosophical guide when we embark on the difficult task of setting boundaries between the mentally "normal" and the mentally "abnormal." This is the approach we used in DSM-IV.”

“modern medical science has never provided a workable definition of "health" or "illness" —in either the physical or the mental realms. [...] Health loses value as a concept when it is so unobtainable that everyone is at least partly sick.”

“The human brain is by far the most complicated thing in the known universe. The brain has 100 billion neurons [more recent research has put the number at ~86 billion], each of which is connected to 1,000 other neurons-making for a grand total of 100 trillion synaptic connections. Every second, an average of 1,000 signals cross each of these synapses; each signal is modulated by 1,500 proteins and mediated by one or more of dozens of neurotransmitters? [...] Teasing out the heterogeneous underlying mechanisms of mental disorder will be the work of lifetimes. There will not be one pathway to schizophrenia; there may be dozens, perhaps hundreds or thousands. [...] We will not have biological markers to set the boundary between normal and mental disorder until we understand the multitudinous mechanisms causing the different forms of psychopathology.”

“there isn't any reason to think that having a IQ of 70 is really different from having one of 71 or even 75? There is a 5-point error of measurement in the test, many factors may have interfered with optimal test taking, and some

people perform in life much better or worse than you might expect just from their IQ."

"Cultures differ dramatically in their conception of normal because they face different survival challenges. [...] Societies all prohibit crime, but crime abounds everywhere—perfectly normal from a statistical point of view, but perfectly abnormal from a legal one."

"Males are more adapted to fight for love and glory—consonant with their existential struggle for access to females, their prominent role in war with other tribes, and the needs of the hunt. Females are more likely to have inborn skills in nurturing and in food gathering.
But there are huge individual and cross-cultural differences and there is far from any fixed normal when it comes to male or female behavior."

[Compare the last sentence with the following quote from Baumeister & Wheelis's extraordinary book* Willpower*: "The shift in people's characters was noticed by a psychoanalyst named Allen Wheelis, who in the late 1950s revealed what he considered a dirty little secret of his profession: Freudian therapies no longer worked the way they were supposed to. In his landmark book, The Quest for Identity, Wheelis described a change in character structure since Freud's day. The Victorian middle-class citizens who formed the bulk of Freud's patients had intensely strong wills, making it difficult for therapists to break through their ironclad defenses and their sense of what was right and wrong. Freud's therapies had concentrated on ways to break through and let them see why they were neurotic and miserable, because once those people achieved insight, they could change rather easily. By midcentury, though, people's character armor was different. Wheelis and his colleagues found that people achieved insight more quickly than in Freud's day, but then the therapy often stalled and failed. Lacking the sturdy character of the Victorians, people didn't have the strength to follow up on the insight and change their lives."]

[Freud] used dreams to uncover the meaning of symptoms, symptoms to uncover the meaning of myths, and his patients' fantasies to interpret Hamlet and Oedipus. [...] Freud emphasized the ways we are all in the same boat. He saw no great qualitative difference between the artist and the lunatic, and both resemble the rest of us every night when we dream. [...] No one is ever completely normal for Freud; everyone is neurotic and could use more insight.

"Some mental disorders describe short-term states, others lifelong personality; some reflect inner misery, others bad behavior; some represent problems rarely or never seen in normals, others are just slight accentuations of the everyday; some reflect too little self-control, others too much; some are intrinsic to the person, others are culturally determined; some begin early in infancy, others emerge only late in life; some affect thought, others emotions, behaviors, interpersonal relations; some seem more biological, others more psychological

or social; some are supported by thousands of research studies, others by a mere handful; some may clearly belong in *DSM*, others could have been left out and perhaps should be eliminated; some are clearly de-fined, others not; and there are complex permutations of all of these possible differences."

Billions of research dollars have failed to produce convincing evidence that any mental disorder is a discrete disease entity with a unitary cause.

"Schizophrenia is a useful construct—not myth, not disease. It is a description of a particular set of psychiatric problems, not an explanation of their cause. Someday we will have a much more accurate understanding and more precise ways of describing these same problems."

"There are no genetically caused racial differences in mental disorder."

There is really nothing magical or preordained about any of the DSM *thresholds —shades of gray exist between their seemingly black and white cutoff points. Requiring five symptoms and two weeks for major depressive disorder derives from a fairly arbitrary choice, not a scientific necessity.*

"Before DSM-Ill, there were too few diagnoses-now, because of diagnosis inflation, there are far too many. [...] Reliability means agreement and consistency—will different clinicians seeing the same patient arrive at the same diagnosis. Validity means truth—will the diagnosis tell you what you want to know. [...] *DSM* definitions do not include personal and contextual factors, such as whether the depressive symptoms are an understandable response to a loss, a terrible lite situation, psychological conflict, or personality factors."

"in 1997 [...] drug companies brought new and expensive medicine for ADD to market [...] Soon the selling of ADHD as a diagnosis was ubiquitous [...] an unexpected epidemic was born, and the rates of ADHD tripled."

"In real life, making a diagnosis is like finding a needle in a haystack containing hundreds of possible choices. [...] Field trials are absolutely necessary but extremely fallible. New suggestions will perform much better in the trial than in real life. Possible future misuses may be entirely undetectable and unpredictable. At their best, field trials will help you avoid some, but certainly not all, the possible future trouble spots."

Most normal people have at least occasional mild and transitory symptoms (e.g., sadness, anxiety, sleeplessness, sexual dysfunction, substance use) that can easily be misconstrued as mental disorder.

"Disease mongering is the fine art of selling psychiatric ills as the most efficient way of peddling very profitable psychiatric pills. Manipulating the market is particularly easy in the United States because we are the only country in the entire world that allows drug companies the freedom to advertise directly to

consumers."

"Resiliency is built into every aspect of our biological, psychological, and social being. We are hardwired to work remarkably well, but are far too complicated always to work perfectly and we can lose purchase on normality by mislabeling as mental disorder each and every one of our glitches. [...] Each of our cells is a complex and hardworking factory whose survival depends on maintaining the proper metabolic balance of millions of chemical interactions. Each organ is a collaboration of cells and our body is a collaboration of organs, each dependent for its survival on the balanced functioning of all the others. Homeostasis is what keeps our body temperature, blood pressure, and pulse rate stable. Our body is a constant wonder of billions of trade-offs."

"Cancer, diabetes, hypertension, heart failure, obesity, and most other illnesses all represent the breakdown of homeostatic feedback mechanisms that normally keep our bodies in balance. [...] Our thoughts, emotions, and behaviors are the final result of an indescribably complex coordination of billions of cells firing off in a carefully tuned, exquisite equilibrium."

[Diagnostic inflation—an interesting term...]

Diagnostic inflation occurs when we confuse the typical perturbations that are part of everyone's life with true psychiatric disorder [...] The best way to deal with the everyday problems of living is to solve them directly or to wait them out, not to medicalize them with a psychiatric diagnosis or treat them with a pill. [...] Medication is essential when needed to reestablish homeostasis for those who are suffering from real psychiatric disorder. Medication interferes with homeostasis for those who are suffering from the problems of everyday life.

"we have far too much faith in pills, far too little trust in resilience, time, and homeostasis."

Chapter 2 - From Shaman To Shrink

"In the eighth century BCE (at the very time Homer was compiling his songs of Troy), the first medical temple was dedicated to the cult worship of Asclepius, god of healing. You could recognize Asclepius by his distinctive rod with coiled snake, which remains the symbol of medicine. [...] The Asclepieia were all-purpose—temple, hospital, hotel, health spa, resort, entertainment center, and medical school—some combination of Lourdes, the Mayo Clinic, and a Ritz-Carlton."

[7th century BC]

The worship of unseen supernatural forces was replaced by close observation of the natural world and careful reasoning about the underlying principles that

govern its operation. [...] Hippocrates introduced a fully biological understanding of mental and medical illness that required no gods, no priestly authority, no sacrifice, and no ritual incantation. "From nothing else but the brain come joys, delights, laughter and sports, and sorrows, griefs, despondency, and lamenta-tions... and by the same organ, we become mad and delirious, and fears and terrors assail us... all these things we endure from the brain, when it is not healthy." [...] Hippocrates clustered symptoms into many new diseases, each with well-documented course, predictable prognosis, and particular epidemiology. He described mania, melancholia, phrenitis, and phobia. No mysticism of any sort intruded upon diagnosis and treatment.

[There are 3 groups of people, according to Hippocrates...]

those who get better on their own; those who need medical treatment; and those who will not respond to any intervention.

[Galen—interested in personality; lived 130-200 AD]

Our fate is not determined by our stars or by the demons or the gods—instead it is based on the balance of our bodily chemistries. This biological model of temperament and its effect on behavior is not very different from modern theories, except that he got the specific chemistries wrong. [...] Too much blood produced an excessively sanguine personality; too much yellow bile, the choleric; too much black bile, the melancholic; too much phlegm, the phlegmatic. [...] Illnesses might come and go but your temperament was inborn and fairly stable. It could be influenced and brought into balance with appropriate interventions—diet, activity, herbs, bloodletting, cupping, purging. [...] The humoral theory wasn't conclusively overturned until the mid-1800s, when Virchow demonstrated the role played by the cell in disease. But Galen's insight that inborn tendencies in personality affect mental and physical illness is as fresh as the day it was born.

[The Church and demons...]

The treatment of the mentally ill in Europe went into the Dark Ages, which lasted from the fall of Rome (in the fifth century) to the rise of Philippe Pinel (in the late eighteenth). The dark ages were never nearly so benighted as we imagine (and there were always isolated bright spots), but for the mentally ill this was the worst of times, the worst of places. [...] Exorcism, inquisition, torture, and the stake replaced medical treatment. The mentally ill were inhabited by dangerously contagious, demonic forces that had to be destroyed as part of God's struggle against the devil.

"The *Malleus Maleficarum*, published in 1487, codified demonic doctrine and provided rationale and legal force for an inquisition of the mentally ill' They were weeded out with brutally efficient and inhumanly cruel bureaucratic methods. The mad were judged by God and man to be witches and demons,

deserving no mercy and (with few exceptions) receiving none."

"Many Christian charity hospitals were founded in the thirteenth century in monasteries and on the stops to the holy land or pilgrimage sites. The mad, the physically ill, lepers, orphans, and the poor were given room, board, prayers, and Christian understanding by monks and nuns."

