

Grand Valley State University presents



The Medicalization of Society

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University Professor, Professor of Social Work
Professor of the Conceptual Foundations of Psychiatry
School of Medicine, New York University

Michael B. First, MD
Professor of Clinical Psychiatry, Columbia University
Research Psychiatrist, New York State Psychiatric Institute
Practice – Schematherapy and Psychopharmacology

September 26, 2016
Cook-Deos Center for Health Sciences • Robert C. Pew Grand

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DeVos Medical Ethics Colloquy

The Bi-Annual DeVos Medical Ethics Colloquy Series was started in March 2005, at Grand Valley State University in Grand Rapids, Michigan, by a generous endowment from the Richard and Helen DeVos Foundation. Richard and Helen DeVos saw the need for a forum where subjects of medical and ethical significance could be discussed under the guidance of a learned speaker, with opportunity for participation by the public in general. The proceedings of the Colloquy are printed and distributed free of charge to institutions across the continent and interested individuals.

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**William Sanders, DO
(Moderator)
Director, Pine Rest Psychiatry Residency Program
Pine Rest Christian Mental Health Services**

Dr. William Sanders, D.O. graduated with his Bachelor of Science Degree from Alma College with a double major in Biology and Chemistry and a master's degree in biomedical sciences from Barry University in Miami Shores, Florida. He subsequently received his doctorate of osteopathic medicine degree from Michigan State University College of Osteopathic Medicine and completed his psychiatry residency at Michigan State University. He completed a forensic psychiatry fellowship at the University of Florida. He is board certified in adult psychiatry by the American College of Osteopathic Neurologists and Psychiatrists and the American Board of Psychiatry and Neurology. He is also forensic board certified by the American Board of Psychiatry and Neurology. Upon completing his forensic psychiatry training Dr. Sanders returned to Michigan and began employment at Pine Rest Christian Mental Health Services in Grand Rapids, Michigan. At Pine Rest his academic roles included working as the Michigan State University clerkship director and subsequently the Pine Rest/MSU psychiatry residency director. He was also involved in developing the Forensic Psychology and Psychiatry Services Department. He currently services as the vice president for the Michigan Psychiatric Society.

INTRODUCTION

Dr. Sanders:

Thank you Dr. Tomatis. It is an honor and a privilege to be here. I was connected with Dr. Tomatis and he asked me if I would be the moderator for this event. At first I wasn't sure exactly why he chose me, but then we talked about the topic – the medicalization of society – and how that may interface with not only medicine but psychiatry in general. So welcome to the 24th DeVos Medical Ethics Colloquy. Think about those words for a second – ethics and colloquy. I'm going to circle back to that phrase.

This colloquy is hosted by Grand Valley State University, so thank you Grand Valley State University for hosting this. My nephew is currently living in my basement and going to the Grand Valley State University Honors College, so I thank you Grand Valley State University. My nephew wakes me up at five o'clock every morning to work out, so I don't know how I feel about that right now.

Regardless, we're extremely happy and excited to have you joining us today. Just to introduce myself, my name is Bill Sanders. I am a psychiatrist, and I work at Pine Rest Christian Mental Health Services in town here. I did my general psychiatry residency training at Michigan State University and then after I finished my general adult psychiatry residency training, I went down to the University of Florida and did a fellowship in forensic psychiatry for one year. I had the privilege of working in the prison system, working on death row, and kind of with the medicalization of society sometimes I think about that in terms of the medicalization of criminal behavior. That too is a topic that we talk about in forensic psychiatry quite a bit. In terms of thinking about ethics, at Pine Rest we started a psychiatry residency training program, and as we were developing that training program and thinking about our roles as psychiatrists and as physicians, I felt that ethics is one of

the most important things we have to deal with. Just to be able to take a step back when we're training our psychiatrists. So much of their focus is on the day to day standardized medicine and the care of patients that sometimes you need to take a step back and really kind of think about what we're doing. So I insisted that we have ethics in the first year of the curriculum of that training program.

When we talk about the definition of ethics with the residents, the definition I like and that's easy for them to remember is ethics is knowing the difference between what you have the right to do and what is right to do. So, we're trying to help them distinguish between knowing the rules in practicing medicine and doing the right thing in medicine. I was just kind of reviewing that concept with the residents today. It's not always clear what is the right thing to do, especially with the medicalization of society and thinking about the different things, and I'm sure our speakers are going to touch on this so I don't want to get too much into the definition. But thinking about things that may have been medicalized like obesity, depression, anxiety, or child birth. I'm always a little bit taken aback that male pattern baldness is one of those as well. So I half wonder if that's why Dr. Tomatis wanted me to do the moderating today.

Regardless, I think that we have an interesting topic to review today. In the real world sense of things, just today there was an article that was sent to me by a residents titled *Does Psychiatry Worsen Mental Illness Stigma?* It stimulated a really thoughtful discussion by board certified psychiatrists who were sending emails back and forth within a couple hours. So just briefly, one of the comments was, "The brain, as we know, is more than the sum of its anatomic parts. It is Grand Central Station for all the other organs to communicate with one another. The brain is the organ that controls feelings, thoughts, and behaviors of the organism. When we feel sick because of physical or emotional pain, it is our brain telling us we feel sick. It is our brain thinking of ways to feel better. It is also our brain controlling our

sickness behavior. It's okay for us to be the people who name what we do instead of letting others name it for us. We are psychiatrists, the first physicians to specialize in the treatment of brain disorders. Just as Pinel freed women from chains in the 1800's, let us physicians and knowledge sharers free the minds of others and embrace our brains in sickness and health."

One more comment and then I will get to our speakers. In a reply it said – this is the end of the next statement, which brings me to the point brought up by the previous doctor – stating that "it is a biological fact that the brain is the organ that controls feelings, emotions, thoughts, and behaviors. I personally refuse to reduce my entire humanity and that of others to a collection of synapses, action potentials, and neurotransmitters. Our feelings and thoughts, which control our behavior and clearly abstract notions, are immaterial whereas the brain is very tangible, concrete, and physical. Does the brain actually have a localization for our sense of beauty, compassion, love, poetry, hope, peace, and justice? The cerebral cortex is nothing but layers of neurons, dendrites, and glial cells communicating and sending electrical impulses to subcortical areas and other organs in the body. But who/what is giving others these neurons in the first place? I think psychiatrists and other scientists should free themselves from the reductionist views of the brain as the master organ and start embracing the existence of higher controlling and pervasive power." That just happened today. That's why we're getting today to kind of figure out, what is this all about? What is the medicalization of society? I'm not going to talk much more because we have two very distinguished presenters who are going to answer that very question for us today.

Speaking first will be Dr. Jerome Wakefield. Dr. Wakefield is university professor of social work and professor of the conceptual foundations of psychiatry in the school of medicine, as well as affiliate faculty and advisory board member of the Center of Bioethics, at New York University. After Dr.

