Practitioner Perspective

The Validity of the DSM: An overview

By Dr. Terry Lynch.

Strict adherence to the DSM-5 would remarkably result in fifty per cent of people supposedly having a so-called "mental disorder" by age 40 (Rosenberg, 2013). A conversation about the DSM is therefore welcome (McHugh, 2018).

The American Psychiatric Association describes the DSM as "the authoritative guide to the diagnosis of mental disorders", "the handbook used by health care professionals in the United States and much of the world" (American Psychiatric Association, 1). Given the authority generally bestowed upon the DSM, one might expect a commensurate level of validity as a core DSM characteristic.

The validity of the DSM-5

Arguably the world's most influential mental health organisation, the American National Institute of Mental Health's (NIMH) 2002-2015 director psychiatrist Thomas Insel wrote prior to DSM-5's publication:

> "While DSM has been described as a 'bible' for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been 'reliability' – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity." (Insel, 2013)

At a 2005 American Psychiatric Association meeting, Insel stated that the DSM had "0% validity" (Johnston).

According to psychiatrist Steven Hyman, Insel's predecessor as director of the National Institute of Mental Health, the creators of the DSM:

> "Chose a model in which all psychiatric illnesses were represented as categories discontinuous with 'normal.' But this is totally wrong in a way they couldn't have imagined. What they produced was an absolute scientific nightmare." (Belluck, 2013).

DSM-IV Task Force lead psychiatrist Allen Frances has spoken of "DSM-5's flawed process and reckless product"; "discredited and scientifically unsound; "the gross incompetence of DSM-5" (Frances, 2013); "deeply flawed"; "untested". (Frances, 2012). Frances also wrote:

> "More than 50 mental health professional associations petitioned for an outside review of DSM-5 to provide an independent judgment of its supporting evidence and to evaluate the balance between its risks and benefits. Professional journals, the press, and the public also weighed in — expressing widespread astonishment about decisions that sometimes seemed not only

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to lack scientific support but also to defy common sense." (Frances, 2012).

No such independent review has been undertaken.

The validity of earlier DSM editions

The 1980 DSM-III is the most significant edition, heralding a major shift from psychoanalytic/psychotherapeutic perspectives to a biologically-focused approach. Prominent American psychiatrist Nancy Andreason wrote:

> "Although the authors of DSM-III knew that they were creating a small revolution in American psychiatry, they had no idea that it would become a large one and that it would ultimately change the nature and practice of the field." (Andreasen, 2007).

Andreasen continued:

> "DSM-III and its successors became universally and uncritically accepted as the ultimate authority on psychopathology and diagnosis. Validity has been sacrificed to achieve reliability. DSM diagnoses have given researchers a common nomenclature—but probably the wrong one. Although creating standardized diagnoses that would facilitate research was a major goal, DSM diagnoses are not useful for research because of their lack of validity." (Andreasen, 2007).

According to renowned British-based psychologist and author Dorothy Rowe:

> "Apart from where it deals with demonstrable brain injury, the DSM is not a valid document. The DSM is a collection of opinions. When the committee of psychiatrists change their opinions, a mental disorder might be removed from the DSM and some new one included. Believing in the DSM is much the same as believing in, say, the doctrines of the Presbyterian Church. Neither can point to evidence that supports the doctrine that lies outside the doctrine itself. When our ideas are supported by evidence, we can regard them as truths. Ideas unsupported by evidence are fantasies." (Rowe, 2010, p.130).

American physician and author Maria Angell MD, former Editor-in-chief of the New England Journal of Medicine, Senior Lecturer, Department of Global Health & Social Medicine, Harvard Medical School said:

> "Given its importance, you might think that the DSM represents the authoritative distillation of a large body of scientific evidence. It is instead the product of a complex of academic politics, personal ambition, ideology and, perhaps most important, the influence of the pharmaceutical industry. What the DSM lacks is evidence.
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> The problem with the DSM is that in all of its editions it has simply reflected the opinions of its writers. Not only did the DSM become the bible of psychiatry, but like the real Bible, it depends on something akin to revelation. There are no citations of scientific studies to support its decisions. That is an astonishing omission, because in all medical publications, whether journals or books, statements of fact are supposed to be supported by citations of scientific studies". (Angell, 2009).