"Galen's treatises that had previously been translated from Greek to Arabic were now translated from Arabic to Latin. Town universities began to replace monasteries as centers of learning, and each established a medical faculty with a naturalistic worldview that to some degree balanced the demonology of its theology department. The professors of medicine taught that natural, humoral causes of madness should be considered exclusions before assuming demonic possession."

[Did the Arabs 'invent' psychiatry?]

The Arabs were the first people in the world to introduce quantitative experimental science, taking advantage of their convenient number system (now ours), which greatly facilitated the computations that were so tedious using Roman numerals. [...] The Koran has an enlightened view of mental illness, with none of the denigrating demonology of the Judeo-Christian and Greco-Roman traditions. No angry spirits, no jealous gods. Mental illness was a practical problem to be dealt with on human and humane terms, with no supernatural blinders. The Koran enjoins "feed and clothe the insane... and tell splendid words to him." [...] The first hospital specifically for the mentally ill opened in Baghdad in 705; Cairo followed in 800; and soon many other major cities. [...] The Arab world created a completely workable description of disorders equivalent to a modern DSM. Severity was divided into levels that were equivalent to later concepts of neurosis and psychosis. Depression was divided into endogenous, reactive, agitated, and involutional. There were good descriptions of mania, delirium, dementia, epilepsy, meningitis, and stroke. Delusions, hallucinations, strange behavior, and poor judgment were grouped into something like schizophrenia. Phobias, obsessions, compulsions, impotence, sleep disorder, hypochondriasis, and lovesickness were recognized.

"Living at the dawn of the Enlightenment in seventeenth-century Cromwellian England, Thomas Sydenham['s] special role was to bring nosology, which is the classification of diseases, back to the center of medical attention. He was a master at describing syndromes and diseases. Observe, analyze, and compare. Identify regularly cooccurring clusters of symptoms and study their course and prognosis. [...] **Unlike the more gullible Charcot and Freud, working two hundred years later, Sydenham recognized that patients presenting with the physical symptoms of psychological distress could often be made worse by overtreatment.**" (emphasis mine for this and all future references in similar bolded format, unless otherwise stated)

[The beginnings of modern psychiatry...]

[During the Industrial Revolution, the] mad were considered less than fully human, more like wild animals needing taming, whipping, and chaining, and were subject to zoolike public demonstrations meant to raise revenue. Philippe Pinel saved the patients and created the profession of psychiatry in the Western world. [...] He stripped away the medieval superstition that mental illness was demon possession and that its victims were to be dreaded, denigrated, neglected, perhaps even burned at the stake. He convinced (almost) everyone that mental illness comes from entirely natural causes equivalent to the causes of medical illness. And he developed a new model of "asylum" care devoted exclusively to the needs of the mentally ill, who he felt should be treated with respect in a pleasant and safe environment. [...] Pinel was deeply interested in each patient's life story—the particular hopes, fears, motives, and circumstances that shape who we are. He wanted to learn how their troubles in life interacted with the illness. Pinel believed mental disease was caused by some combination of heredity, physiological damage to the brain, psychological and social stress, and the previous hideous treatment the patients had often received. [...] Pinel was modest. He presented his suggestions tentatively, "for the time being." [...] Following Pinel, there was an amazing flurry of creative classifying a succession of different ways of sorting psychiatric disorders was suggested during the remaining years of the nineteenth century. The early systems were French, but then the center of scientific gravity gradually shifted to Germany, culminating in Emil Kraepelin's crucial distinction between schizophrenia and bipolar disorder. [...] Kraepelin's moonlighting job changed the history of psychiatry. The table of contents of his remarkably popular and influential textbook became the *DSM* of its time and later formed the basis for our own *DSMs*. [...] People usually associate Freud with treatment, not diagnosis-but he did as much to figure out the classification of the outpatient conditions as Kraepelin had done for the inpatient. Interestingly, Freud had also become a classifier only because he too was very short on cash, in his case to get married and start a family. Early in his career, Freud had been a very promising neuroscientist, one of the pioneers in understanding the importance of the neuronal synapse in brain functioning. [...] he became the Darwin of the consulting room, using astute clinical observations to make strikingly accurate guesses on how unconscious, inborn instincts play a central role in who we are, what we feel, how we think, and what we do-both in sickness and in health. [...] In developing the altogether new field of psychoanalysis, Freud reconceptualized "neurosis" as being due to psychological conflict—conditioned by the biology of the brain, but not a simple brain disease. And then he proceeded to classify the neuroses—separating mourning from melancholia; panic disorder from phobias and generalized anxiety; and describing obsessive-compulsive disorder, the sexual disorders, and the personality disorders. [...] Psychiatrists left hospitals in droves to establish outpatient office practices; whereas in 1917, only 10 percent of psychiatrists practiced outside hospitals, now most do.

“Psychiatric illness was identified as a major threat to the war effort—a frequent cause of unfitness for duty; a common form of combat casualty; and a source of continuing disability in those who returned home. […] A new and expanded diagnostic classification was devised by the army, revised by the Veterans Administration and revised again by the American Psychiatric Association as the *Diagnostic and Statistical Manual I*, published in 1952.”

DSM-I (published in 1952) and *DSM-II* (published in 1968) were unread, unloved, and unused.

[A story about the psychologist Robert Spitzer]

[This] clever psychologist showed how easy it was to lure psychiatrists into providing not only inaccurate diagnoses but also wildly inappropriate treatment. Several of his graduate students went to different emergency rooms stating they were hearing voices. Every single one was promptly admitted to a psychiatric hospital despite thereafter acting in a perfectly normal manner, and each was kept for several weeks to several months. Psychiatrists looked like unreliable and antiquated quacks […] Bob had been among the pioneers in creating the checklists of the Research Diagnostic Criteria—a criteria-based method of sorting symptoms into disorders that increased the diagnostic agreement of raters participating in research studies. […] Spitzer had laid the foundations for the psychiatric research enterprise. […] In 1975, he was asked to chair the *DSM-III* Task Force and given wide authority to set his own goals, choose methods, and pick collaborators. […] His goal was nothing less than to transform psychiatric practice as performed everywhere in the world and by all the mental health disciplines. […] *DSM-III* would end the diagnostic anarchy, would focus attention on careful diagnosis as a necessary prerequisite to more precise and specific treatment selection, and would also form a much-needed bridge between clinical research and clinical psychiatry. The development of *DSM-III* faced one great handicap. There was very limited scientific evidence then available to guide any of its decisions […] Bob filled the huge gaps by bringing together small groups of experts on each disorder and picking their brains to thrash out how best to define the criteria sets. […] A group of about eight or ten experts would be virtually locked down in a room and were not to emerge until they could come to an agreement. […] Their passionate views were argued with the fierce determination that comes from lived experience, rather than scientific data, and there seemed to be no rational way of choosing among their differing suggestions. […] *DSM-III* was advertised as atheoretical in regard to etiology and equally applicable to the biological, psychological, and social models of treatment. […] patients were rated not just on Axis I psychiatric symptoms but also on Axis II personality disorders, Axis III medical illness, Axis IV social stressors, and Axis V, overall level of functioning. […] *DSM-III* was the victim of its own success—it became the "bible" of psychiatry […] **Diagnosis should just be one part of a complete evaluation, but instead it became dominant. Understanding the whole patient was often reduced to filling**

out a checklist.

“diagnosis needed to rest in order to let research catch up. It made no sense to keep rearranging the furniture of descriptive psychiatry, creating new diagnoses or altering the thresholds of existing ones, based only on the whims of the experts who happened to be in the room. […] Prozac's sales took off at least in part because the *DSM* definition of major depressive disorder was so loose. The message was clear—psychotropic drugs offered vast market potential, and sales could be greatly influenced by *DSM* decisions.”

“I knew that if we set a high scientific burden of proof, few changes would be made because there would not be convincing evidence to support them. […] **No single person should be left free to determine the future of a diagnostic system that has such wide influence. The numerous problems that afflicted *DSM-5* illustrate the risks inherent to unchecked, potentially idiosyncratic leadership**.”

[On the composition of DSM-IV]

There were no votes, and I don't remember any serious disagreements. […] Stage 1 was a searching literature review that would painstakingly gather the available scientific data, with special consideration given to the possible risks and unintended consequences of any change. Stage 2 consisted of data reanalyses funded by the MacArthur Foundation. This allowed us to access already collected but not yet analyzed data sets that lived in the computers of investigators around the world. […] Stage 3 consisted of NIMH-funded, peer-reviewed field trials covering twelve disorders where changes were contemplated. […] The pet proposals of the experts were consistently shot down because the science wasn't there to support them.

“DSM-5 went far wrong in large part because it was secretive and closed to outside correction.”

“The United States became the only country in the world that allows direct-to-consumer advertising of pharmaceuticals.”

“No one dreamed that drug company advertising would explode three years after the publication of *DSM-IV* or that there would be the huge epidemics of ADHD, autism, and bipolar disorder—and therefore no one felt any urgency to prevent them. […] We made very few changes; developed and implemented a meticulous method of scientific review; improved the precision of the manual's writing and coding; and made only one obvious mistake. On the negative side: **Our changes contributed directly to the false epidemics of autistic, attention deficit, and adult bipolar disorder**; we did nothing to prevent the overdiagnosis of several other disorders that have been puffed up by the drug companies; and our one outright mistake was a disaster, a sloppily worded paraphilia section that has allowed the widespread unconstitutional abuse of

involuntary psychiatric hospitalization."

56 percent of our experts had some financial connection to drug companies.

Chapter 3 - Diagnostic Inflation

Medical research has made such enormous advances that there are hardly any healthy people left.
—ALDOUS HUXLEY

"Diagnostic inflation has led to an explosive growth in the use of psychotropic drugs; this then produced huge profits that have given the pharmaceutical industry the means and the motive to blow up the diagnostic bubble into an ever-expanding balloon."