Wakefield speaks, we'll have Dr. Michael First, who is a professor of clinical psychiatry at Columbia University, a research psychiatrist at the Biometrics Department of the New York State Psychiatric Institute and maintains schematherapy and psychopharmacology practice in Manhattan. So without further ado, I'm going to let these two very capable and distinguished speakers get started. Dr. Wakefield, you're up first.



Jerome C. Wakefield, PhD, DSW
University Professor, Professor of Social Work
Professor of the Conceptual Foundations of Psychiatry
School of Medicine, New York University

Jerome C. Wakefield, PhD, DSW is a university professor, professor of social work, and professor of the conceptual foundations of psychiatry in the School of Medicine, as well as an affiliate faculty and advisory board member of the Center for Bioethics, at New York University. Before coming to NYU, he held faculty positions at University of Chicago, Columbia University, and Rutgers University. His highly eclectic clinical training was primarily at Kaiser Hospital Santa Clara Dept. of Psychiatry and Berkeley Community Mental Health Center. Holding doctorates in both philosophy and clinical social work from Berkeley, Dr. Wakefield writes about issues at the intersection of philosophy and the mental health professions, especially the concept of mental disorder and the boundary between normal distress and psychopathology. Recently his work has focused on using empirical methods of psychiatric epidemiology to address theoretical controversies about the relation between depression and grief. He has published over 250 scholarly articles, and is the co-author (with Allan Horwitz) of "The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder" (Oxford 2007), and "All We Have to Fear: How Psychiatry Transforms Natural Fear into Mental Disorder" (Oxford 2012).

Dr. Wakefield:

I am honored and delighted to be here. Of the many people and organizations to thank for this opportunity, I want to express particular gratitude to Jean Nagelkerk, Luis Tomatis, and others on the organizing committee for their efforts, Bill Sanders for agreeing to moderate, and of course The Richard and Helen DeVos Foundation and Grand Valley State University as well as the other sponsoring organizations for their generous support. One thing that immediately struck me is how highly interdisciplinary this group is, encompassing philosophers and other humanists as well as a variety of health professionals. Such a cross-disciplinary discussion is rare and very important. Philosophy and clinical theory are interwoven and they need to meet, and this is one place tonight where they are meeting.

I need to mention one caveat before I start. I am going to be talking in part about what is and is not a mental disorder. Although in this group I probably don't have to say this, please don't take anything I say as sufficient to diagnose anyone as having or not having a disorder. That requires assessment by an expert clinician. I should also mention that I wasn't officially involved in the DSM effort, and the DSM diagnostic criteria sets I will describe are copyrighted by the American Psychiatric Association.

The topic of medicalization has long been a controversial and important one, and it will grow in importance over the next few decades. Especially in psychiatry, on which I will focus my remarks, as we enter a new era of accelerated exploration of the roots of mental disorders in the brain, the odds are that we are going to increase our ability to intervene in and regulate various behaviors, emotions, and attitudes in a more refined way. To take one example, neuroscientists have a growing understanding of brain triggers of sexual interest and of aggression, and interestingly, there is a specific small subassembly of neurons the firing of which triggers both sexual interest and aggression towards the same object simultaneously. We're learning much that will challenge how we think about ourselves, and will

certainly give us new powers to manipulate behavior. This is one reason why bioethics and philosophy of psychiatry are burgeoning fields. We must start thinking now about the ethical issues that will be raised by this new knowledge. One crucial challenge is to address the implications of medicalization, the common practice of classifying what are in fact normal-range problematic behaviors as mental disorders.

The goals of medicalization are sometimes practical and even admirable, such as to enable the clinician to obtain medical insurance reimbursement for treatment of individuals who may not have a disorder but who are suffering and can benefit from psychological help but cannot afford to pay for such treatment. On the other hand, one might be concerned that our new knowledge of the brain and our ability to manipulate it with recently developed neuronal-level manipulations might contain the seeds of the science fiction dystopian fantasy of a world that doesn't tolerate emotional difference and insists on efficiency, efficiency, efficiency. For example, when I give talks on the medicalization of grief, young people sometimes come up afterwards and complain that if something bad happens in their lives and they are grieving and out of the office for more than a day, their co-workers suggest that they get some medication and get back to work. Similarly, young people report to me that the normal dejection that occurs after the ending of a romantic relationship triggers intense concerns in their elders about pathological depression even when there is no basis for such suspicions. The relentless drive for economic efficiency could influence psychiatry to relabel normal but inefficient emotional reactions as mental disorders, narrowing the domain and range of normal emotional life.

The clinician's dilemma: Should one diagnose a disorder in a nondisordered client who needs and deserves help?

- Broader categories, even if invalid, mean more reimbursement to help more people with problems for which they need and deserve help
- But disorder diagnosis can have negative consequences, such as medication with side effects
- Informed consent demands being truthful with the client
- If the DSM says it is a disorder but you don't believe it is, what do you do? Can two diagnostic wrongs make a reimbursable right?
- This is an ethical issue clinicians face every day within our flawed and self-defeating system of reimbursement

Figure 1

I call the challenge that arises for the clinician in deciding how to diagnose patients suffering from normal distress the clinician's dilemma (Figure 1). There is little doubt, as I will argue later, that DSM diagnostic criteria are too broad and over diagnose mental disorder. If so, then the clinician is faced with the following dilemma: if somebody who is suffering and who satisfies the criteria but (the clinician believes) does not in fact have a mental disorder needs and deserves help, what should the clinician do – consciously misdiagnose the individual as having a disorder to justify reimbursement (but also open the individual to potential issues that arise from having the disorder diagnosis in the chart), or correctly diagnose a “Z Code” non-disordered condition and risk being unable to treat the individual? This isn't a theoretical dilemma or mere thought experiment. Many clinicians face this dilemma every day and report that a sizable portion – likely a majority – of the individuals they treat do not have genuine mental disorders but do have some other sort of problem for which they need and deserve help. For example, articles in the New York Times have described the common practice of diagnosing children who are having difficulties staying focused in school as having attention-deficit/hyperactivity disorder (ADHD)

even if the clinician doubts the presence of a true disorder. Similarly, people come for a consultation who are sad due to life circumstances that are terrible, and it is easy to diagnose them as having a depressive disorder. So, granting that we have a medical reimbursement system that is in many ways self-defeating and unjust, nonetheless the reimbursement system provides support to help people. How does one deal with people who need and deserve help but don't technically fall under the reimbursement requirement of medical necessity?

The clinician's dilemma is a real ethical dilemma, but unfortunately it is one that I am only going to raise but I am not going to try to resolve today. Instead, I am going to try to clarify some of the intellectual underpinnings that lie behind these issues.

The term medicalization has come to have several senses and covers an enormous and heterogeneous domain, which can be confusing. So, I am first going to briefly review two other senses of 'medicalization' before I turn to medicalization in a third sense that is primarily going to occupy me.

