Definition and classification of mental illness can be traced back to the 5th Century (BCE) physician Hippocrates. The concepts of mania and hysteria, which are attributed to Hippocrates, have evolved into 20th century diagnostic terms such as conversion disorder and bipolar disorder. Nosology (classification of diseases) is indispensable to any field of science as it provides a common language of communication among clinicians and researchers. Nosology is also essential for an understanding of etiology, diagnosis and treatment. The history of psychiatric nosology has been fraught with controversies. The major categories of mental disorders to which modern psychiatrists subscribe are based on a priori assumptions about the nature of psychiatric illness, assumptions conceived through the clinical experience of European psychiatrists.

To appreciate the reasons for the debate around the credibility of psychiatric nosology, it is important to view the history of the Diagnostic and Statistical Manual (DSM) by the American Psychiatric Association (APA). The DSM which is considered the Bible of psychiatric diagnosis was first published in 1952 (DSM-I) and has gone through several subsequent revisions of which the latest, DSM-5, was published in 2013. DSM-I and DSM-II were conceived on a psychosocial model influenced by the psychiatric experience of soldiers in World War II and Freud’s theory of personality development based on intrapsychic conflicts. This psychosocial model assumed a fluidity of the boundary between the normal and mentally disturbed and raised questions about the legitimacy of psychiatry as a medical science. Criticism was also leveled from those within the profession by biologically oriented psychiatrists who defended a medical model of classification. This was also a period in which psychopharmacology had advanced; medications like Lithium Carbonate, anti-depressants, and antipsychotics had proved to be beneficial in certain kinds of psychiatric disorders.

The anti-psychiatry movement of the 1970s included psychiatrists who questioned the validity and arbitrariness of psychiatric diagnosis based on family and social environment rather than on a pathophysiologic basis. Thomas Szasz, a notable and renowned critic, claimed that under the guise of psychiatric labels, people were stigmatized and controlled by the powerful establishment of psychiatrists. The legitimacy of psychiatry was further questioned when homosexuality, once listed as sexual deviation, was removed from DSM II following protests by vocal gay rights organizations. This made it embarrassingly evident that a supposedly classified disorder was contingent upon the
political and sociocultural stance of the time rather than on scientific reasoning. It was also in 1972 that David Rosenhan, a psychologist, conducted an innovative study to determine the validity of psychiatric diagnosis. He had pseudo patients feign auditory hallucinations to get admitted in different psychiatric hospitals. Even though the patients acted normal during their hospital stay, they were still discharged with the diagnosis of “Schizophrenia in remission.”

DSM III, published in 1980, was an attempt to provide a solution to these justified criticisms. Its publication was a turning point and marked a paradigm shift in psychiatry. Its approach was descriptive and based on observable symptoms which could be supported by research. A nosology with specific symptoms for diagnostic criteria was the beginning of reconciliation between psychiatry and medicine. At the same time, this nosology minimized the role of social and emotional factors in the etiology of mental disorders.

An approach that did not privilege social and emotional factors benefitted the pharmaceutical industry in promoting psychiatric drugs as a “quick fix” to emotional distress, thereby reinforcing and propagating the medicalization of mental illness. The popular and indiscriminate use, plus the miraculous qualities attributed to Prozac in treating depression is a well-known phenomenon of the 1980s. The much heralded DSM III however, had its own set of criticisms, some of which were directed at the inclusion of new diagnostic categories. Paula Caplan, a clinical and research psychologist, and a human rights advocate, put forth a trenchant argument against the inclusion of diagnostic labels such as Self-Defeating Personality Disorder (SDPD) and Premenstrual Dysphoric Disorder (PMDD). Both these disorders were applicable to a majority of women.

SDPD, facetiously referred to as “good wife syndrome,” included characteristics such as putting needs of others ahead of one’s own, feeling unappreciated etc. Interestingly, this “portrait” of SDPD is most germane to the accepted and desirable gender role for Pakistani women as well. The scientific basis of including PMDD was also questioned as some of its diagnostic features incorporated “bloating,” breast tenderness, irritability, fatigue etc, which are common symptoms of PMS experienced by many women. In lieu of the scathing criticism from feminists, the two diagnoses were not included in the main text of DSM-III-R and DSM-IV-TM (2004) but were instead placed in an appendix titled “Diagnostic Categories Needing Further Study.” Nevertheless, by defining diagnostic categories operationally, DSM III provided a common language for different mental health professionals. Its descriptive approach also made epidemiological research possible.

After a period of 13 years the DSM-5, a 947 page volume with over 300 diagnostic categories, was published in 2013. Well before its publication disputes arose over the intended introduction of new categories and the lowering of new categories and the lowering of the threshold for certain existing ones. Allen Frances, who chaired the task force of DSM-IV, was the most forceful and potent critic of DSM-5. He criticized the arbitrariness of the changes and the scientifically untenable method of diagnosis based on check lists of symptoms more beneficial to drug companies than to the patients. The plausibility of Frances’ concern regarding the enormous potential for misdiagnosis can be illustrated through two examples.

By eliminating the bereavement exclusion from Major Depressive Disorder (MDD), if normal grievers checked 5 out of 9 general distress symptoms they would be falsely
diagnosed to have MDD. If grieving for a loved one can be given a psychiatric diagnosis then it is not too far-fetched to expect specific antidepressants for mourners. Interestingly, Eli Lilly has supported a clinical trial of its antidepressant Cymbalta for treating “bereavement-associated” depression. The second example is the introduction of Disruptive Mood Dysregulation Disorder (DMDD) for ages 6 to 18. With its main criteria being frequent temper tantrums inconsistent with developmental level and disproportionate to the provocation, this runs the risk of diagnosing difficult children with a mood disorder which could exacerbate the already excessive use of medications in children.

Unfortunately, the proliferation of diagnosis and the trend to “pathologize” normal behavior has jeopardized the credibility of the profession of psychiatry. Grave concerns have also been expressed over pharmaceutical companies' influence on the structuring of DSM. A study from the University of Massachusetts-Boston notes that 69 percent of DSM-5 task force members had ties to pharmaceutical companies. While APA has denied such claims, the possibility of conflict of interest is not an issue that should be minimized.

A visible, symptom based, descriptive model of psychopathology (DSM III onwards) has been useful in the treatment of some major psychiatric illnesses. However in its quest to be considered a “science,” psychiatry has lost sight of human suffering and healing. What is being forgotten is that psychic reality, the subject matter of psychiatry, can neither be categorized nor quantified.

References:
