

Inside the DSM

By **EUGENIA TSAO**

Some years ago, a friend told me that he had been diagnosed with a major depressive disorder, and that his psychiatrist had given him a prescription for Forest Laboratories' popular SSRI antidepressant Celexa (chemical name, citalopram hydrobromide; \$1.5 billion in sales in 2003). Knowing him to be a vociferous critic of the pharmaceutical companies, I asked, somewhat perplexed, whether he agreed that the origins of his unhappiness were biological in nature. He replied that he unequivocally did not. "But," he confided, "now I might be able to get my grades back up."

It should be noted that this guy was, at the time, a fulltime undergraduate student who managed rent, groceries, and tuition only by working two part-time jobs. He awoke before dawn each morning in order to transcribe interviews for a local graduate student, then embarked upon an hour-long commute to campus, attended classes until late afternoon, and then finally headed over to a nearby café to wash dishes until nine o'clock in the evening. By the time he arrived home each night, he was too exhausted to work on the sundry assignments, essays, and lab reports that populated his course syllabi. As the school year dragged on, he had become increasingly disheartened about his slipping grades and mounting fatigue, and decided, finally, that something had to be done. Hence his trip to the psychiatrist and, from there, the pharmacy.

It is worth reflecting on this anecdote, and others like it, as research proceeds on the upcoming revision of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*, a draft of which is slated for release in late 2009. When perceived through the aseptic lens of statistics, diagnostic rates, and other seemingly objective metrics, the urgency with which companies like Pfizer exhort us to monitor ourselves for sadness or restlessness and to "ask your doctor if Zoloft is right for you" assumes a superficially unproblematic aspect. According to the National Institute of Mental Health, over 17 million American adults are afflicted with clinical depression each year, costing the national economy \$30 billion in absenteeism, inefficiency, and medical expenses. Eighty percent of those afflicted will never seek psychiatric treatment, despite the American Psychiatric Association's regular reassurances that 80 to 90 percent of chronic depression cases can be successfully treated, and 15 percent will attempt suicide. Suicide is, indeed, the third leading cause of death among American youth aged 10 to 24. Things are scarcely better in Canada, where an estimated \$11 billion is reportedly lost each year to the growing mass misery.

Implicit to the drug companies' messianic promises of health, happiness, and economic productivity is a spurious parable of linear scientific progress: in spite of consistently inconclusive clinical trials, new psychotropic drugs are regularly marketed as improvements on old ones, ever more specific in their targeting of neurotransmitters, ever less productive of pernicious side-effects. While revelations that put the lie to the industry's feigned beneficence have belatedly crept into the mainstream press in recent years, the extent to which our lives and livelihoods have been colonized by the reductive logic of pharmaceutical intervention remains breathtaking. As Laurence Kirmayer of McGill University has suggested, the millennial rise of a "cosmetic" psychopharmaceutical industry, wherein drugs are "applied like make-up to make us look *and* feel good, while our existential predicaments go unanswered," raises disturbing questions about the consequences of our willingness to use chemicals to treat forms of distress that would seem to signal not biological, but social, maladies.

What is revealed about a society in which drugs are touted with increasing regularity as a treatment of choice for entirely natural responses to conditions of unnatural stress? How have we been persuaded to equate

such things as recalcitrant despair (“Dysthymic Disorder,” *DSM-IV-TR* 300.4), adolescent rebellion (“Oppositional Defiant Disorder,” *DSM-IV-TR* 313.81), and social apathy (“Schizoid Personality Disorder,” *DSM-IV-TR* 301.20) with aberrant brain chemistry and innate genetic susceptibilities rather than with the societal circumstances in which they arise? What does it mean when increasing numbers of people feel as though they have no choice but to self-medicate with dubious chemical substances in order to stay in school, stay motivated, stay employed, and stay financially solvent?

The DSM finds its niche

In the summer of 2003, a small group of psychiatric survivors convened in Pasadena, California, to hold a hunger strike with the aim of forcing the American Psychiatric Association (APA) and the National Alliance on Mental Illness (NAMI) to admit that they had no conclusive evidence to support their claim that mental illness is based in biological dysfunction. Though the APA was, at first, quite indignant—its medical director initially compared the protestors to opponents of Copernican heliocentrism—it did eventually issue a statement, three weeks into the strike, conceding that “brain science has not advanced to the point where scientists or clinicians can point to readily discernible pathologic lesions or genetic abnormalities that in and of themselves serve as reliable or predictive bio-markers of a given mental disorder or mental disorders as a group.”