The first sense of medicalization refers to the shift of authority over a condition from some other institution to the medical profession and thus the expansion of the domain of authority and responsibility of the profession of medicine. When this sort of shift occurs, conditions that generally have been addressed by other non-medical social institutions come to be monitored and treated by physicians. Such relocation of professional authority can occur in relation to an enormous variety of conditions, which do not necessarily have to be seen as medical disorders but may be thought to benefit from medical supervision or intervention due to the risk of developing a disorder or the potential alleviation of suffering. For example, traditional processes of childbirth using natural delivery or delivery at home aided by a midwife were largely replaced in Western societies by a process monitored by a physician and generally occurring in hospitals under medical supervision. The shift to hormonal treatment of menopause is another example often mentioned here.

An obvious example would be the advent of widespread cosmetic surgery in the pursuit of beauty. Medicalization in this sense of the relocation of authority to within the medical profession also sometimes occurs because a condition formerly seen as a nonmedical problem comes to be reclassified as a medical disorder and thus considered to appropriately fall within the authority of medicine. For example, alcoholism used to be considered more of a moral problem, but it is now considered a medical disorder.

Rambunctious children were seen as disciplinary challenges in school, but now many of them are classified as suffering from ADHD. Of the many conditions that have been relocated within the authority of medicine, some are non-disorders that are believed to benefit from medical involvement and others are conditions that have come to be newly seen as disorders.

Much of the discussion of medicalization in the sense of the growth of medical authority goes back to Ivan Illich's book, *Medical Nemesis* in which he wrote about the medicalization of death and how what was formerly considered a natural process has become anything but, with end-of-life patients placed in the hospital and doctors fighting death every step of the way, even when it makes no sense. Illich's influential critique helped give rise to the hospice movement and palliative care that to some extent wrested control over end-life processes from physicians in the name of a broader humanistic perspective. Illich's argument ushered in movements to alter the seeming tyranny of the medical model by emphasizing the rights of patients in terms of informed consent, patient activism, and medical self-determination.

The second sense of medicalization refers to biologicalization, that is, taking some human phenomenon formerly understood in humanistic or moral or psychological terms and reconceptualizing and describing it in terms of its underlying biology, thus transforming the way we think about it. For example, we are endlessly told by the National Institute of Drug Abuse (NIDA) that addiction isn't primarily about lack of other viable life options or foolish desires for a uniquely intense pleasure but rather is sheerly a chronic

brain disease that arises due to damage done to the brain by abused substances. Treatment research consequently focuses on biological approaches. (Actually, in fairness, NIDA does allow that there are many collateral psychosocial aspects of addiction, but places the brain damage at the center of the nature of addiction.) Certainly, there is some truth to this perspective on addiction, but carried to an extreme it seems to dehumanize the addict to an excessive degree.

To some extent, biologicalization is also taking place within the entire domain of mental disorder. The focus in research is thus on the brain dysfunctions that underlie mental disorders, as in the new Research Domain Criteria (RDoC) brain initiative being emphasized in grant funding at the National Institute for Mental Health (NIMH). Indeed, psychiatry has adopted the organizing belief that all mental disorders must be brain disorders. For example, Nobel prize-winning neuroscientist Eric Kandel states: "All mental processes are brain processes, and therefore all disorders of mental functioning are biological disease. The brain is the organ of the mind. Where else could (mental illness) be if not in the brain?" One can immediately see the problem with this argument if one compares it to the obviously invalid argument, "All computer software programs are computer hardware processes (where else does software run if not in hardware?) and therefore all software malfunctions are hardware malfunctions." The fallacy is the same in both arguments. Although software/mental processing takes place within the hardware/brain, things can go wrong with software/mental processing at that level symbol-manipulation level even if nothing at all is broken at the hardware/brain level.

In everyday life, biologicalization can lead to a mechanical approach to understanding the actions of the disordered (e.g., an actual conversation: "Why did X commit suicide?" – "Because he was bipolar.") There is no meaning content to it at all in explaining action, just reference to a disorder that is presumed to be biologically based (even though we as yet possess not

even one well-worked out biological explanation of a mental disorder) and that is directly causing behavioral events. This illustrates a general concern by critics that biologicalization conflicts with moral evaluation. Critics raise the question of whether it talking about each other in this biologicalized way that describes processes taking place below the meaning-system level undermines our moral discourse.

On the other hand, defenders of biologicalization argue that seeing disorders as brain diseases relieves the mentally disordered of the social stigma to which they are subject, thus gaining them greater acceptance and encouraging them to seek help. This standard doctrine, that the “brainifying” of human problems inherently eliminates or is in opposition to attributions of moral deficiency, is commonly expressed by leading mental health professionals, as in the assertion by Nancy Andreasen, the former Editor-in-Chief of the *American Journal of Psychiatry*, that “people who suffer from mental illness suffer from a sick or broken brain, not from weak will, laziness, bad character, or bad upbringing,” or in the statement that appears on a billboard on 72nd street in Manhattan (pictured on the cover of my book, *The Loss of Sadness*) that “depression is a flaw in chemistry not character.” The stigma argument is so prominent in psychiatry as an argument for biologicalization that it is worth briefly examining it both in terms of its conceptual coherence and the empirical evidence.

I believe that the argument that biologicalizing our talk about mental disorders relieves people of moral censure is conceptually flawed. Think about it this way: people who believe in biologicalizing our descriptions of disorder generally argue that all mental disorders must be brain disorders because everything mental is biological, therefore we might just as well describe everything in biological terms. However, if we accept that premise as true, then whatever constitutes moral weakness must itself also be a biological feature of the brain. Thus, for all we know, the biological trait that constitutes a mental disorder may well be a biological trait that also

corresponds to or includes the brain feature that constitutes moral weakness. And so it may well be, by the very assumptions of the biologicalizing theoreticians, that in talking about biology, although you are not directly talking about morality, you are indeed actually still talking about moral traits, because the relevant biological processes are the substrate for such traits.

In fact, morality and disorder judgments do sometimes seem to be compatible. That is pretty obviously true for disorders that directly impair the functioning of moral faculties, such as antisocial personality disorder and conduct disorder. An unfortunate historical example is that some people blamed soldiers for getting War Neurosis in earlier times (conditions that would now probably fall under PTSD) because they considered it a byproduct of being a coward, on the theory that if you weren't brave enough to handle being under enemy fire, that moral weakness is what caused you to fall prey to this disorder, an argument that we now know is false. However, there are other more contemporary examples. For example, much of the "brain disease" talk about addiction, when it is closely examined, turns out to be just another way of describing in "brainese" the psychological weaknesses that are often attributed to those who are addicted. For example, standard "brain disease" accounts of addiction offer brain-based translations of the addict's out-of-control desire, tendency to place immediate pleasure over future personal harm or harm to loved ones, reduced capability for inhibitory control of impulses, lessened interest in other of life's rewards, and so on. Even though these features of addiction are described in terms of alterations in brain activity, it can hardly escape notice that these are all considered weaknesses or moral deficiencies at the psychological level. Thus, it remains unclear to what extent biologicalization actually does relieve the diagnosed individuals of moral evaluation.