Proponents of a biologically-slanted perspective argue that failure to identify cause is common to both many medical illnesses and many "mental illnesses".

American psychologist, social justice and human rights activist Dr. Paula Caplan is a former professor of psychology, assistant professor in psychiatry and director of the Centre for Women's Studies at the University of Toronto. Her illustrious career included a Presidential Citation and a Distinguished Career Award from the Association for Women in Psychology. Caplan was an invited consultant to two committees involved in the creation of the DSM-IV. In 2014 she wrote:

"I resigned from those committees after two years because I was appalled by the way I saw that good scientific research was often being ignored, distorted, or lied about and the way that junk science was being used as though it were of high quality, if that suited the aims of those in charge. I also resigned because I was increasingly learning that giving someone a psychiatric label was extremely unlikely to reduce their suffering but carried serious risks of harm, and when I had reported these concerns and examples of harm to those at the top, they had ignored or even publicly misrepresented the facts." (Caplan, 2014)

In 1995 Caplan wrote:

> "As a former consultant to those who construct the world's most influential manual of alleged mental illness, I have had an insider's look at the process by which decisions about abnormality are made. As a longtime specialist in teaching and writing about research methods, I have been able to assess and monitor the truly astonishing extent to which scientific methods and evidence are disregarded as the handbook

is being developed and revised. I could not attempt in a single book to address the vast array of its biases, examples of its sloppiness and illogical thinking, and just plain silliness. Mental disorders are established without scientific basis or procedure." (Caplan, 1995, xv, 90).

Paula Caplan cites psychologist Lynne Rosewater, who participated in a DSM-III committee:

"They were having a discussion for a criterion about Masochistic Personality Disorder and Bob Spitzer's wife says 'I do that sometimes', and he says, 'Okay, we'll take it out'". (Caplan, 1995, p. 91).

Robert (Bob) Spitzer was the lead psychiatrist of the DMS-III Task Force. Psychologist Renee Garfinkle also attended DSM-III committee meetings. She subsequently said:

"The low level of intellectual effort was shocking. Diagnoses were developed on the majority vote on the level we would use to choose a restaurant. You feel like Italian. I feel like Chinese. So let's go to a cafeteria. Then it's typed on a computer". (LeGault, 2006, p. 91).

"Mental disorder"

The centrality of "mental disorder" to the DSM is illustrated in its name – The Diagnostic and Statistical Manual of Mental Disorders. One might assume that this term's meaning would be without ambiguity.

Aforementioned psychiatrist Allen Frances – lead psychiatrist of the DSM-IV Task Force – said in a 2010 interview: "There is no definition of a mental disorder. It's bullshit. I mean, you just can't define it." (Greenberg, 2012). In a Twitter conversation with me, Frances wrote: "I've read 50 definitions of mental disorder/ wrote one. None helpful." (Frances, 2017). DSM-5 Task Force vice-chair American psychiatrist Darrel Regier wrote: "Mental disorder definitions . . . are almost impossible to test." (Regier, 2012).

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DSM Depression criteria

Problems arise even within DSM sections generally considered uncontroversial. In my best-selling book Beyond Prozac I wrote:

"Why did the American Psychiatric Association select five criteria as the magic figure? What is so different between a person who meets six criteria — and is therefore diagnosed as having a Major Depressive Episode and needing antidepressant treatment — and one who meets four criteria, and therefore receives no psychiatric diagnosis or treatment? Why five criteria? Why not three? Or seven? How valid are these criteria?" (Lynch, 2001, p.81).

Nine years later, American psychiatrist Daniel Carlat put similar questions to Robert Spitzer, lead psychiatrist of the 1980 DSM III Task Force, the psychiatrist responsible for introducing these criteria:

Carlat: "How did you decide on 5 criteria as being your minimum threshold for depression?"

Spitzer: "It was just consensus. We would ask clinicians and researchers, 'How many symptoms do you think patients ought to have before you give them a diagnosis of depression?' And we came up with the arbitrary figure of five."