This acknowledgement raises interesting questions. Although medical textbooks and even drug advertisements have, for years, admitted evidentiary uncertainties in psychiatric research (as a 2004 advertisement for a Pfizer antidepressant oddly proclaimed, “While the cause [of depression] is unknown, Zoloft can help”), the notion that mental disorders are ubiquitously and irrefutably founded in genetic, neurochemical, and physiological anomalies is a mainstay of Western popular culture. The psychiatric fixation on brains and genes, vaunted in newspaper headlines on weekly basis, has quite deftly captured the public imagination, leading many people to view even mild forms of social maladjustment as pharmaceutically remediable. Today, we are everywhere urged to repackage ourselves into medicalized identity categories whenever we discover that we do not fit the productive, gregarious norm: the eight year-old who cannot focus on her spelling exercises because of an energetic imagination has an attention-deficit/hyperactivity disorder, easily remediable with the aid of psychostimulants such as Ritalin or Adderall; the mother who cannot overcome her grief at losing her son in Iraq has clinical depression, readily dispatched with regular doses of Paxil, Prozac, or Lexapro.

Psychiatrist Joel Paris admits in his recent book *Prescriptions for the Mind* that, “in reality, psychiatrists are treating conditions that they barely understand. Our diagnoses are, at best, rough and ready, and do not deserve the status of categories in other specialties. We have no laboratory tests that can reliably identify any mental disorder, and the measures we use are entirely based on clinical observations.” If this is true, how is it that psychiatric diagnoses are now the driving force behind a multibillion-dollar international industry? “The force driving psychiatry today,” Paris openly grants, “is its wish to be accepted as a medical specialty.” Indeed, the history of this wish reveals much more about the inordinate preoccupations of psychiatrists than of their supposed beneficiaries.

Psychiatry did not always suffer from biology envy. The project of systematically categorizing and enumerating types of mental illness in fact began in the United States not as a medical venture but a criminological one. As philosopher of science Ian Hacking writes, in the wake of the Industrial Revolution, the increasing stratification of wealth and resources in Western societies facilitated an exhilarating new pastime for the educated classes: the scientific documentation of social misery. Beginning with “an avalanche of numbers that begins around 1820,” physicians developed a raft of new medical categories within which to group such behaviours as suicide, prostitution, drunkenness, vagrancy, and petty crime. Informal attempts at condensing these data into diagnostic manuals were made in the ensuing decades: the 1840 national census documented occurrences of “idiocy/insanity,” while the 1880 census split these figures

into seven discrete categories (mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy). Unsurprisingly, this precipitated a sharp increase in diagnoses of what became homogeneously known as “feeblemindedness,” and, by 1918, mental hospitals and asylums everywhere were bursting with inpatients. The earliest official medical nosologies of mental illnesses were then adopted in order to better manage the incarcerated populace.

The first editions of the *DSM* would have been unrecognizable to modern practitioners of psychiatry. The *DSM-I*, published in 1952, conceptualized mental disorders as dysfunctions of personality rather than of neurobiology following a former president of the American Psychiatric Association’s advocacy of “mental hygiene,” and the *DSM-II*, published in 1968, consisted of 180 categories of illness framed in a flowery psychoanalytic cant that drew scorn from the medical community, which viewed it as something of an unscientific embarrassment. In their 1997 exposé *Making Us Crazy*, Herb Kutchins and Stuart Kirk note that the *DSM-II* was, in fact, a slim guidebook of dubious analytic value that clinicians could purchase for \$3.50, designed to *describe*, rather than to *prescribe*, current psychiatric practices.

Things began to change in the next decade. Following the public outcry over thalidomide, a tranquilizer that was linked to thousands of birth defects despite originally being proclaimed safe by its manufacturers, the U.S. Food and Drug Administration initiated new regulations in 1962 covering the drug industry’s activities: companies were now required to establish a direct correlation between the physiological effects of newly designed compounds and particular medical diseases. This was a fateful moment for the psychiatric enterprise, which at the time lacked standardized disease entities to which specific compounds could be tailored. Increasingly attacked by its critics as unscientific, passé, inadequately somatic, and borderline illegitimate, psychiatry was in danger of slipping into medical irrelevance and was in dire need of reinvention. Enter Robert Spitzer, head of biometrics research at Columbia University’s Psychiatric Institute. Under Spitzer’s direction, an aggressive initiative to revise the *DSM* was launched, new diagnostic instruments were devised, and quantification became the disciplinary catchword. When completed in 1980, the *DSM-III* was, in every sense, an entirely new document. Whereas the *DSM-II* was 134 pages long, the *DSM-III* ran to nearly 500 pages and described 265 mental disorders in fastidious, grocery-list-like detail. (Spitzer in fact vehemently pushed for the *DSM* to classify “diseases,” though the editorial board ultimately settled on the term “disorders” in order to placate the APA-member psychologists who found Spitzer’s overly clinical zeal disturbing.)