What about the related reduction-of-stigma argument? This is one of the main arguments used by people who want to focus on the biological level of discourse. Such a focus will rid the disordered of stigma, they argue,

because then we are not talking about morality or meaning, and we are not talking about the individual's personality. Instead, we are talking about things that are happening to the individual's brain that are beyond the individual's control and that mechanistically cause certain consequences. Therefore, the argument goes, biologicalization should do away with stigma because it will do away with moral judgments that the individual is weak or cowardly and so on.

However, the effects of biologicalizing mental disorders on stigma has been studied extensively by researchers, and from the empirical literature one must conclude that biologicalization is no panacea for reducing stigma. As one might have expected, people's attitudes are more complex and sophisticated than the destigmatization-via-biologicalization strategy assumes. It is empirically not true that attributing mental disorder to biogenetic underpinnings relieves disordered individuals of all major aspects of stigma. Stigma is measured in a variety of ways, not only in terms of moral blame but, for instance, by whether one would be willing to live near a disordered person, whether one would consider the individual dangerous, whether one considers it likely the individual might get better, and whether one would associate or let one's children associate with the individual. Depending on the specific nature of the disorder and the specific biological theory of it, people come to varying conclusions. A recent review found that biologicalization did reduce moral blame but on the other hand it increased pessimism about whether the person would ever change for the better and it did not alter the desire to be distant from and avoid the person. So, biologicalization offers no simple cure for stigma, contrary to what is commonly assumed in the psychiatric literature.

I now turn to a third sense of medicalization which is the one I am going to focus on for the remainder of my discussion, and which might be called conceptual medicalization. Another common term for it is pathologization, which consists of newly classifying a condition as a disorder

that is not a disorder and was not formerly believed to be a disorder. I will focus especially on mental disorders, and how diagnostic criteria classify conditions (versus when individual clinicians may make various kinds of errors not due to the official criteria). When diagnostic criteria pathologize a condition that is not in truth a disorder, then you get what is generally referred to as a false positive diagnosis in which a condition that is not a disorder is nonetheless diagnosed as a disorder. (A disordered condition that diagnostic criteria mistakenly classify as a non-disorder is correspondingly called a false negative.) So, for the remainder of this discussion I will be focusing on the problem of false positive diagnosis of psychological conditions due to invalid formulation of diagnostic criteria.

It is important to recognize that psychiatry is mandated to do much more than treat disorders. DSM-5 itself has an extensive list of Z Codes that are conditions that not disorders but that are often seen by mental health professionals, such as family tensions, occupational failure, and normal grief. Psychiatrists and other mental health professionals help people to cope with stress and life transitions and relational conflicts such as marital problems, none of which need be disorders, and beyond that they help people to enhance their human potential in various directions such as resilience, creativity, and leadership. However, mental disorder remains at the core of the mental health professions' mission because that is what makes us *health* professions. Otherwise we would not have the privileges and responsibilities of the health professions. So, treatment of mental disorder is a necessary and essential part of our domain, and all these other services are add-ons to one degree or another. This is analogous to physical medicine, in which treatment of disorder and promotion of health is at the conceptual core of physicians' mission and yet there is a sizable effort addressing problems that are not disorders, ranging from contraception to cosmetic surgery.

This complex mission that encompasses disorders at its core and also addresses many non-disorders is not problematic in itself. Problems only

arise if one confuses disorders with other conditions and thus misclassifies conditions, for reasons I will elaborate below.

DSM-5 uses symptom-based operationalized criteria to specify how to diagnose each mental disorder. This increases the reliability of diagnosis, but it does not guarantee validity. Even a very precise and clear measuring instrument, such as a set of symptom-based criteria, can just be measuring the wrong thing. Slapping down a set of criteria for something that is negative isn't enough to make it a disorder. Jordan Smoller, who is now an eminent psychiatric geneticist at Harvard, published a humorous paper when he was a medical student on *The Etiology and Treatment of Childhood* in which he illustrated the point by formulating symptom-based operationalized criteria for the (purported) disorder of "childhood." He indicated that childhood is a serious clinical condition that the mental health professions have been ignoring, and listed the symptoms. There is major social role impairment because a child can't really do anything occupationally. There is congenital onset, which obviously suggests a genetically mediated disorder. There is severe dwarfism relative to normal people. Moreover, there is emotional lability and immaturity that's comparable only to severe personality disorders, and so on. My favorite symptom is legume anorexia – the inability to eat vegetables that are good for you, like spinach and broccoli. The point is that formulating a set of criteria that indicate something that's problematic (because children do irritate quite a few people) is not enough to make it a disorder. Beyond just operationalized criteria, the criteria must be formulated to pick out disorders from among all the other problematic conditions to which human beings are subject.

Thomas Szasz really started the conversation about psychiatric medicalization of normal-range conditions in its contemporary form with his claim in *The Myth of Mental Illness* that there is no such thing as a mental disorder and that psychiatry is just about using medical categories for social control purposes. In effect, Szasz argued that the entire psychiatric

nomenclature is just one enormous set of false positives. According to Szasz, our society uses medical jargon to justify psychiatric intervention and the use of medical techniques to control behavior that we find socially undesirable. Michel Foucault helped this argument along with a historical perspective on the transformation of nonmedical problems into medical problems of psychiatric disorder. To answer Szasz's and Foucault's critiques one needs to formulate a persuasive concept of mental disorder that reveals how it is perfectly coherent that there can be mental disorders in the same sense that there are physical disorders. I will return to the analysis of disorder shortly.

Negative versus descriptive views of medicalization

- Often used negatively, as an accusation, but need not be.
- I will use it descriptively; medicalization is a fact about a conceptual process. Evaluating medicalization is an additional step.
- By definition, there is at least one thing that is negative about conceptual medicalization: it is untrue that the condition is a disorder.
- But, perhaps there is good that outweighs the bad
 - Steven Hyman: "I have shamelessly used medicalization to achieve what I believe are very good ends in other parts of my life."
- What good ends might pathologization be achieving?

Figure 2

Medicalization is often used as an inherently negative term (Figure 2). In principle, I am using the term neutrally here to describe a certain phenomenon. However, medicalization in the conceptual sense does have something against it right out of the gate because conceptual medicalization refers to cases that are not correctly diagnosed. That is intrinsically negative because the diagnosis represents an untruth about the condition, classifying it as a disorder when it is not a disorder. However, it could well be that in

some cases that untruth is overall morally justifiable, as I indicated before in talking about the clinician's dilemma. So, it is not necessarily always bad to pathologize.