"The risks of getting cancer from the X-ray exposure far outweighed any potential benefit in picking up early cancers. Preventive intervention would be wonderful, if only we had an accurate way to identify who needs it. **But most early screening picks up lots of people who are better left alone**. [...] Preventive medicine is a terrific goal gone badly astray because it became industrialized and enslaved by profit and hype. [...] Prostate cancer screening is no longer recommended—it failed to save lives and resulted in much needlessly aggressive surgery. Breast cancer screening has been much truncated. No more CT scans for headaches or X-rays for back pain. And it turns out that bronchodilators and oxygen don't work for most people with chronic obstructive pulmonary disease. [...] Screening tests routinely set their bar low so as not to miss people who need identifying but in the process inevitably wind up mislabeling lots of people who don't."

Meanwhile we neglect what are the best forms of prevention—i.e., promoting exercise, proper diet, moderation in alcohol use, abstention from tobacco and drugs.

[Can the environment make us sicker?]

Among the hundreds of thousands of generations of our ancestors who have ever walked this earth, we are undoubtedly the luckiest— extraordinarily privileged to live now and to live here. [...] our mental discomforts can preoccupy us as much as they do only because most of us don't have to worry about our next meal or the threat of being eaten by a passing tiger. [...] The only environmental pollutants to have a proven substantial impact on mental disorder are alcohol and drugs. [...] **it is the childhood disorders not much affected by substances that have recently expanded the most**. [...] **Societal stress is not causing more real mental illness**, but there are other societal trends that do promote the sense that we are getting sicker. Our world is homogenizing—**we have increasingly less tolerance for individual difference or eccentricity and instead tend to medicalize it into illness**.

[The quote above reminds me of something dopamine expert Dr. Anna Lembke said: "we are wired to consume as much as possible of whatever releases dopamine in our brains, to have survived evolution to this date, and yet we're living in this world where we have access to so many drugified substances and behaviors that we've all become vulnerable to this problem. [...] **one of the things that I think has happened in the field of addiction medicine that maybe isn't the best, is that oftentimes patients themselves, as well as their providers, are digging really deep to find the trauma or the reason that someone has become addicted. And I think that that's important to do in some cases. But in other cases, it can lead to kind of manufacturing trauma where there really isn't any.** *[...] I do believe we have gone a bit soft, but I don't think it's a moral problem or a character problem. I actually think it's a physiological problem based on the fact that we're insulated from pain and we're exposed to all kinds of pleasures. So I really think that we have, individually and collectively, reset our reward pathways to the side of pain [...] because we've had so much pleasure. [...]* ***So that*** **now we need more and more pleasure to feel any pleasure at all, and the slightest little pain, and we're experiencing excruciating pain.** *You add to that the fact that we have a culture that tells us we should never be in pain—and that if we are, something's wrong with our life, or something's wrong with our wife, or something's wrong with our job—and so now you've got a whole generation of folks who feels like they're experiencing more pain because they literally do not have the mental calluses to tolerate pain. And now they're being told [...] "If you have any pain at all, you must have something wrong with your brain. Go see a doctor. Go take a pill." And I think this is really, this is not a direction we want to keep going in." From The Diary Of A CEO with Steven Bartlett: The Dopamine Expert: Doing This Once A Day Fixes Your Dopamine! What Alcohol Is Really Doing To Your Brain! Your Childhood Shapes Future Addictions!, 2 Jan 2025 https://podcasts.apple.com/au/podcast/the-diary-of-a-ceo-with-steven-bartlett/id1291423644?i=1000682374097&r=3669]*

"Because **there are no biological tests or clear definitions that distinguish normal from mental disorder**, everything in psychiatric diagnosis depends on very easily influenced subjective judgments. [...] Experts become true believers who really come to love their pet diagnoses and want to see them grow."

"If autism, ADHD, or pediatric bipolar disorder is a prerequisite to being admitted to a small class with lots of individual attention, equivocal cases get shoehorned into these categories, and soon an epidemic is born."

"Because veterans' benefits require a diagnosis of PTSD, PTSD gets overdiagnosed. There is a paradox—trying to help by providing a diagnosis may wind up hurting. Many returning vets from Iraq and Afghanistan are having trouble landing jobs because of the stigma associated with their diagnosis of

PTSD."

It would be a lot cheaper and better for insurance to reimburse the doctor for watchful waiting and counseling, rewarding him for not jumping to diagnostic conclusions that are very costly in the long run.

"Every so often, the newspaper will report that rates of psychiatric disorder are climbing [...] Don't believe the numbers.
The "rates" have been generated by psychiatric epidemiologists, using a method that is inherently flawed and systematically biased in the direction of overreporting. [...] isolated or mild symptoms alone do not define psychiatric disorder—they must cohere over time in a specified way and also cause significant distress or impairment. Epidemiologic studies routinely ignore these crucial requirements. They mistakenly diagnose as psychiatric disorder symptoms that are mild, transient, and lacking in clinical significance."

[Some comments on pharmacology...]

"benzos" required no great expertise, primary care physicians took over most of the prescribing. [...] it turned out that Librium and Valium (and even more, their dreadful younger sib Xanax, introduced in the 1980s) were really quite addicting and not so benign in overdose, particularly when mixed with alcohol or other drugs that depress respiration. [...] SSRIs were also prescribed for panic disorder, generalized anxiety, social phobia, OCD, PTSD, eating disorders, premature ejaculation, and compulsive gambling, and as a general pick-me-up. [...] SSRIs fit so neatly into everyday life that 20 percent of women now take them. Diagnostic inflation will always be an inevitable consequence of an aggressively marketed, easy-to-take pill. [...] The newer generation of atypical antipsychotics (Risperdal, Zyprexa, Seroquel), introduced in the mid-1990s, are an even more astounding and frightening marketing triumph. [...] the fixed stare, rigid posture, tremors, abnormal movements, and drooling were dead giveaways. [...] Antipsychotics were soon being prescribed promiscuously, even by primary care physicians, to patients with garden-variety anxiety, sleeplessness, and irritability. [...] Primary care physicians are prescribing potentially dangerous medications, outside their competence, for people who should not be taking them.

[Follow the money—there you'll find the motive...]

Pharma spends twice as much money ($60 billion) on promotion as on research, and too often they fund the wrong kind of clinical research, done in the wrong way, and with the wrong motives [...] **The claim that drugs are so expensive because they require so much research is pure smoke screen**.

"There is never a fair risk/benefit/cost calculus—the benefits are exaggerated, the risks minimized, the costs ignored."

“An alert French surgeon noticed that a drug called Thorazine, used preoperatively to prevent nausea, also happened to calm down his patients and made them indifferent to the stress of the procedure. He passed this nugget on to his psychiatrist brother-in-law, and before long the first specific antipsychotic was born. MAO inhibitors that were used to treat tuberculosis were noted to also cheer up the patients, and we had our first antidepressants. And lithium had an unexpected calming effect on laboratory animals that led to its use in mania.”

“Valium and Librium [...] calmed people down but often addicted them and caused all sorts of withdrawal problems.”

“never once has Pharma created a product that exceeded the effectiveness of the drugs available sixty years ago.”

Only a very few people have severe mental illness, many more have mild mental illness, but **the real mother lode of market share is the worried well**.

“Pharma has not been constrained by the fact that children and the elderly are the two most difficult demographic groups to diagnose accurately or that they are the most vulnerable to harmful drug side effects or that excessive use of antipsychotics in nursing homes results in increased mortality. And, even more trou-bling, it is the very most vulnerable of kids who get the most medicine—those who are economically disadvantaged or in foster care. Seven percent of Americans are now addicted to a legal psychotropic drug? **Prescription drug abuse has become a bigger problem than illicit drug abuse**.”

DRUG COMPANY HALL OF SHAME

PREPARED BY MELISSA RAVEN PHD

DATE	COMPANY	FINES/ SETTLEMENTS	DRUG(S)	CULPABLE ACTS
August 2012	Johnson & Johnson	$181 million civil	Risperdal	Off-label promotion[25]
July 2012	GlaxoSmith-Kline	$3 billion: $1 billion criminal, $2 billion civil	Paxil, Wellbutrin, Avandia	Off-label promotion; failure to report safety data (Avandia)[26]
May 2012	Abbott	$1.5 billion: $700 million criminal, $800 million civil	Depakote	Off-label promotion[27]
April 2012	Johnson & Johnson	$1.1 billion criminal	Risperdal	Off-label promotion to children and elderly; fraudulent marketing tactics[28]
January 2012	Johnson & Johnson	$158 million	Risperdal	Off-label promotion, misrepresentation of safety[29]
September 2010	Novartis	$422.5 million: $185 million criminal, $237.5 million civil	Trileptal	Off-label promotion, for bipolar disorder, neuropathic pain[30]
September 2010	Forest	$313 million: $164 million criminal, $149 million civil	Lexapro, Celexa, Levothroid	Off-label promotion, for children and adolescents; false claims; distribution of unapproved drug (Levothroid)[31]
April 2010	AstraZeneca	$520 million civil	Seroquel	Off-label promotion, targeting geriatricians, PCPs, pediatricians[32]
September 2009	Pfizer	$1.3 billion criminal, $1 billion civil	Geodon, Lyrica, Bextra, Zyvox	Off-label marketing[33]
January 2009	Eli Lilly	$1.415 billion: $515 billion criminal, $800 million civil	Zyprexa	Off-label promotion, for dementia, agitation, aggression, hostility, depression, and generalized sleep disorder[34]
September 2007	Bristol-Myers Squibb	$515 million civil	Abilify, Serzone, among others	Illegal marketing and pricing; off-label promotion[35]
July 2007	Purdue	Nearly $635 million civil fines, penalties, and restitution payments, $500,000 criminal	OxyContin	Fraudulent misbranding, causing false claims to be filed[36]
2004	Warner-Lambert (Pfizer)	$430 million: $240 million criminal, $190 million civil	Neurontin	Off-label promotion, for bipolar disorder, pain, migraine, alcohol withdrawal[37]

[On placebo...]

The "placebo effect" refers to people getting better because of positive expectations independent of any specific healing effect of the treatment. The placebo effect is very effective— people routinely get great results from treatments that have nothing whatever to do with their illness.

[The real contributor to healing is not a pill...]