Carlat: "But why did you choose five and not four? Or why didn't you choose six?"

Spitzer: "Because four just seemed like not enough. And six seemed like too much."

Robert Spitzer "smiled impishly" as he uttered the last sentence. (Carlat, 2010, p. 53).

British psychologist James Davies also interviewed DSM-III lead psychiatrist Robert Spitzer. Spitzer having admitted that no biological abnormalities had been identified in any psychiatric disorder, Davies asked, "So without data to guide you, how was this consensus reached?" Spitzer replied:

"We thrashed it out basically. We had a three-hour argument. There would be about twelve people sitting down at the table...and at the next meeting some would agree with the inclusion, others would continue arguing...if people were still divided. the matter would be eventually decided by a vote." (Davies, 2013, pps 22, 29, 30).

"Biology never read that book"

A peculiar situation pertains in relation to psychiatry and the DSM. Mainstream psychiatry has long asserted that the experiences and behaviours understood as "mental illnesses" are fundamentally biological. The virtual absence of any evidence verifying these claims paints a different picture – as does the absence of characteristic physical examination findings and diagnostic laboratory/radiological tests, which

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are never carried out to diagnose "mental illness", only to exclude known organic disease, check drug levels and check bodily functions, given the potential for drug toxicity.

Proponents of a biologically-slanted perspective argue that failure to identify cause is common to both many medical illnesses and many "mental illnesses". However, the correct categorisation of biological illness depends not on causation but the presence of verified biological abnormalities – pathology. The cause of many cancers is not known, but so established is the pathology of cancer that one will rarely hear questioning of the centrality of biological pathology – e.g. cancer cells – to cancer.

A corresponding fundamental weakness – the lack of scientific verification of biological pathology – surfaces throughout the DSM-5. The virtual absence of reference to biology within the DSM-5 has been highlighted by the aforementioned Thomas Insel MD:

> "As long as the research community takes the DSM to be a bible, we'll never make progress. People think that everything has to match DSM criteria, but you know what? Biology never read that book." (Belluck, 2013).

By 2013, the National Institute of Mental Health had all but abandoned the DSM-5, "re-orienting its research away from DSM categories". (Insel, 2013). The lack of biological verification has been acknowledged by the Chair of the DSM-5 Task Force, American psychiatrist David J. Kupfer MD:

> "The problem that we've had in dealing with the data that we've had over the five to 10 years since we began the revision process of DSM-5 is a failure of our neuroscience and biology to give us the level of diagnostic criteria, a level of sensitivity and specificity that we would be able to introduce into the diagnostic manual". (Belluck, 2013).

De-emphasising psychological-mindedness

The DSM is akin to a distorted radar system, set up to pick up certain aspects of human experience and behaviour and miss others, and to interpret these experiences and behaviours in ways that exclude other often more legitimate ways of understanding these experiences and behaviours. In his 2010 book, psychiatrist Daniel Carlat wrote of the DSM:

> "It has drained the color out of the way we understand and treat our patients. It has de-emphasized psychological-mindedness, and replaced it with the illusion that we understand our patients when all we are doing is assigning them labels." (Carlat, 2010, p. 60).

In my work in mental health, I regularly encounter people given various DSM diagnoses, core aspects of whose stories have been largely or completely missed. On the day of writing this, two such clients attended me. In both cases the diagnosis happened to be "clinical depression", but I regularly encounter this phenomenon across the range of psychiatric diagnoses.

One person had been attending psychiatrists continuously for six years with a diagnosis of "clinical depression". She was repeatedly told that she had a biological illness, a brain chemical imbalance – which incidentally has never been verified to exist in any human being – and that her psychiatrists would eventually find the right drug combination. At our first meeting, a significant narrative emerged involving major parental attachment problems and loss of selfhood since early childhood. This narrative, known to be associated with depression, previously went unnoticed, unexplored, unresolved.