Theodore Millon, one of the original members of the *DSM-III* revision task force, has acknowledged that the editors’ intentions were, in fact, to “embrace as many conditions as are commonly seen by practicing clinicians,” and, in so doing, expand psychiatrists’ access to fiscal coverage from third-party insurance providers. The rhetorical paraphernalia of the *DSM-III*, through which entirely normal forms of human behaviour were transformed into somatic ailments, thus equipped psychiatrists with a unprecedented level of authority over problems of mental health throughout civil society, in fulfillment of a longstanding wish to attain the prestige of other medical specialties. By reconceptualizing everything from unhappiness to inefficiency to social anxiety as discrete illnesses, each indexed with formally objective criteria, fixed etiologies, and clear-cut prognoses, the *DSM-III*’s authors—many of whom were recipients of major research grants from pharmaceutical companies—secured for themselves a substantial gift in the form of guaranteed insurance remittances, and furnished the drug barons with an equally lucrative gift: a slate of well-defined diagnostic entities at which to market their concoctions and, thus, an elegant solution to the challenges posed by the regulatory pressures of 1962.

In 1994, the *DSM-IV* was published to considerable acclaim, with a text revision released in 2000. A quick glance through its list of contributors is revealing. As was reported in a 2006 study lead-authored by Lisa Cosgrove of the University of Massachusetts, 56 percent (95 of 170) of the researchers who worked on the manual had at least one monetary relationship with a drug manufacturer between 1989 and 2004. Twenty-

two percent of these researchers received consulting income during that period, and 16 percent were paid spokespersons for a drug company. The percentages are even higher—100 percent in some instances—for researchers who contributed to the manual’s subsections on psychotic disorders such as schizophrenia. While Cosgrove and her coauthors were not able to determine the percentage of researchers who received funds from the drug industry during the actual production of the *DSM-IV*, the chorus of protest that arose following their paper’s publication was shrill and telling. “I can categorically say,” scoffed the *DSM-IV*’s text and criteria editor, Michael First, “that drug-company influence never entered into any of the discussions, whatsoever.”

First’s objection is probably accurate. The implementation of commercial agendas in medical research rarely takes the form of industry agents archly ordering doctors around. While it’s true that the annual conventions of the APA have become glitzy trade fairs at which attendees spend much of their time absorbing product pitches, it is the subtler forms of influence that have the most impact. As Joel Paris points out, “Although nothing forces us to prescribe their products, marketing strategies work. And the industries know it.” By sponsoring the scholarly activities of researchers—such as conferences, whose keynote speakers are often booked by industry representatives—companies are able to clinch remarkable levels of goodwill from academic faculty and medical residents. The psychiatric literature is, additionally, infested with a voluminous amount of corporate ghostwriting, wherein drug companies invite doctors to add their names, and thus their scientific imprimatur, to pre-written articles. (In return, naturally, these doctors get to pad their publication histories.) Many medical journals, moreover, manage their operating expenses by occasionally publishing corporate-sponsored “supplements,” which readers are not always able to distinguish from the journal’s regular issues. Due to governmental agencies’ lack of interest in funding clinical trials, finally, the companies have a virtual monopoly on pharmacological research, and have been free to regularly suppress negative results and finesse methodologies in order to generate favourable outcomes. The drug companies are now *de facto* members of the medical research community, and it has become virtually impossible to determine where the academy ends and the industry begins.

As the history of the *DSM* makes clear, it is not possible to speak of modern psychiatric nosologies without speaking of the professional interests from which they have arisen. The serviceability of this branch of the medical-industrial complex to the neoliberal fetishization of state non-interference, finally, should not be underestimated. With the innovation of increasingly marketable psychotropic drugs over the past four decades, public health officials have been free to legitimize healthcare budget cuts, hospital closures, and the widespread dismantlement of social services by devolving responsibility for mental health to the individual, and by transforming happiness into a problem of consumer choice. Miserable people—the exhausted assembly-line worker, the desperate college student, the alcoholic veteran—no longer pose a threat to the status quo so long as they agree to self-medicate, and to thereby keep themselves in a state of artificial equanimity. As sociologist Nikolas Rose observes, “In the majority of cases, such treatment was not imposed coercively upon unwilling subjects, but sought out by those who had come to identify their own distress in psychiatric terms, believe that psychiatric expertise would help them, and were thankful for the attention they received.” And this is the crux of the matter.

The myth of informed consent

A common objection to criticisms of our society’s growing infatuation with psychopharmaceuticals is that distressed people should be free to undertake whatever course of action they feel is necessary to dispel their misery. I cannot dispute this contention. No one who is familiar with the texture of crushing, existential despair can fail to sympathize with another person’s decision to resort to whatever is available to help them through the day, and it is not my intention to indict the personal logics that underpin these choices.