One question that I want to address is: why are we so open to doing this? You would think if there is massive overdiagnosis and there are protests against it, that it would be easy to just extirpate it from the manual because everybody would agree. But we don't agree. And, although no doubt sheer conceptual confusion has something to do with this, I think there are reasons beyond conceptual confusion for why we don't agree and why the manual is allowed to be inflated with nondisordered conditions that are labeled as disorders. I think these are value-based moral reasons.

To explain what I have in mind I have to have an account of the concept of disorder as a framework to identify valid versus false positive diagnoses. Unfortunately, the full development of such an analysis would take up the whole time we have available. The concept of disorder itself is highly controversial, and I have staked out a position that has been widely discussed and endorsed by some leading nosologists, and I will presuppose it in what follows.

Concept of mental disorder

- Value versus scientific accounts
- “Hybrid” proposal: *harmful dysfunction* account of medical disorder (consistent with but expands upon DSM approach) (Wakefield, 1992)
- Harm interpreted largely in terms of a society’s values; the dysfunction in the individual causes distress or role impairment or some other negative outcome
- Dysfunction interpreted as a failure of biologically designed functioning of some internal mechanism – which may be (fallibly) inferred to exist from circumstantial evidence

Figure 4

I propose, then, that a mental disorder or any other medical disorder is a harmful dysfunction (Figure 4). This is a hybrid notion consisting of both factual scientific and value components. First, to be a disorder, a condition must cause harm, which is a value component judged according to social values. The harm must be caused by a dysfunction, something that has gone wrong with the functioning of some internal mechanism. By “going wrong” I specifically mean that the internal physical or psychological mechanism is not doing something it was biologically designed to do, which is based ultimately on evolutionary theory and why the mechanism was naturally selected. One strength of my analysis is that it reflects and elaborates on and is consistent with the definition that appears in the introduction to DSM-5.

To see why the biological design criterion is essential, leave aside Smoller’s example of childhood and consider the example of sleep. Sleep is surely the single most harmful condition of the human race, stealing one-third of our lifespans and rendering us functionally grossly impaired, partially paralyzed, and periodically hallucinating. Yet, even though until recently we

have not understood the functions of sleep, no one has considered sleep in itself to be a disorder because the circumstantial evidence suggests that it is part of our biological design.

For our purposes in considering psychiatric medicalization, the crucial point about the concept of disorder is the dysfunction requirement; for a condition to be a disorder, it must be objectively true that something is going wrong from an evolutionary biological-design perspective. The condition cannot just be something that we don't like. That eliminates the misuse of diagnosis to label social deviance and various interpersonal conflicts as disorders. Almost all of the conditions listed as disorders in the DSM-5 are indeed harmful or negative. The problem is the failure of DSM-5 criteria to carefully separate the negative conditions due to pathology from those resulting from the normal vicissitudes of everyday life.

Of course, we often don't know what mechanisms underlie problematic psychological conditions, let alone precisely what might be going wrong with them. However, in such cases, we can infer from circumstantial evidence that something is going wrong from the way human beings are biologically designed to operate, and thus judge that there is a disorder – which is not very different from what, say, Hippocrates and Galen did when, without any real knowledge of underlying mechanisms, they judged quite validly that certain conditions are disorders. So, for example, we presume that anxiety is biologically designed as a response to threat and danger, and thus when panic attacks occur randomly when there is no danger or threat we infer that something is likely going wrong with the relevant systems, even though we don't know what those mechanisms actually are or what is actually going wrong with them at a deeper level.

What are the problems with conceptual medicalization? From a clinical perspective, misclassifying a condition as a disorder is problematic because non-disordered distress has a different prognosis from a mental disorder in which something has gone wrong with psychological functioning. Thus the choice of treatment – and acceptable cost-benefit tradeoffs between the

potential usefulness of treatment and potential negative side effects are different, and obtaining informed consent should involve a different kind of discussion. Especially in our brain disease era, in which every mental disorder is hypothesized to be a brain disease, once a diagnosis is in a chart the patient may well be given medication at some point even if the potential side effects may not be warranted in that case. In cases of depression, for example, because recurrence is a major issue with depressive disorder, guidelines tend to emphasize continued treatment to prevent recurrence, whereas those with intense normal sadness are not at the same risk of experiencing recurrences and so aggressive preventive efforts may not be justifiable.

From a research perspective, if research to find cures for disorders or identify their causes uses mixed samples of disordered and non-disordered individuals, the meaningfulness of the research results is cast into doubt. For example in depression research, if the sample consists of a mix of people who have something genuinely wrong with their sadness generating emotional systems and people who are having normal sadness reactions to life's vicissitudes that are making them sad, the results will be uninterpretable in terms of generalization to populations of disordered individuals. In fact, one might not even be able to tell whether a treatment, for example a pharmacological agent, helps the disorder because the results may be distorted by the inclusion of people who are going to naturally be getting better because they have transient emotional conditions. Extensive false positives thus poses basic challenges to the entire research enterprise on which future progress in treatment depends, and yet this may be the situation in large segments of our research enterprise. Moreover, there are many unwanted practical implications of being diagnosed with a disorder when you don't have a disorder, from difficulty or greater cost obtaining life insurance to having the diagnosis used against you in child custody battles, and so on. From a policy perspective, if many nondisordered individuals are misclassified as disordered, resources may not be targeting those most in

need. Medicalization also encourages reliance on experts, and undermines existing institutions that have traditionally dealt with people's suffering and need for guidance.

A further problem is the potential incursion on civil liberties from expanding the domain of disorder. The Supreme Court has affirmed the constitutionality of sexual predator laws, in which individuals who have completed their prison terms for sexual crimes can be assessed for dangerousness of recidivism in a civil proceeding and if the civil proceeding concludes that they have a mental disorder that reduces control in a way that increases the likelihood of committing further sexual crimes, they can be incarcerated in a mental institution indefinitely. Because the evaluation is a civil proceeding, the court has ruled that all of the constitutional protections in criminal proceedings concerning double jeopardy, self-incrimination, and preventive detention are not applicable. In principle, these Court judgments could apply to other psychological disorders as well.

What about the advantages of being placed in the sick role? One generally hears about the positive benefits of the sick role, particularly being relieved of one's usual responsibilities without being blamed. What we don't talk about as much is the other side of the sick role's implicit bargain. Once you are in the sick role, it is assumed that you are going to try to get better. It is assumed that you have a disorder that is perturbing you from your normal state and that if you have a way back to normality and thus full responsibility you will take it. Consequently, the sick role entails a lack of full acceptance of the kind afforded normal variation. The problem here is that as more emotions and behaviors become medicalized, we create a narrowed range of acceptable emotions and behavior for our children and our grandchildren. We have to consider the difficult question of what kind of world and what kind of life we want to give them in terms of acceptable ranges of human emotions and human behavior that are considered as part of normal human variation. We must ask whether we want to medicalize a

range of conditions that are not truly disorders and thereby make psychiatry the enforcer of what are in fact constraints on the full range of normal human experience.