The second client had attended her GP on three separate occasions, and was told each time that she had "clinical depression" and that medication was the answer. Within these exchanges, a raft of emotional and psychological issues went unnoticed and unaddressed, including considerable trauma, rejection and abandonment issues, selfhood reduction, much unfinished business, learned helplessness and powerlessness, all of which fed into the experiences and behaviours labelled as "clinical depression".

The People Behind DSM-5

According to the American Psychiatric Association, which produces and publishes the DSM:

> "The DSM-5 development process has involved not only psychiatrists, but also experts with backgrounds in psychology, social work, psychiatric nurs¬ing, pediatrics, and neurology. DSM-5's Task Force and 13 Work Groups include more than 160 mental health and medical profession¬als who are leaders in their respective fields. The selection of such a diverse group of professionals means that a multitude of viewpoints is being considered in each decision". (American Psychiatric Association, 2)

However, nearly 100 of the 160-plus Task Force and Work Group members were psychiatrists. Less than half this figure – 47 – were psychologists; just one social worker, and no psychotherapist/counsellor.

The control centre within the DSM-5 was the American Psychiatric Association-appointed Task Force, consisting of 35 members. Both chair and vice-chair were psychiatrists. The remaining 33 members included 25 psychiatrists, 3 psychologists and not a single psychotherapist, counsellor, social worker, or occupational therapist. The emergence of a medicalised approach with the DSM is therefore hardly surprising.

"Mental disorders" as medical conditions

A common assertion regarding so-called "mental disorders" is that they are medical conditions. This claim has been made so widely and for so long that it is generally assumed to be an established fact. Eugene McHugh quotes a 2014 book which refers to "the philosophical assumption that mental disorders are medical conditions". (Dailley, 2014 p. 15). This book's authors referred to two major underpinning philosophical changes within the DSM:

> "The first philosophical change involves a shift in focus from phenomenological interpretations (i.e., symptom identification and behavioral observations–a medical model) to identifiable pathophysiological origins (i.e. functional changes associated with or resulting from a disease or injury–a biological model". (Dailley, 2014 p. 17).

I was struck by aspects of this passage. Published by the American Counseling Association, this book is written by experienced counsellors for counsellors. The medical model has long been primarily a biological model. I would caution against accepting without question the profoundly significant "philosophical assumption that mental disorders are medical conditions".

Rather than embrace the DSM, I encourage the counselling professions to press for trauma-informed responses, within which experiences and behaviours are accepted and addressed in their own right,

Many authoritative medical sources do – wrongly – claim that psychiatric diagnoses are known brain disorders. The highly influential US National Institute of Mental Health (mis)informs its readers that "mental illnesses are disorders of the brain", and "Through research, we know that mental disorders are brain disorders". (National Institute of Mental Health).

If psychiatric diagnoses were verified biological disorders, they would appear within authoritative comprehensive lists of brain and neurological disorders. All of the major comprehensive such lists I have reviewed include no psychiatric diagnosis as a known brain disorder, including a sister organisation of the National Institute of Mental Health. (National Institute of Neurological Disorders and Stroke).

Conclusion

The experiences and behaviours diagnosed as various "mental disorders" are real and valid. The interpretation of these as primarily biological entities within the DSM framework is not valid, fostering a dominant modus operandi that may have prompted global trauma expert psychiatrist Bessel van der Kolk to create a video entitled "Psychiatry must stop ignoring trauma". (van der Kolk, 2015).

Following publication of the DSM-5, the Division of Clinical Psychology of the British Psychological Society issued a Position Statement calling for "a paradigm shift" away from a "'disease' model". (British Psychological Society, 2013).

The words of Louise Armstrong, author of many books including Kiss Daddy Goodnight – a ground-breaking book on incest – are accurate:

> "To read about the evolution of the DSM is to know this: The DSM is an entirely political document. What it includes, and what it does not include, is the result of intensive campaigning, lengthy negotiating, infighting and power plays." (Le Gault, 2006, p. 91).

Rather than embrace the DSM, I encourage the counselling professions to press for trauma-informed responses, within which experiences and behaviours are accepted and addressed in their own right, rather than repackaged as "mental disorders" within a system whose "bible" is utterly lacking validity.

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