Time may not always be the best healer and it certainly doesn't heal all wounds, but it always has been and still is the most efficient and safest way to deal with many of life's physical and psychological problems. [...] **People get better if they believe in a treatment and have full confidence that it will help them get better**—however irrelevant or even dangerous it may be. [...] Your brain's pleasure centers actually light up more when you think you are drinking the costlier wine, even if you're not. Expectation isn't all of experience, but it certainly does shape a goodly portion of it. Similarly, placebo pain pills dampen the brain's response to painful stimuli; placebo antidepressants mimic the brain effects of real antidepressants; placebo Parkinson's pills stimulate the brain's dopamine system; placebo diabetes pills affect blood sugar: placebo caffeine and Ritalin have a stimulating impact on brain centers; and placebos profoundly affect the immune system. [...] The best way to get great results with a pill is to treat people who don't really need it—**the highest placebo response rates occur in those who would get better naturally and on their own**.

“To paraphrase Voltaire, the art of medicine sometimes consists in amusing the patient while nature cures the disease.”

“you now need to have a *DSM* diagnosis to get a prescription for an expensive pill that often has no more usefulness than would a placebo—a great boost to diagnostic inflation.”

“Almost three fourths of the 11 percent of the U.S. population now taking antidepressant drugs have no current symptoms of depression. Some of these people would soon get quite sick again were they to stop the pills—they need them as prophylactic protection against the return of a chronic or recurring depression.”

“The seeming great disadvantage of having little (if any) efcacy against anxiety was more than counterbalanced by Buspar's also having almost no side effects. Being the perfect, easy-to-use, and expensive placebo was just the right prescription for bringing in huge profits.”

“it would be nice if people could be more skeptical of drug company claims that the worries and miseries of everyday life are just a "chemical imbalance" that can be cured with a pill.”

“Primary care physicians (PCPs) now do most of the prescribing of psychiatric drugs: 90 percent of antianxiety drugs; 80 percent of antide-pressants; 65 percent of stimulants; and 50 percent of antipsychotics. [...] Anywhere between 25 to 50 percent of patients seen in primary care present with at least some emotional distress as part of the reason for coming to the doctor. Most of the patients treated by PCPs have mild disorders—precisely the ones most likely to have a placebo response. **Once recovered, the patient will usually misattribute his improvement to a medicine that did nothing and feel**

compelled to stay on it unnecessarily and for prolonged periods. […] Psychiatric medications can do a lot of good when properly prescribed, but a lot of harm when handed out so casually and after such incomplete diagnostic evaluations."

"Accurate diagnosis requires expertise and simply can't be done properly in the seven minutes most PCPs now get to spend with patients—especially when the patients have been primed by false advertising to demand the wrong thing. […] There is almost never a justification for the use of antipsychotic and antianxiety medication in primary care, but it is done all the time. […] He is the health provider of first, and perhaps last, resort, as often the patient can't afford specialty care or it may be unavailable."

"One study found that by age thirty-two, 50 percent of the general population had already qualified for an anxiety disorder; more than 40 percent for mood disorder; and more than 30 percent for substance dependence. […] The trumpeting of inflated rates has fueled drug company claims that we are underdiagnosed and undertreated—keeping the vicious cycle spinning. […] **Childhood bipolar disorder increased by a miraculous fortyfold; autism by a whopping twentyfold; attention deficit/hyperactivity has tripled; and adult bipolar disorder doubled**."

[The following is flabbergasting!]

Antipsychotics have proven usefulness only in treating the disabling symptoms of schizophrenia and bipolar dis-order, but this has not stopped drug company seduction promoting their general use for anyone having trouble sleeping, or run-of-the-mill anxiety, or depression, or irritability, or eccentricity, or the temper tantrums of youth, or the crankiness of old age. […] We have become a pill-popping society, and very often it is the wrong people who are popping the wrong pills as prescribed by the wrong doctors.

"A drug company is a multinational corporation whose main goals are profit, market share, and survival. […] drugs prescribed by doctors now account for more emergency room visits for overdoses than do street drugs and are also increasingly responsible for accidental iatrogenic deaths. […] Sometimes the cause is **doctor creep**—a drug-seeking patient getting all the meds he can from different doctors blind to one another's prescriptions. […] Some doctors seem to use the same combination of medications on every patient, regardless of symptom presentation. […] All this said, polypharmacy is sometimes rational and even necessary. The combination of antipsychotic and antidepressant works much better than either alone in treating bipolar disorder or psychotic depression. When a patient has had a definite but partial response to one drug, another may be needed to get a full response."

[On psychotherapy… It takes works, so people avoid it.]

psychiatrists who provide psychotherapy along with medication during a forty-five-minute outpatient visit earn 41 percent less than do psychiatrists who provide three fifteen-minute medication management sessions. [... That said, p]sychotherapy [...] lacks a unified, catchy message to counter the seductively misleading drug company promo "it is all chemical imbalance." But psychotherapy does have a much more important and truthful story to tell—that **it performs as well as drugs when compared head-to-head in people with mild to moderately severe problems. Though psychotherapy takes a bit longer to work and costs more upfront, it has more enduring beneficial effects, and that may make it cheaper and better in the long run than long-term medication**. Taking a pill is passive. In contrast, psychotherapy puts the patient in charge by instilling new coping skills and attitudes toward life.

“Evolution has wired into human nature an uncharitable wariness and lack of compassion for those who are different and don't satisfy tribal standards. [...] A great deal of the trouble comes from a change in how you see yourself—the sense of being damaged goods, feeling not normal or worthy, not a full-fledged member of the group. [...] **Labels** can also **create self-fulfilling prophecies. If you are told you are sick, you feel and act sick, and others treat you as if you are sick**. [...] Our ancestors lived through wars and privations unimaginable to us—without resorting to an overdose of labels and an overuse of pills.

Part II: Psychiatric Fads Can Be Bad For Your Health

Chapter 4 - Fads Of The Past

We don't see things as they are. We see things as we are.
—TALMUD

“Exorcising the demon can work well when the exorcist and the patient both believe it will. [...] The Catholic Church is less radical in its belief in demons, recommending exorcism only when the symptoms are specific to sacrilege and after mental illness has been ruled out.”

“Suicide clusters occur when people copy either a celebrity suicide or that of a relative, friend, classmate, or coworker. [...] only one in a thousand people take death into their own hands. The self-destructive often die young, taking their genes with them into oblivion. Life-affirming DNA wins the procreation sweepstakes and keeps us struggling to stay in the game, whatever the hardship and pain.”

“The label we create, however inaccurate, provides a comforting explanation of the patient's suffering and a target for treatment. It is a metaphor of distress appropriate to the technology and worldview of a particular time and place. When everyone is interested in electrical power, the metaphor of distress becomes energy depletion. When people get interested in neurotransmitters

(as is the case now), the glib metaphor becomes "chemical imbalance.""

“Hysteria described patients presenting with neurological symptoms that were puzzling because they did not conform to the distribution of the nervous system or to established neurological disease. Most common were paralysis, sensory loss, strange sensations, posturing, speech loss or alteration, gagging, convulsions, dizziness, or loss of consciousness.”

“Freud coined the term "transference" for the parental role that tied patients to their doctors and made them so vulnerable to influence. […] In real life, Anna O. was Bertha Pappenheim, who recovered and went on to become one of the founders of the profession of social work. […] Suggestible patients seeing neurologists naturally enough presented with neurological symptoms.”

[On multiple personalities… Allen seems very skeptical. I wonder what he thinks, then, of IFS? The theory driving this therapy is that there are many ‘sub-personalities’ that drive a person. Clinically, it’s an exceptional treatment. Theoretically, well, I’d assume personality psychologists would take issue with it, its veracity … and scoff.]

A collaboration of suggestible patients and suggestible doctors elaborated the notion that the individual was harboring a hidden personality (or two or three or more). Through a process of "dissociation," the hidden personalities had established their own independent existence and might even at times temporarily take charge and do things that were outside the control, or even the awareness, of the dominant personality. […] The goal was to induce the "alter" personalities to enter the light of day so that they might be melded together into a cohesive whole. Not surprisingly, the overall effect of hypnotic treatment was to promote, rather than to cure, the presumed illness […] Multiple personality disorder disappeared when hypnotists were replaced by psychoanalysts, who focused the patient's attention on fragmented repressed impulses and memories, father than on integrating repressed personalities. […] The revival of MPD was fueled by a renewed therapeutic interest in hypnosis and other regressive and suggestive treatments aimed at bringing out "alters." […] I have seen at least a hundred people who claimed to harbor multiple personalities. Almost all of them presented in a flock during the heyday of the epidemic in the late 1980s and early 1990s. In every case, I discovered that the emerging personalities had taken on a life of their own only after the patient had entered treatment with a psychotherapist interested in the topic, or after joining an Internet chat group, or after meeting someone else with the problem, or after seeing a movie that portrayed it.

“Our new fads are globalized, mone-tized, and becoming part of the societal infrastructure.”

Chapter 5 - Fads Of The Present

"*DSM-IV* unwittingly contributed to three new **false epidemics** in psychiatry—the overdiagnosis of attention deficit, autism, and adult bipolar disorder."

"The lesson of the last fifteen years is that the DSM alone does not establish standards. Physicians, other mental health workers, drug companies, advocacy groups, school systems, the courts, the Internet, and cable TV all get to vote on how the written word will actually be used and misused."

a fad diagnosis is a useful diagnosis gone wild.

"Every classroom now has at least one or two kids on medication. And increasingly, **ADHD** is becoming an explain-all for all sorts of performance problems in adults as well. [...] We now diagnose as mental disorder attentional and behavioral problems that used to be seen as part of life and of normal individual variation. [...] Boys born in January were at 70 percent higher risk than those born in December simply because January 1 was the cutott for grade assignment. [...] We have turned being immature because of being young into a disease to be treated with a pill. [...] Medication for these correctly diagnosed kids can (at least in the short run) improve learning, prevent restlessness, reduce impulsive outbursts, help them feel more comfortable in their own skins, and reduce blame and stigma. [...] Drug company marketing pressure often leads to unnecessary treatment with medications that can cause the harmful side effects of insomnia, loss of appetite, irritability, heart rhythm problems, and a variety of psychiatric symptoms. [...] Diagnose early and begin medication quickly only when the ADHD symptoms are very severe, pressingly urgent, and classic in presentation. [...] **Often the symptoms will be transient—reactive to family, peer, or school stress**.