Those are some of the problems with medicalization. Now I will consider some examples of over-medicalization that yield false positive psychiatric diagnoses. I also promised to say something about why we accept such medicalization so readily – beyond the obvious social control motives and the sheer pragmatic calculus of reimbursability--and why medicalization of normal psychological variation can appear positive and tolerable.

“Psychological Justice”: An explanation for the acceptance of some forms of medicalization

- Psychological Justice: The treatment of normal variation to allow greater access to culturally defined goods or conformity with social values
- False positives as addressing problems with a segment of normal variation that come about as the result of our society’s demands for non-natural role performances
- E.g., Public speaking anxiety– social anxiety disorder

Figure 6

I think there are several different reasons why the expansion of diagnosis has been acceptable, but I will focus on what I consider one of the most important, namely, what I call psychological justice. In any given culture with its values and demands, some non-disordered normal trait variations will be strongly disadvantageous in a way similar to the disadvantages conferred by disorders, but because of social values not

dysfunction (Figure 6). In our culture, we make many culturally sanctioned demands on people that limit the possibilities for people whose normal traits do not match those demands. One can be a normal-range individual but be towards the socially problematic end of a trait dimension and thus deprived of significant opportunities. A sense of justice suggests that such disadvantaged individuals should be treated if possible to allow them to develop the appropriate skills for taking advantage of social opportunities otherwise denied them.

For example, one may be a more-than-average rambunctious child who does not suffer from a disorder of ADHD but nonetheless has serious trouble achieving the unnatural levels of self-constraint and attentional focus demanded in our schools. Thus, one may be doing poorly in school and strongly biasing one's opportunities in life in a negative way given our society's demands for educated workers. If so, treatment may help one to focus and gain opportunities that otherwise would have been out of reach. Consistent with this perspective, the evidence suggests that ADHD is subject to extremely high rates of over diagnosis; indeed, remarkably, about one out of every five boys is diagnosed with ADHD at some point in their school years according to the CDC. Note that I am not at all saying that this disorder does not exist or denying that there are children who have genuine disorders of their attentional or impulse control mechanisms. However, there are multiple lines of research that suggest that many normal-range children who have trouble adapting to the demands of our schools are being misdiagnosed with ADHD.

I'll just mention one line of evidence that is particularly elegant. Consider all the kids in a given grade in school, where in a large school system children are assigned to their grade by the month of their birth. Thus, in any one grade, children's biological ages vary by up to a year from the youngest to the oldest. Now, the study I'm describing has been replicated in several school systems. You take all the kids in a given grade in school and

look at the rates of ADHD diagnosis in a given grade. One of the biggest risk factors – a risk factor that increases the probability of diagnosis by sometimes 50% to 100% – is being one of the youngest in the class. There is no plausible explanation for this other than that we are massively confusing disruption of class due to normal range developmental immaturity with disorder.

The DSM-5 had a chance to alter the criteria to do something about ADHD over diagnosis, but they ignored it. Instead they expanded ADHD to adults which potentially extends the over diagnosis to the general population from children where it is already quite evident. They did offer new examples of the criteria to apply to adults, so for instance instead of your pencils and books for school, now it's your tools, wallets, keys, paperwork, eyeglasses, and mobile telephones that you might misplace as a symptom of ADHD. If you hate reviewing lengthy papers or completing forms or reports, this now is an adult form of an ADHD symptom, and so on. A very important adult symptom is difficulty remaining focused during lectures, conversations, or lengthy reading – so you'd better wake up now!

Another good example of psychological justice is the diagnostic category of social phobia (or social anxiety disorder), and especially the "performance only" subtype in which the only social fear is fear of public speaking or performance. There is no reason to think that this is generally a disorder. Our competitive society demands that if people are to succeed, they must have initiative and self-confidence in the context of interacting with groups of unfamiliar people. The individual who is more-than-average socially anxious about such performance, in a mass society that demands mass communication and networking for success, may be within normal range in terms of how social anxiety was biologically during our evolution but is socially greatly disadvantaged. Such performance anxiety protected us from too easily offending groups of others in a way that could lead to potentially fatal ejection from the small social groups within which our psychological

natures evolved. Consequently, even though such primitive fears are misplaced in our environment, an individual within normal range may feel fear upon getting up in front of an audience and seeing a large number of unsmiling faces staring back and evaluating the individual. However, even if within normal range, if such symptoms of anxiety are intense enough to keep one from speaking to groups of strangers, that makes it difficult to pursue many opportunities because many of the best positions require that people speak in front of audiences. Consequently, even if not a matter of treating disorder, it is plausibly a matter of justice to treat people whose only problem is social performance anxiety in order to help them gain access to social opportunities. It can be argued that as a matter of justice our system, which is designed in a way that makes it difficult for these individuals to succeed and leaves them seriously disadvantaged, owes them at least an opportunity to be helped to control their natural tendencies to anxiety and adapt to our social demands. Psychiatry, to the degree it can help make up for disadvantages imposed by the nature of our social structure, is quite justified in offering help to such individuals. Such intuitions about psychological justice, I am suggesting, make it seem appropriate and acceptable to treat many non-disordered conditions.

Two subtypes of DSM-5 Circadian Rhythm Sleep-Wake Disorders

- DSM-5 “circadian rhythm sleep-wake disorder -- shift work type”: sleep disruption and consequent sleepiness are “primarily due to...a misalignment between the endogenous circadian rhythm and the sleep-wake schedule required by an individual’s physical environment or social or professional schedule” that is “associated with a shift work schedule (i.e., requiring unconventional work hours)” (p. 391). The “history of recent shift work” (p. 367) is crucial to diagnosis.
- 307.45 (G47.26) Shift work type: Insomnia during the major sleep period and/or excessive sleepiness (including inadvertent sleep) during the major awake period associated with a shift work schedule (i.e., requiring unconventional work hours). E.g., “The Good Wife” episode – military personnel who have double shifts operating drones, all are taking a stimulant to stay awake, “no one can stay awake that long.”
- (Note: This makes no more sense than Smoller’s “childhood” example.)
- 307.45 (G47.21) Delayed sleep phase type: A pattern of delayed sleep onset and awakening times, with an inability to fall asleep and awaken at a desired or conventionally acceptable earlier time.
- (Note: Even sleep researchers consider “night owl” to be a normal variation, more common during the teenage years. As in all things human, natural variation in circadian rhythm within broad parameters is normal.)

Figure 7

There are other even more obvious DSM justice-related categories that have nothing to do with disorder. To take one example, consider circadian rhythm disorder, shift work type (Figure 7). This is the disorder that afflicts you if you cannot adapt to having your sleep cycle shifted around constantly by shift work. In fact, it is of course absolutely normal for sleep to take place in coordination with a natural circadian rhythm sleep cycle, and many people have trouble adapting to other sleep patterns. This is not an abnormality. However, a surprisingly large proportion of jobs in our 24-hour culture require the ability to sleep at odd and changing hours. So, we have this diagnosis to allow the medical profession help people to adapt to the requirements of their jobs. This diagnosis is a matter of justice, not disorder.