The rationality of consumer choice, however, is inevitably limited insofar as authentic data on the health risks of specific compounds are rarely available in the public domain, and insofar as the drug companies

continue to inundate airwaves, newspapers, magazines, and billboards with mollifying untruths about the efficacy of their products. As Alexander Cockburn has recently revealed in these pages, as much as a third of consumers who view an advertisement for a particular prescription drug go off and talk to their doctors about it, and nearly half of those who ask for a drug end up getting a prescription for it. How many of these consumers know of the plethora of peer-reviewed studies that have demonstrated that selective serotonin reuptake inhibitor (SSRI) compounds are closely linked with violence and suicide? What percentage of those who have come to conceptualize their pain in biological terms are aware that definitive links have yet to be established between neurotransmitter action and complex, culture-bound emotional states such as grief, anguish, and loneliness?

In 2006, the *New York Times* divulged, with the aid of internal documents leaked from a product liability lawsuit, that the pharmaceutical multinational Eli Lilly had systematically minimized the blood-sugar risks of its top-selling antipsychotic, Zyprexa (chemical name, olanzapine; \$4.8 billion in sales in 2007) for at least a year. The story had the feel of groundbreaking journalism: the *Times* had obtained sensitive documents and was now representing the interests of those deemed unable to represent themselves, the mentally ill. However, it is no longer any great epiphany that data manipulation and elision are rampant in psychopharmaceutical research. The list of revelations, past and present, is by now extensive and cannot be thoroughly inventoried here. In the 1990s, the litigation-averse *Los Angeles Times* killed an investigative report coauthored by Cockburn and former *Scientific American* editor Fred Gardner, in which evidence was presented linking Prozac to, among other things, domestic violence and tumour growth. Journalist Evelyn Pringle has, more recently, reported that Janssen-Cilag's antipsychotic Risperdal (chemical name, risperidone; \$3.5 billion in sales in 2005) induced severe side-effects, including strokes and death, in 1,207 children between 1993 and 2008. Two recent studies conducted independently in the United States and Great Britain have additionally revealed that newly released antipsychotics differ from their predecessors only in price, not in efficacy or safety.

In light of such disclosures, the industry's old standby of promoting "consumer choice" in an open and accessible marketplace begins to assume a dubious mien. Indeed, the teleological narrative of upward scientific progress in psychopharmaceutical research has lost much of its lustre in the last decade, and psychiatric survivors have come forth in increasing numbers to debunk industry representatives' counterfeit goodwill. But a question remains. What if, in some hypothetical future, a new generation of unambiguously safe and effective psychotropics could be developed? If it were one day discovered that contentment and productivity could be harmlessly produced with the ingestion of a magic cocktail, would it become ethically acceptable to urge the depressed and the despondent to take drugs?

When psychiatrists lament that over half of depressed people are "treatment-resistant," what they do not consider is this. It is not the "stigma" of being labelled mentally ill that discourages many people from seeking medical help; it is a strenuous aversion to being told that one's existential grievances are irrational, a mere result of a pathological neurochemical imbalance. It is the fear of being coerced into ingesting foreign substances, whether safe or dangerous (since 1997, NAMI has sought to expand a medication compliance program first developed in the 1970s, wherein mental health workers visit outpatients on a daily basis to confirm that they've taken their drugs, and to forcibly administer drugs if necessary). It is the resentment of being told that only the happy and productive are sane, and that one's judgement is *ipso facto* suspect if one cannot live comfortably with the way things are.

We are at a strange point in history. It should come as no surprise that the exhausting and alienating conditions in which we live and labour are productive of myriad forms of psychological suffering. Yet critics of biological psychiatry are commonly subjected to the fallacious accusation that, because we reject the equation of unhappiness with sickness, we must believe that it is a weakness. This is a false dichotomy. Is it so difficult to understand the pain engendered by life under neoliberal capitalism as something worthy of

dignified reflection, irreducible to either sickness or weakness? Is it so hard to grasp that to *detrivialize* the social conditions that give rise to crippling despair, or the ideologies that equate difference with disease, is not to trivialize despair or difference? Rather than resorting to the explanatory red herring of mass psychopathology, we ought to be directing our attentions toward those who have something to gain from the widespread medicalization of distress and dissent in all their forms.

Let's be candid. The drug barons' ongoing project of pathologizing entirely natural emotional responses to hunger, humiliation, financial insecurity, racism, sexism, overwork, and isolation is a mercenary tactic designed to create markets, maximize profits, and minimize dissidence. Whether intended or unintended, the consequence is that we have come to reflexively view ourselves—our bodies, brains, and genes—rather than our societal environment as pathogenic, against all evidence to the contrary. As the *DSM-V* goes into pre-production, it may be worth pondering the implications of this trend. ■

Eugenia Tsao is a PhD candidate in medical anthropology at the University of Toronto. The author is grateful to the Social Sciences and Humanities Research Council of Canada (SSHRC) for its support and to Alexander Cockburn for invaluable editorial assistance. She can be reached at tsao.eugenia@gmail.com.

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