"[**Childhood Bipolar Disorder (CBD)**] has become the most inflated bubble in all of psychiatric diagnosis, with a remarkable fortyfold inflation in just one decade. CBD satisfied three essential preconditions for excessive pop-ularity: a pressing need, influential prophets, and an engaging story. [...] CBD no longer required the presence of classic mood swings between mania and depression. Instead the diagnosis could be made in a free-form, inclusive way to include a variegated hodgepodge of kids who were irritable, temperamental, angry, aggressive, and/or impulsive. [...] Mood swings are rare in kids—not a good sales target. But irritability is common enough to bring in blockbuster sales. And bipolar disorder is usually considered a lifelong diagnosis. [...] mood-stabilizing and antipsychotic medications were given out wildly to treat fake CBD. [...] The most egregious malpractice has been loading up two- and three-year-olds with medication to treat a ridiculously premature diagnosis of bipolar disorder—in some cases killing them with lethal overdoses. [...] The diagnosis can distort a person's life narrative, cutting off hopes of otherwise achievable ambitions, and also may reduce a sense of control over, and responsibility for, undesirable behavior. Other more specific causes of temper outbursts are much

shorter lived and amenable to time-limited treatment. Substance abuse should always be the first thought for any irritable teenager. And attention deficit disorder often presents with an irritability that responds best to stimulants, but these may be withheld in the face of an incorrect bipolar diagnosis.

“Before DSM-IV, [**autism**] was an extremely rare condition, diagnosed in one child per two thousand. The rate has now jumped to one in eighty in the United States and an even more amazing one in thirty-eight in Korea. [...] the typical age of onset of autism happens to occur at around the same time that vaccinations are scheduled. Conclusive studies have since disproved any causal connection [cf. more recent CDC data] The autism "epidemic" has three causes. Some part surely comes from improved surveillance and identification by doctors, teachers, families, and the patients themselves. [...] Some was triggered by the SM-IV introduction of Asperger's disorder, a new diagnosis that grealy broadened the concept of autism. [...] Few people have the incapacitating symptoms of classic autism, and these are extremely easy to identify. In contrast, Asperger's describes people who are strange in some ways (with stereotyped interests, unusual behaviors, and interpersonal problems) but not nearly so gravely impaired as those who have classic autism (which also includes an inability to communicate and lowered IQ). [...] Autism received extensive and favorable press and television coverage and was presented sympathetically in movies and documentaries. [...] About half the kids now diagnosed don't really meet the criteria when these are applied carefully, and about half will have outgrown it on repeat evaluations. The epidemic has had both pluses and minuses. For correctly identified patients, getting a diagnosis has brought the advantages of improved school and therapeutic services, diminished stigma, increased family understanding, reduced sense of isolation, and Internet support. For mislabeled patients, there are the personal costs of stigma and the reduced self and family expectations.”

“[In **Bipolar II**] Antidepressants are good for lows but can worsen the overall course of bipolar disorder by causing irritability, mood swings, and rapid cycling. To reduce this risk, bipolar patients receive either a mood stabilizer or an antipsychotic (or too often, both) in addition to the antidepressant. [...] The side effects of the mood-stabilizing drugs are dangerous weight gain, diabetes, and heart disease. [...] Manic episodes are unmistakable and un-forgettable. The person is supercharged in thought and deed; racing around; talking under pressure; spouting grandiose ideas, heightened creativity, a wild succession of totally impossible schemes; joking non-stop; floating on an elevated mood, but irritable if crossed; spending money like a drunken sailor; feeling boundless energy; acting inappropriately and impulsively; being intrusively sexual; and needing little sleep. [...] less-than-full manic episodes are called "hypomanic" and they represent a conundrum. Patients who have alternating periods of depression and hypomania are at the crucial boundary separating bipolar and unipolar disorder. They could have been classified in either camp. If we classify them as bipolar, they will receive mood-stabilizing medication that may prevent rapid cycling, but they might be exposed to unnecessary mood-stabilizing

medication that could be quite harmful. If we classify them as unipolar, they will receive only antidepressant medication, and this may trigger a manic episode. Faced with these ambiguous cards, we chose to add a new category, bipolar II, to describe patients who have depressions and hypomanic episodes. [...] advertisements began suggesting that even slight shifts upward in mood or passing irritability might be a subtle sign of bipolar disorder. [...] the drug companies pounced on bipolar II, The pitch in selling the ill was that any sign of irritability, agitation, temper, or elevated mood indicated a tendency to bipolar disease."

"Shyness is a ubiquitous and perfectly normal human trait with the enormous survival value of keeping people safe rather than sorry. [...] Of course, there are some people whose **social anxiety** is totally incapacitating and enough to meet anyone's definition of mental dis-order. But these are rare individuals, far too small a market ever to interest the drug company. [...] social anxiety disorder emerged from its lowly status as a rare psychiatric footnote and became a blossoming diagnostic star, one of the most common and commonly treated of the mental disorders. [...] This is a population with an appallingly high placebo response rate. For the drug companies, this was actually appealingly high. Once someone (who wasn't really sick) got better due to the placebo effects of a drug (he never really needed), he was likely to stay on it as a good luck charm so as not to risk rocking the boat. [...] Our definition of social anxiety should have set an extremely high threshold to filter in only the really incapacitated and to filter out the merely uncomfortable."

"[The **Major depressive disorder**] definition works well at the severe end, but at the mild end it has led to the creeping repackaging of everyday normal unhappiness into mental disorder. [...] If we try to diagnose everyone who really has major depression, inevitably we will misdiagnose many people who are simply having a rough patch in their lives that needs no medical label and requires no treatment. [...] **Our capacity to feel emotional pain has great adaptive value equivalent in its purpose to physical pain**—a signal that something has gone wrong. We can't convert all emotional pain into mental disorder without radically changing who we are, dulling the palette of our experience. [...] The biggest weakness is not recognizing the role of severe life stress in causing reactive sadness. [...] The "epidemic" of MDD initiated by the loose DSM definitions was then driven by a combination of biological reductionism among physicians and fancy drug company marketing. Doctors bought the story line that all depression results from a chemical imbalance in the brain and therefore requires a chemical fix—the prescription of an antidepressant medication. [...] **psychotherapy is just as effective as medication for milder depressions, and neither has a big edge over placebo**. [...] The antianxiety drugs Valium and Librium ruled the 1970s and 1980s with a dominance almost as impressive as that enjoyed now by antidepressants [...] most medicine taken for most ill-nesses, most of the time, since the dawn of time, has at best been of very little specific help, usually has been completely inert, and very often has been directly harmful, even

poisonous. [...] The popularity of placebo seems to be built into our DNA. My medical purism rebels against the idea that millions of people are taking expensive, potentially harmful, largely placebo medication for a psychiatrically endorsed, drug company promoted "illness" that istay no more than an expectable discomfort or existential problem, inevitable in life as we know it. [...] **People should have more faith in the remarkable healing powers of time, natural resilience, exercise, family and social support, and psychotherapy—and much less automatic faith in chemical imbalance and pills**. [...] It is a shame and a tragedy that one third of the people with severe and incapacitating MDD get no treatment whatever for it.
Medications would be enormously valuable in these situations when they are so sorely needed, but instead they have been oversold for situations when they are not."

"Of all the many conditions in *DSM-IV*, **post-traumatic stress disorder (PTSD)** is paradoxically one of the most underdiagnosed and also one of the most overdiagnosed. [...] PTSD is missed when people suffer its symptoms stoically and in silence. [...] The human reaction to trauma is a great equalizer—regardless of all the differences in our personalities or previous life experiences, we all have the same set of remarkably uniform and stereotypical symptoms in response to a life-threatening stress. We relive the moment over and over and over again in a profoundly emotional way. Images, memories, or flashbacks bring it alive again, intruding incessantly during the day, and at night there are terrifying dreams. Anything resembling the event cues avoidance and terror. Every strange male face is a reminder of the rapist. A car backfiring is a reminder of being under rifle fire. Driving seems impossibly difficult after a bad car accident because the driver keeps visualizing the accident about to happen again. This set of reactions must have had enormous survival value— providing an absolutely indelible object lesson in the importance of avoiding similar dangers in the future. It was the ultimate in powerful one-trial learning—our ancestors had to learn fast and learn well because predators don't often give second chances. [...] The mental disorder PTSD should be diagnosed only when the symptoms persist and cause significant disability. At the severe extreme, PTSD can become chronic and incapacitating. Life is filled with haunting memories and scary triggers. It feels empty, stale, flat, and without meaning. **The suicide rate is high**. [...] PTSD is more likely the more terrible the stress, the longer it lasts, the more intense and intimate the exposure, the more helpless the person feels. [...] Horrors intentionally inflicted by humans—torture, rape, and assault-tend to cause worse symptoms than accidents or natural catastrophes. The course also depends on the person and his context. People who have had more emotional troubles before the trauma are more likely to have worse and more prolonged reactions to it. [...] The diagnosis of PTSD is imprecise because it is based exclusively on the person's own self-report [...] Everyone has some PTSD symptoms after going through something horrible, but these usually wear off without causing long-term or clinically significant hardship."

“Viagra changed the world, becoming one of the best-selling drugs in history and turning an obscure sexual disorder into a ubiquitous lifestyle issue. Viagra could not have risen to its heights of fame and fortune without first convincing the world that "erectile dysfunction" (affectionately nicknamed ED for the TV and print ads) was a ubiquitous problem that could occur even in the seemingly hardy.”

[I must comment on the quote below … Too often I see clinicians say something like, “He’s unwell” when referring to some of the actions that person has committed. And, yes, there are instances where underlying malady may explain some of the determinants behind the action—but these must* never *excuse a behaviour because “the person is just sick.” This here goes into legal territory that, frankly, I’m not qualified to comment on. The psychological, I can. Personal responsibility is prime in my field—where one shirks it one finds themselves getting worse and worse. They come in with a confirmation bias and a willing clinician fans the flames and strokes the ego. They don’t want to offend. Yes, one must come to sessions with compassion, congruence, and hope for change (are we not, after all, merchants of hope?) … but not at the expense of accountability. This must be done carefully. A clinician must never allow their countertransference dictate their clinical mood. Bracket it. Become aware of it. Don’t let it drive you. But call a spade a spade.]