The DSM-5 also includes social role impairment – including occupational, school, or interpersonal problems – a major criterion for diagnosis of disorders all through the manual. Such role impairment criteria

are sometimes useful or necessary for diagnosing mental disorder. However, using them as general criteria throughout the manual potentially confuses cultural pressures and the demands of our society, and thus fair equality of opportunity, with medical disorder.

A somewhat different kind of example is offered by the categories of sexual dysfunction. All of the sexual dysfunction categories include a situational subtype specifier. That means that to qualify for diagnosis you do not need to have to have a general dysfunction that occurs whenever you attempt to have sex, but you can have the specified problem only when you're with your partner. That sort of specific situational problem with one individual could be due to all sorts of specific feelings and attitudes and relational issues and not due to a disorder. It is not necessarily a medical disorder to have a lack of sexual interest or excitement with your partner but be able to function perfectly well with other partners. However, if one experiences this normal-range feeling within a culture that demands monogamy and disapproves of infidelity, it is a problem and may be an obstacle to the opportunity to pursue one's happiness and experience some of the most intense pleasures of life. If so, treatment may enable you to more fully enjoy your sexual relations with your spouse and achieve your desires in a socially approved manner. Such situational criteria that allow treatment of spousal sexual mismatches due to normal sexual variations seem partly a way for DSM-5 to offer support for individuals to meet social expectations within a monogamous society.

Unfortunately, I will not have time in this talk to detail the one example on which I have done the most work, the diagnosis of depression. Depression is probably the most egregious example of over diagnosis of normal experiences as disorders. Major depression is diagnosed in DSM-5 by having five or more symptoms out of a list of nine during at least a two-week period. These symptoms include some that do often indicate disorder, such as psychotic ideation, suicidality, psychomotor retardation, and a profound

sense of worthlessness. However, the list also includes many symptoms that can also be present in a normal distress reaction, such as sadness, lack of interest or pleasure in usual activities, insomnia, decreased appetite, and difficulty concentrating on usual activities. Individuals who had recently lost a loved one and who had only the milder depressive symptoms used to be exempted from depression diagnosis. However, the bereavement exclusion was eliminated in DSM-5. It is thus possible to be diagnosed with major depressive disorder based only on general distress symptoms even within weeks of losing a loved one, as well as after other extreme stressors such as the end of a romantic relationship or the loss of one's job. My own research provides evidence that we are over-diagnosing depressive disorder and that many such currently diagnosable reactions are normal distress, not depressive disorders.

If you like, I will answer questions about my work on depressive disorder during the question period. I will stop at this point.

Thank you.



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Michael B. First MD, is a professor of clinical psychiatry at Columbia University, a research psychiatrist at the Division of Clinical Phenomenology at the New York State Psychiatric Institute, and maintains a schematherapy and psychopharmacology practice in Manhattan. Dr. First is a nationally and internationally recognized expert on psychiatric diagnosis and assessment issues and conducts expert forensic psychiatric evaluations in both criminal and civil matters. Dr. First is the editorial and coding consultant for the DSM-5, the chief technical and editorial consultant on the World Health Organization's ICD-11 revision project, and is an external consultant to the National Institute of Mental Health's Research Domain Criteria (RDoC) project. Dr. First was the editor of the DSM-IV-TR, the editor of text and criteria for DSM-IV and the American Psychiatric Association's Handbook on Psychiatric Measures. He has co-authored and co-edited a number of books, including the fourth edition of the two-volume "Psychiatry" textbook, "A Research Agenda for DSM-V", the DSM-5 Handbook for Differential Diagnosis, the Structured Clinical Interview for DSM-5 (SCID-5), and the forthcoming "Learning DSM-5 by Case Example". He has trained thousands of clinicians and researchers in diagnostic assessment and differential diagnosis.

Dr. First:

Well thank you very much. So, I'm much more of a practical person. My career has been involved in creating this book that Dr. Wakefield has been making fun of a little bit. So I'm going to talk about the DSM's role in the medicalization of normality. I guess I agree that there's no question that for a lot of the reasons that Dr. Wakefield talked about, there is this trend. I guess I'm going to be very focused on what's the DSM's contribution to this issue.

One quick disclosure: I do get royalties from books related to the DSM.

Confusion About Inclusion in the DSM

- DSM = Diagnostic and Statistical Manual of Mental Disorders
 - May suggest that everything included in the DSM is a mental disorder
- Not so—justification for inclusion is to provide definitions for entities that mental health professionals might encounter
- DSM is NOT a compendium of what the field considers to be a mental disorder

Figure 8

One of the problems – in fact, Dr. Wakefield illustrated it – is confusion about what it means when something is in the DSM (Figure 8). The DSM is the Diagnostic and Statistical Manual of Mental Disorders. That title suggests perhaps that everything included in the DSM is a mental disorder, and I noticed that Dr. Wakefield included in his presentation is circadian rhythm sleep disorder, shift work type. There's also another one that I'm surprised

Dr. Wakefield didn't pick on: jet lag type. That was in there for a while. So having jet lag could be a disorder. Well, you know, it's not a disorder. Circadian rhythm sleep disorder is not a mental disorder.

It's in the DSM for one reason: people come see doctors with this complaint. There are people who are in bad shift work situations where they keep changing the shift, you know, week to week, and these people are unable to function because of that. They'll go in for an evaluation, maybe not to a psychiatrist but to a sleep specialist, sometimes a psychiatrist, sometimes a general practitioner, and that person needs to get a code to explain what was the reason for the interaction. The treatment may simply be quit your job or whatever, whatever it might be, but the clinician needs to have a diagnostic code to put into the medical chart. This is a real problem. There is nothing that says that that is necessarily mental disorder. It happens to be in the DSM because the DSM includes a section for sleep disorders and it includes lots of things in there like narcolepsy and sleep apnea. Nobody claims that these are mental disorders but they're there because the DSM is fundamentally a book to help mental health professionals practice on a day to day basis. That was its purpose was when it got started. The DSM goes all the way back to 1952. DSM-III in 1980 was the one that became popular. Somehow, because this book has become so popular, people like to look at it as the authoritative guide to what's normal and not normal, and that's a problem. So being in the DSM does not necessarily mean it's a mental disorder.

As I just was saying, there are lots of non-mental disorders, such as the sleep disorders, and there are things that Dr. Wakefield mentioned that people come in to see a mental health professional for things that aren't disorders, like grief. People come in for counseling because their spouse died. The counselor seeing that person needs to have a code to write down in the chart and do the treatment. So there's a whole section recognizing the fact that mental health professionals and counselors and other people see people

who don't necessarily qualify for a medical condition. There's a whole chapter called *Other Conditions That May Be a Focus of Clinical Attention*, and in that section it defines conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis or treatment of a patient's mental disorder. These are the kinds of things included in that chapter, things like bereavement, relationship problems, physical, sexual, and psychological abuse and neglect, religious or spiritual problems, child or adolescent antisocial behavior, phase of life problems, and so on. These are things that you could imagine somebody might walk into a mental health professional's or a GP's office for help with, and nobody is saying that simply because the person walked in with one of these complaints that they're going to be getting a diagnosis of a mental disorder.