“Rape as a mental disorder was considered in the last four DSM revisions (DSM-III, DSM-IIIR, DSM-IV, and DSM-5) and definitively rejected by all of them and also by a special task force report. Rape is a crime, not a mental disorder. […] The very worst writing in all of DSM-IV is concentrated in the sexual disorders section. […] Zealous, misinformed, and highly paid evalu-ators, employed by the government, badly misinterpreted the intent of DSM-IV and began the strange practice of diagnosing the act of rape as itself an indication of the presence of a qualifying mental disorder that would justify psychiatric incarceration. […] rape was magically medicalized, in the service of legal and public safety expediency, to allow preventive detention and deprive rapists of their civil rights. […] Rapists are always bad people, very rarely mad people. They should not be able to use mental disorder as a legal excuse, but neither should rape be a legal excuse for mental hospitalization. Rapists should be kept off the streets with very long prison sentences, not loopholed into involuntary psychiatric commitment. Once they have served their time, they should be released, as would any other common criminal. […] my fear is that treating them unfairly greases that slippery slope to a more general degradation of the Constitution, lessening respect for the sacred values of due process and the protection of civil liberties.”

Patients self-misdiagnosed and asked their doctor for the magic pill that would correct their chemical imbalance. The doctors listened. Patients who requested a drug they had seen advertised were seventeen times more likely to walk out

of the office with a prescription.

Chapter 6 - Fads Of The Future

[A serious critique of the* DSM-5 *follows...]

"DSM-5 HAS JUST been published not a happy moment in the history of psychiatry or for me personally. [...] The good news is that a last-minute reform effort, instigated by a new leadership team at the American Psychiatric Association, eliminated about one third of the worst changes that would have opened the floodgates of diagnostic inflation even further. The bad news is that, despite this, *DSM-5* kept the other two thirds and will significantly add to, not correct, the already existing problems of overdiagnosis and overtreatment. [...] **Neuroscience will inform everyday psychiatric diagnosis only at its own slow and steady pace**; it cannot be rushed forward before its time— and that time is decidedly not yet. [...] excessive early screening is just now being discredited across many of the medical specialties that had served as the exemplars for *DSM-5*. [...] DSM-5 developed unnecessarily complex dimensional ratings that could never be used clinically. [...] *DSM-5* was a hodgepodge of disorganized method. Work groups were instructed to be innovative but were provided no clear marching orders that would cohere their separate productions. Not surprisingly, the different groups varied widely in the methods, thoroughness, quality, impartiality, and clarity of their reviews. [...] The original publication date had to be pushed back two years. Even with this added time there was a mad scramble at the end—and *DSM-5* had to cancel its crucial quality control step when work fell so far behind there was no time left to complete it. [...] The *DSM-5* literature reviews should have been conducted by independent evaluators who would have had the dual advantages of special expertise in evidence-based methods and impartiality, with no pet proposals to protect. [...] **There has been no real advance in diagnosis since *DSM-III* in 1980, and no real advance in treatment since the early 1990s. Psychiatric diagnosis doesn't need much updating, much less a paradigm shift**. [...] Recent *DSM* history teaches us that whatever changes are made will be subject to unexpected misinterpretation and misuse under pressure from drug companies, school services, disability requirements, and the legal system. [...] The *DSM-IV* trials were funded by the National Institute of Mental Heath after an extensive external peer review of their scientific method and merit. This was the most meticulously designed and carefully performed trial ever done. And yet we missed predicting the epidemics in ADHD, autism, and bipolar disorder. [...] **the DSM-5 field trials tested the wrong question, in the wrong way, in the wrong settings, and with an unrealistic deadline**. The results are impossible to interpret—a waste of time, money, effort, and talent. [...] The original plan had included a quality control step. If diagnoses had poor reliability in Stage 1 (as many did, Stage 2 (rewriting and retesting) would correct them. But Stage 1 came in so late, there was no time left for Stage 2 [...] APA has spent an astounding $25 million on DSM-5. I can't imagine where all that money went. DSM-IV cost only about $5 million, more than half of which

came from outside research grants."

"Previously I mentioned a study that found 83 percent of kids qualify for mental disorder diagnosis by the time they are twenty-one. [...] First called "temper dysregulation," then rechristened with the tongue-twisting **disruptive mood dysregulation disorder (DMDD)**; the idea of turning temper tantrums into a mental disorder is terrible, however named. [...] The experts working on *DSM-5* meant well. Recognizing the catastrophic misdiagnosis of childhood bipolar disorder, they hoped to replace it with DMDD, which doesn't carry the same implication of lifetime illness and is less likely to be overmedicated with obesity-inducing drugs. [...] Kids have only so many ways of responding to the world and frequently resort to temper tantrums as a way of communicating anger and distress. Almost always, this is not indicative of a mental disorder but rather represents a developmental stage or a temperamental variant or a response to stress or a symptom of any number of mental disorders. [...] The research evidence on DMDD is almost nonexistent, based only on a few years of work by just one research group. [...] There is no bright line distinguishing normal temper tantrums from abnormal ones. [...] Atypical antipsychotic drugs may be helpful in reducing some forms of explosive temper outbursts. But their beneficial effects for the few must be balanced against their very great dangers when used inappropriately for the many."

"physical decrement with age doesn't get defined as sickness because it is expectable and inevitable.
In contrast, losing a mental step is now the *DSM-5* psychiatric illness **mild neurocognitive disorder** (MND). This diagnosis is intended to cover people who don't yet have dementia but who do have signs of mental decline that may put them at risk for later developing it. [...] But there is no treatment and little predictive power. If I gave myself this diagnosis, I wouldn't know what to do with it. ***[Diagnosis is only ever useful if it is followed up by a treatment plan]*** Accepting mental aging makes more sense than diagnosing it until we have an accurate biological test or an effective treatment. [...] Finding out that you are (only possibly) at risk for later developing Alzheimer's would provide little or no benefit-but would create needless worry, testing, treatment, expense, stigma, and insurance and disability issues."

"[**Binge eating disorder**] Why do I binge eat? Why does anyone? Nature made it so. Our appetites are perfectly designed to ride out famine, but they make us terribly vulnerable to feast. When food was hard to come by, the best bet for survival was to be the biggest binger at the carcass. [...] psychiatry has no answers here—no cure for binge eating or for obesity. [...] For hundreds of thousands of years, until just three hundred years ago, the average person rarely it ever got to taste anything sweet. Then sugar entered our lives, and now fructose, and we are being fattened like cattle on a feedlot."

"The easy path to **adult ADHD** suggested by DSM-5 will mislabel many normal people who are dissatisfied with their ability to concentrate and get their work

done, especially when they feel bored and don't like the work they're doing. It will also misdiagnose those whose problem in concentrating is really caused by something else—e.g., substance abuse, bipolar disorder, depression, all the anxiety disorders, OCD, autistic disorders, psychotic disorders, and many others. No one should ever get diagnosed or treated for adult ADHD until all of these are first ruled out as the primary cause—lest inappropriate stimulant treatment may worsen their already existing psychiatric problems. [...] Symptoms are mostly subjective, based on fallible self-perceptions of poor concentration and task accomplishment. [...] **Stimulants are among the most effective and safe of medications in psychiatry when given under appropriate supervision for someone who is accurately diagnosed**. But they can cause serious side effects in anyone and are especially harmful when taken by someone with another diagnosis that has been misidentified as ADHD (especially substance use or bipolar disorder)."

difficulties people have in meeting society's expectations should not all be labeled as mental disorders.

"MDD need not be diagnosed unless the bereaved becomes suicidal, or delusional, or suffers from symptoms that are severe, prolonged, and incapacitating. [...] **Medicalizing grief reduces the dignity of the pain, short-circuits the expected existential processing of the loss, reduces reliance on the many well-established cultural rituals for consoling grief, and would subject grievers to unnecessary and potentially harmful medication**. [...] When a griever becomes suicidal, psychotic, agitated, or incapacitated, the diagnosis of depression is certainly warranted and treatment should begin immediately. [...] Grief is part of life, and most people work through it best with family and cultural supports, not psychiatric diagnosis and treatment."

"DSM-5 has introduced the concept of "**behavioral addictions**." For starters, only pathological gambling will qualify as an official mental disorder. But watch out for false epidemics of addictions to the Internet," shopping, working, sex, golf, jogging, tanning." model railroads, cleaning house, cooking, gardening, watching sports on TV, surfing, or chocolate, or whatever else commands passionate interest and media attention. [...] The term "addiction" is being stretched to include any passionate interest or attachment. It was once narrowly restricted to describe physical dependence on a substance or alcohol [...] Then "addiction" was expanded to cover compulsive substance use. The addict is someone who feels compelled to take the drug even though it no longer makes any sense. [...] Lately, "addiction" is loosely and incorrectly applied to any frequent drug use—even if it is purely for pleasurable recreational purposes, not yet compulsive. [...] We are all ruled by short-term brain pleasure centers that favor our immediate survival or the survival of our DNA into the next generation. [...] **The evolution of our brains was strongly influenced by the fact that, until recently, most people did not live very long**. Given our lengthened life spans, longer term planning has become the much better bet, **but instincts don't change quickly, and balancing short-**

term gains against long-term consequences just doesn't come very naturally to most people. Our pleasure systems are still responding to the world of our ancestors and often cause us trouble in our current world. [...] "Addiction" should be reserved for those who feel compelled to keep repeating the act even when the fun has worn off and the cost is so high that no reasonable person would pay it. [...] **A vibrant society depends on having responsible citizens who feel in control of themselves and own up to the consequences of their actions-not an army of "behavioral addicts" who need therapy in order to learn to do the right thing**. [...] It would be silly to define as psychiatric illness behavior that has now become so much a necessary part of everyone's daily life and work. [...] We also don't know what proportion of excessive users is stuck on the Internet because they have another psychiatric problem that may be missed if Internet addiction becomes an explain-all masking underlying problems. So far, the research on "Internet addiction" is remarkably thin and not very informative. Don't get too excited by pretty pictures showing the same parts of the brain lighting up during Internet and drug use—they light up nonspecifically for any highly valued activity and are not indicative of pathology. "Inter-net addiction" needs to be less a media darling, more a target of sober research."

"[In **mislabeling medical illness as mental disorder**, there] are four ways mistakes are made. **First**, some medical illnesses present with severe physical symptoms, but no definitive pathology (typical examples are irritable bowel, chronic fatigue, fibromyalgia, chronic pain, Lyme disease, and interstitial cystitis). Too often the patients are told that it is all in their heads and are called "crocks" behind their backs, thus adding insult to the injury and impairment of their chronic and sometimes debilitating illness. **Second**, medical illnesses may present with symptoms that go unexplained for many years before the underlying cause clearly declares itself. Typical examples are multiple sclerosis, lupus, rheumatoid arthritis, peripheral neuropathies, connective tissue diseases, and yes, brain tumors. Uncertainty is hard to live with, but much better than jumping to the false and risky conclusion that the problem is psychiatric. **Third**, some people have very strong psychological reactions to their cancer or heart disease or diabetes or other serious illness. And why not? When you are sick, it is understandable that you may become worried about your health, preoccupied with efforts to improve it, and hyperalert to possible new symptoms. [...] **Fourth**, the mislabeling also goes in the opposite direction. Many psychiatric disorders present with prominent somatic symptoms that are often mistaken for medical illness. The best example: People with panic attacks [...] depression sometimes also presents with prominent somatic symptoms, especially weight loss. *DSM-5* will make even fuzzier the already fuzzy boundary between medical and mental illness by introducing a new diagnosis, "somatic symptom disorder," and providing it with a loose and easy-to-meet definition."

"*DSM-5*'s own field trials produced pretty scary results. One in six cancer and coronary disease patients met the criteria for *DSM-5* "somatic symptom

disorder." So did one in four patients with irritable bowel syndrome or fibromyalgia.”

Possible harms include:

- Stigma
- Missed medical diagnoses through failure to investigate new or worsening somatic symptoms
- Disadvantages in getting or keeping a job
- Reduced medical and disability reimbursement
- Reduced eligibility for social, medical, and education services and workplace accommodations
- A reluctance on the part of patients with life-threatening diseases to report new symptoms that might be early indicators of recurrence, metastasis, or secondary illness for fear of attracting a mental disorder diagnosis
- The patient's view of herself and her illness may be skewed, as are the perceptions of family and friends
- The prescription of inappropriate psychotropic drugs

“**The golden rules**: An underlying medical illness has to be ruled out before ever deciding that someone's symptoms are caused by a mental disorder. People suffering from a medical illness should never be casually mislabeled as also being mentally ill just because they are upset about being sick.”

“Some drugs create a particular good imitation of prepsychotic or psychotic symptoms—seeing or hearing things that aren't there, developing strange beliefs that approach the delusional, becoming paranoid and hypervigilant, losing motivation, neglecting responsibilities and personal hygiene, and entering into weird countercultures. […] one percent of all teenagers will develop schizophrenia, a serious psychiatric illness characterized by psychotic delusions, hallucinations, and strange thinking and behavior. […] *DSM-5* proposed a new diagnosis intended to take on this daunting task. It has gone by two different names: "**psychosis risk syn-drome**" and the tongue-twisting "**attenuated psychotic symptoms syndrome**." […] The value of early intervention to prevent psychosis rests on three fundamental and necessary pillars-diagnosing only the right people, having a treatment that is effective, and also safe. Psychosis risk syndrome (PRS) strikes out badly on all three counts.”

“In the real world, the ratio gets really ridiculous: nine misses for every hit. The raters in general practice are much less expert than specialists in research clinics, and the "patients" are closer to normal and harder to discriminate.”

“**there is no proof whatever that antipsychotic medications are effective in preventing psychotic episodes**.”

"**Mixed anxiety depression (MAD)** is perhaps the most flagrant attempt ever to medicalize the transient, nonspecific, almost ubiquitous sadness and worries that are an inevitable part of everyday life. [...] Studied a year later, most people tagged with it either will have gotten over their symptoms and need no diagnosis at all or will have evolved into another more established diagnosis. [...] Antidepres-sants, already used by 1 percent of the population, would have gotten another big boost. Sanity finally prevailed on this one and MAD was shelved—but just barely."

"Sex with an underage, pubescent teenager is a despicable crime deserving imprisonment, not a mental disorder treatable in a hospital. There is nothing inherently psychiatric about being sexually attracted to budding teenagers. Numerous studies have proven the obvious—such attraction is common and completely within the range of normal male lust. [...] Evolution has built teenage sexual attractiveness into male hard-wiring. When our lives were much shorter and likely to end unpredictably at any moment, it made sense for our DNA to seek expression as soon as sexual maturation made this at all possible. [...] Changes in basic appetites require evolutionary time frames of at least tens or hundreds of thousands of years; changes in laws can happen overnight. [...] If having sex with a teenager today constitutes mental disorder, what prevents future slippage in a possibly less enlightened time to revisit whether homosexuality isn't a mental disorder, or the use of psychiatry to suppress political dissent or minority religious belief."

"Evolution has wired our brains to do what it takes to get our sperm and eggs into the next generation. Considerations of love, morality, loyalty, and long-term consequence often get swamped by low resistance to temptation."

"**Perhaps the only solace is that the controversy surrounding *DSM-5* has widely discredited it, raising concerns about the harms done by diagnostic inflation. Many clinicians will see through *DSM-5*, will not give it undeserved "biblical" authority, and will perhaps be more cautious in diagnosis and prescribing. And many potential patients have been put on alert not to accept diagnoses that may make no sense for them**."

Part III: Getting Back To Normal

Chapter 7 - Taming Diagnostic Inflation

[We're fighting the wrong war on drugs...]

The price of illegal drugs remains pretty constant and is never high enough to drive away the market. [...] Usage patterns aren't significantly impacted by even the biggest drug bust, making the whole drug interdiction campaign no more than a phony Whac-A-Mole charade. [...] The success of companies like Pfizer or Eli Lilly or Jansen is not dependent on who happens to be the current CEO.

They have built-in operating procedures and infrastructure that govern business decisions and ensure continuity and enduring profits regardless of who happens to be in charge at any given moment. The illegal drug trade is much more violent (and marginally more ruthless), but its administrative structures are equally effective in the long-term pursuit of profit. [...] **the misuse of legal drugs has now become a bigger public health problem than street drugs**. It is unacceptable that 7 percent of our population is addicted to prescription drugs and that fatal overdoses with them now exceed those caused by illegal drugs.

FOURTEEN WAYS TO TAME PHARMA

- No more direct-to-consumer advertising on TV, in magazines, or on the Internet
- No more drug company-sponsored junkets, dinners, promotional gifts, or continuing medical education for doctors or medical students
- No more financial support for medical professional organizations
- No more beautiful salespeople congregating in the doctors' waiting room
- No more free samples
- No more off-label marketing
- No more co-opting of thought leaders!!
- No more drug company funding for the Food and Drug Administration
- Bigger fines and criminal penalties for malfeasance that are directed against the executives as well as the companies
- Shortened patent protection for companies that break the law.
- No more financial aid for consumer advocacy groups
- No more disease-awareness campaigns
- No more unlimited and undisclosed contributions to politicians
- A three-year quarantine before politicians, staffers, and bureaucrats involved in setting or monitoring drug company regulations can join a drug company as officer or employee

“The FDA's postapproval surveillance program is greatly underfunded and not up to the task of monitoring all the useless and/or harmful drugs that have made it to market.”

“Xanax has been more a wonder of profitability and longevity than a useful medication. Its therapeutic dosage is often high enough to be addicting, and its severe withdrawal anxiety is enough to keep patients hooked for life. Attempts at withdrawal may bring on severe panic or anxiety symptoms that are worse than the problems the patient started with.'5 Xanax is also a frequent collaborator with other prescription drugs and alcohol in iatrogenic overdoses and deaths.”

“**the few really bad apples [doctors] see the most patients for the shortest**

number of minutes. In the limited time allotted, they give the most psychiatric diagnoses-and often these are the same diagnoses and medications for every patient. They write the most prescriptions for multiple medications per patient at the highest average doses, and every patient may be on the same drug cocktail."

"Our highflier probably drives the best car and lives in the best house. Every so often, a patient dies of a drug overdose of the medicine he has prescribed (perhaps helped along a bit by alcohol), but he has never been disciplined, is a pillar of the professional community, and thinks highly of his or her clinical skills. [...] Professional disciplining of one highflier would bring the others into line, and public shaming would ground them all."

"School services should be based on a thorough evaluation of educational need, not just on the presence or absence of a diagnosis."

"Changes need to be gradual and incremental. It makes no sense to continue the practice of changing the entire diagnostic system at arbitrarily chosen intervals. Each diagnosis should be taken up individually in turns that are decided by the emergence of new research evidence. Change should not be just for the sake of change and must be supported by solid evidence and consensus approval."

"**The first visit is the worst time imaginable to make a definitive diagnosis**, and diagnoses made in this way are often wrong. [...] Once a definitive diagnosis is made, a definitive treatment is usually begun—and both are likely to be unneeded, harmful, and expensive.
After all, people with milder problems have a fifty-fifty chance of being back to their usual selves within a few weeks without needing any diagnosis or treatment."

STEPPED DIAGNOSIS

STEP 1–Gather baseline data.
STEP 2–Normalize problems: take them seriously, but reformulate positively as expectable responses to the inevitable stresses in life.
STEP 3—Watchful waiting: continued assessment with no pretense of a definitive diagnosis or active treatment.
STEP 4—Minimal interventions: education, books, computer-aided self-help therapy.
STEP 5—Brief counseling.
STEP 6—Definitive diagnosis and treatment.

"In nonurgent situations, first-line diagnosis and treatment should be the least intensive, with a "step up" only when needed. **Stepped diagnosis is cost-effective because it filters out situations where treatment will not be necessary and separates those who would benefit from psychiatric**

diagnosis from those who will do fine—or even better—on their own."

"All of the mental health professional associations have remained remarkably passive in the face of massive drug overusage. None has raised much opposition to the recent false epidemics of childhood attention deficit disorder, autism, and bipolar disorder. Neutrality in these situations is not really neutral—it amounts to passive collaboration with bad diagnoses and inappropriate treatment."

"Less attention is given to the fact that drug companies are much more engaged in, and better at, marketing and political lobbying than they are at scientific research."

Chapter 8 - The Smart Consumer

"accurate diagnosis is totally dependent on your complete openness and willingness to share your most embarrassing thoughts, feelings, and behaviors. However shameful or shocking your revelations may seem to you, be assured that they are part of the human condition and that the clinician will have heard similar (as well as much stranger and more embarrassing) descriptions numerous times before. It is the safest bet in the world that you are many times more judgmental of yourself than any clinician will ever be. [...] Start keeping a daily diary with a description of your symptoms as they arise. Note particularly the type of symptom, time of onset, severity, duration, level of functional impairment, stress, and the things in life that help you feel better or worse. Do your best to gather together as complete a record as possible of all past data that might inform your present diagnosis. [...] **Neither you nor your current clinician should blindly follow the diagnostic impressions and treatment plans of past clinicians—**these may have been wrong at the time they were made or have become dated by the things that have happened since. [...] Learn everything you can about the history of your problems, the most pertinent DSM criteria sets, and the most likely differential diagnoses. **Occasionally a clinician may feel threatened or be defensive if you seem to know too much**. But unless you are being obnoxious about it, this is probably a sign that you might be better off with a different clinician. [...] **If you don't feel comfortable with a clinician, find someone else you can communicate with**. And remember that collaboration is always a two-way street—for you to get the best result, you have to really put your heart into it. It is difficult having a psychiatric problem, but it doesn't have to be tragic."

"If your symptoms get better on their own within a reasonable period of time, the questions will have answered themselves. But be sure to get help if they hang around, get worse, and continue to cause trouble. [...] **When there are inconsis-tencies, don't be shy about politely asking the clinician to explain the rationale for her diagnosis and how she believes the criteria are met**. [...] My experience has been that some clinicians make the same diagnosis and offer the same treatment for almost every patient they see. Others develop an

ephemeral enthusiasm for a particular diagnosis after attending a conference or meeting with a drug salesman. [...] always expect your clinician to provide commonsense rationales and explanations for any diagnostic decision, and question them carefully if they do not."

"**No discipline has a monopoly on great diagnosticians or terrible ones**. On average, the training and skill in diagnosis would roughly follow the hierarchy: (1) psychiatrists; (2) psychologists; (3) psychiatric nurse-practitioners; (4) social workers; (5) counselors; and
(6) psychiatric occupational therapists. But **many of the worst diagnosticians I have known have been psychiatrists**, and some of the best have been nurses and social workers.

always be suspicious about a diagnosis and treatment plan when you are offered a prescription after a seven-minute visit or if the doctor offers to start you out with free samples.

"two thirds of people with severe mental disorders fail to get the treatment that might make a huge difference in improving their lives. This is where the family comes in. Loved ones can very usefully fill in gaps in information and insight and instill the sense of urgency that is often necessary before someone will seek help. [...] Each family member can bring unique information and insights that in aggregate are much more likely to lead to an accurate diagnosis than would the conclusions of any one person. [...] Young adults who are struggling to become more independent may need to sort things out for themselves without the involvement of their families. But these exceptions are rare. In most situations the family is a crucial ingredient in accurate diagnosis."

"The first question should always be: Did you really take the medicine that was prescribed or do the psychotherapy homework that was assigned? **A treatment shouldn't be judged a failure if it hasn't had a fair shot**. But even good trials have on average about a one-third failure rate."

"Diagnostic failure is also often the result of missing the causative or complicating role of substance abuse (especially in younger patients) or of medical problems or medication side effects (especially in older patients)."

Diagnoses made early in the onset of psychiatric symptoms are much less likely to be accurate and stable than those based on a longer track record.

"You and your clinician should feel comfortable testing the diagnosis with repeated systematic reevaluations.
And when things are unclear, accept that they are unclear rather than jumping to a premature and inaccurate closure."

"you must have the full cluster of symptoms at a sufficient level of severity and duration before talking yourself into having a mental disorder. [...] Everyone has

occasional flashes of anxiety, or de-pression, or attention deficit, or memory loss, or binge eating (and so on down a list of dozens of symptoms). But **most people don't have a mental disorder**."

"Time and resilience are almost always on your side. Symptoms that are mild and stress related are probably just part of life and will get better on their own or if you make some simple life or psychological adjustments. [...] Give yourself **time** to sort things out and to see how nature takes its course. And do the obviously helpful things that most people know they should do but don't. Exercise, **exercise**, and exercise—it is a great healer of both mental and physical problems. Make sure you are getting enough **sleep**—sleep deprivation causes psychiatric symptoms. **Reduce or eliminate your intake of alcohol or drugs**. Reach out to **friends and family**. Seek **spiritual** help. Figure out what you would most like to do and put more good minutes into your day."

Chapter 9 - The Worst And Best Of Psychiatry

Psychiatric diagnosis at its worst leads to psychiatric treatment at its worst, and together the combination is a recipe for disaster.

"For every patient harmed by psychiatry, I have known ten whose lives have been dramatically helped, in some cases probably saved."

"As psychiatrists, we heal whenever we can, and we provide empathy and consolation whenever we can't. We are good at listening, caring, and using our experiences and personalities in the privileged journey helping others to heal, adapt, and help themselves."

"Medical doctors frequently miss the diagnosis of panic disorder because they don't know that its physical symptoms are caused by hyperventilation. This leads to unnecessary testing and aggressive treatment of imaginary medical problems."

"**There is no pill for grief, and the medications for PTSD are not very effective and sometimes add new problems**. Everyone has a personal way of grieving and dealing with catastrophic life experiences. For many, the best approach in the long run is the most painful in the short. Acceptance and catharsis require the reliving and sharing of the horrible memories and the gut-wrenching feelings. **Facing the event rather than avoiding it is often the only way of gaining a measure of control and peace of mind**. This can be done with family and friends, but if the feelings are tightly sealed, then a therapist is helpful, sometimes essential."

the only way to beat OCD is to face the anxiety, not neutralize it with rituals.

"Mistakes are also frequent when diagnoses are made casually by the undertrained and unqualified. **Psychiatric diagnosis is a serious business**

with major and often lifelong consequences. It requires training, experience, time, empathy, and (above all) modesty."

The key ingredients to getting it right are not mysterious: a clinician with appropriate training, experience, and people skills; a patient who presents an honest and thorough description of problems; the development of a positive therapeutic relationship between them; and sufficient time to explore the past and see how things are developing in the present. If the situation is unclear, definitive diagnosis should be postponed—**uncertainty is far better than false certainty**. [...] The act of diagnosis provided a helper, an explanation, a community of fellow sufferers, a call to action, a sense of predictability, and hope for the future. [...] **One of the best predictors of the success of any treatment is the quality of the relationship that forms between clinician and patient**. A great relationship certainly doesn't guarantee a quick cure and a lousy one doesn't foreclose it, but on average the better the relationship, the better the result."

Epilogue

Human difference was never meant to be reducible to an exhaustive list of diagnoses drawn carelessly from a psychiatric manual. It takes all types to make a successful tribe and a full palette of emotions to make a fully lived life. We shouldn't medicalize difference and attempt to treat it away by taking the modern-day equivalent of [Aldous] Huxley's soma pills [read about this in Huxley's dystopia *A Brave New World*]. The cruelest paradox of psychiatric treatment is that those who need it most often don't get it, while those who do get it often don't need it.

"Psychiatrists should stick to what they do best-treating people who have real psychiatric problems—and not expand the field to include the normal worried well, who will do just fine on their own. Primary care doctors should stick to what they do best and stop being amateur psychiatrists. Drug companies should stop acting like drug cartels, irresponsibly pushing product where it will do more harm than good. Consumer advocacy groups should advocate for their consumers, not for the group. The media should expose excessive medical claims, rather than mindlessly trumpeting them."

"**We opponents to inflation are too few, weak, unfunded, disorganized, and face odds that are impossibly imposing**. [...] Every once in a while, scrawny David does pull off the seemingly impossible, and invincible Goliath does bite the dust."

My two goals-"saving normal" and "saving psychiatry"—are really one and the same. We can "save normal" only by "saving psychiatry," and we can save psychiatry only by containing it within its proper boundaries. The legacy of Hippocrates rings as true today as it did 2,500 years ago—be modest, know your limitations, and first do no harm. **Normal is very much worth saving**. And

so is psychiatry.

[**A brief commentary:** I remember when the DSM-5 was still in the works—I was in my final years of my undergraduate studying psych … and even then there was a lot of talk and controversy around it. Some loved the idea of having a 'new' version to refer to (Who doesn't like new stuff?) while others were concerned about what's to be included. I recall the big debate around grief. According to some, this new version would pathologise the grieving process. If you feel sad about a loved one dying, well, you might have some kind of depressive disorder. Prior to DSM-5, grief was an exclusionary(?) factor to major depressive disorder. Now, it wasn't to be. I was excited to buy the manual when it came out—and true to form, it was *much* bigger than the previous edition. (Laughable, in a way … How many more disorders could have been 'discovered' in the interceding years?) Dr. Allen tackles this controversy of the DSM in *Saving Normal*. And does so as an 'insider'. I'm but a counsellor—I'm not interested (for the most part) in diagnostics. I'm all about therapy. But, as I tell my clients, diagnosis is incredibly useful … only to *frame treatment*. Why else would it be necessary? Imagine getting a medical diagnosis without any discussion whatever about what to do about it. And yet that happens way more often than we'd like in our field. Too many clients have complained about their diagnoses … and when asked about what kind of treatment they received? Nada. Nothing. Nope. Except, well, I lie—they were put on some meds … that didn't 'work' but that they now couldn't stop taking for fear of things getting worse. In my reading of Allen's book, I was struck at the history he lays out before jumping into the meat of why DSM-5 is such a problem. So far you've read about what his thoughts are, and you've made your own conclusions. I left rethinking the utility of psychiatric diagnostics … and jumped more intop learning about ways to help treat the person before me. Sure, I do understand many of the 'disorders' included in the DSM (who can say they understand them all?)—but that's a first consideration; good to clarify the pain points but rarely to inform much else. The person before you is your greatest teacher—and, to be honest, I've come across too many who've complained about having a doctor or shrink read from a text to tell them about the problem they presumably have. As you can see, my bias shines through here. And I think that's where I'll leave it. Thanks for reading!]

These notes were collected by psychotherapist and author Emil Barna in his efforts to assist with professional development and further education for himself and those who read them. You can find out more about Emil by visiting www.barnacc.com

"A text without a context is a pretext to a proof text."
—Dr. Don Carson