Now, what sometimes happens that I think Dr. Wakefield was indicating is that the insurance companies and the government in their wisdom have drawn a line about what they want to pay for. Historically, medical insurance exists to treat medical conditions. So that has sort of driven the whole industry. Anything that is a medical condition, insurance companies will cover. Because the conditions in this section of the DSM are explicitly labeled as not being disorders, the insurance companies are off the hook in terms of being obligated to provide coverage for them. Now if we lived in a perfect world, and in those parts of the world where a medical diagnosis is not required for payment, these conditions would be covered by the healthcare system. In contrast to the United States, I don't think people in Scandinavian countries are unable to get insurance coverage for grief management because grief is not a disorder. However, in the United States and some other countries, this line is drawn and counselling for such conditions is not covered by health insurance.

So what do clinicians do in such circumstances so that their patients can get their health care paid for? As Dr. Wakefield talked about with respect to the clinician's dilemma, clinicians will sometimes make a disorder

diagnosis simply to allow the patient to get paid, even though in their heart of hearts they know that that patient doesn't really have a disorder. These diagnostic codes and conditions from this section of the DSM are rarely used code-wise because nobody gets paid for these codes. So there is an unfortunate tendency for clinicians to pull codes from the rest of the book.

So one aspect of the DSM that I think contributes to the belief that life problems are being medicalized is the fact that the DSM includes things that are actually not explicitly psychiatric disorders, but people get confused about what that means. But in fact there is a real problem here of medicalizing normality, and Dr. Wakefield talks about false positives. I have been in agreement with Dr. Wakefield for years that this is a serious potential problem with the DSM, which is basically labeling a presentation that is not a disorder as a disorder (Figure 9). This is true in all of medicine, but it's even worse in psychiatry. Our disorders are defined by signs and symptoms that are not inherently evidence of psychopathology. So if you go through the DSM, as Dr. Wakefield did with ADHD, and pull out a couple of

Qualities of DSM That May Predispose to False Positives – I

- Disorder definitions consist of signs and symptoms that are not inherently evidence of psychopathology
 - e.g., anxiety, depression, dissociation, somatic concerns, euphoria, irritability, fixed beliefs, perceptual disturbances, etc.
- Definitions usually set disorder/non-disorder boundary on presence of "clinical significant distress or impairment"
 - Based entirely on clinical judgment

Figure 9

examples of diagnostic criteria, of course those symptoms occur in normal people all the time. The symptoms which form the building blocks of the DSM categories occur in normal individuals all the time: anxiety, depression, dissociation, somatic concerns, euphoria, irritability, fixed beliefs, or perceptual disturbances. Those are the building blocks of the DSM disorders. But each one of those, occurring in isolation, is not inherently evidence of psychopathology.

What makes something a disorder in the DSM is usually two things. Forget the concept that Dr. Wakefield referred to as harmful dysfunction; that's sort of conceptual, how you think of something as a disorder. The way the DSM is put together is lists of symptoms that usually have to have to be clustered together, not just an isolated symptom. Several symptoms must occur together, but most importantly, following what Dr. Wakefield referred

DSM Mechanisms to Reduce False Positives – CSC

- Inclusion of requirement that disturbance must cause clinically significant distress or impairment
 - Required by lack of knowledge of precise nature of underlying dysfunction
 - In contrast to medicine-- patient gets diagnosis of tuberculosis if bacilli are present, regardless of distress or impairment

Figure 10

to as the requirement for harm, usually most of the disorders of the DSM have a requirement that they've got to cause clinically significant distress or impairment (Figure 10). The problem, of course, is it's entirely a clinical judgment.

There's this phrase over and over again in the DSM that the diagnosis of a disorder requires clinically significant distress or impairment. People ask what "clinically significant" means, and unfortunately it's up to the clinician making the diagnosis to decide what it means to be clinically significant. So it's a very fuzzy line, which means that it can be bent and stretched. So you could have somebody who has an attention problem, they come in, their parent drags them into the doctor's office and the doctor thinks, well it must be clinically significant--the parent is dragging the kid in for help. It's clinically significant, therefore end of story: it's a disorder. The built-in judgment here is – it goes both ways – the clinician needs to decide whether a particular diagnosis validly applies to the person coming in to his or her office. Theoretically, in the case that Dr. Wakefield was talking about, which is this issue about kids who are younger in the grade are getting diagnosed with ADHD – that's not a problem with the DSM definition of ADHD, that's a problem with the clinician applying the DSM criteria. People are making the wrong diagnosis because they're not using common sense. If you think about the idea of attentional capacity as something that's developmental, you have a certain capacity. Younger kids, of course, normally will have less capacity for maintaining attention. The clinician is supposed to take that into account when applying the diagnosis of ADHD. Unfortunately, more often than not, that doesn't happen. So this clinical judgment goes both ways. It can sometimes cause cases to be put in that shouldn't be there, but it also helps keep cases out.

Another predisposing quality of the DSM with respect to the medicalization of normality is the fact the DSM – by the way – Dr. Wakefield and I keep talking about the DSM. How many people have ever seen the DSM? Are most people familiar with it? The DSM is maybe the number one or number two best-selling medical book ever. Each edition of the DSM sells over a million copies, which is astonishing if you think about the fact that there are only 400,000 mental health professionals in the United States. Who is buying the book? Nobody quite knows for certain – but it almost certainly

includes patients, their families, students, lawyers. It's all over the place. But you can see it's really out there in the hands of the public, so a lot of people, even if they're not mental health professionals, may be familiar with it. The thing that makes it very appealing to the public at large is the operationalized criteria. It boils the mystery of psychiatry and psychology into these check lists of required symptoms, which is both a strength and a serious disadvantage which can lead to be being misused. A lot of people have criticized the DSM rightly by the fact that it makes pretend you can boil the field of psychiatry down to lists of symptom so that psychiatric diagnosis can be made by checking off symptoms on a list. This idea also has encouraged the development of self-report instruments and computerized diagnostic interviews and other screening tests, things that leave out the clinical judgment. This greatly increases the possibility of false positives when such methods are used.

Another reason why the DSM has promoted medicalization of psychiatric symptoms is the whole – when the DSM was created in 1980 there was a big push at that point for psychiatry to be like the rest of medicine. In the 1960's and 1970's, psychiatry as a field was marginalized. It was heavily dominated by psychoanalysts. Psychiatrists are in fact medical doctors and many wanted psychiatrists to function more like other doctors. So the DSM really help psychiatrists to function more like other doctors. When you open up the DSM it looks pretty scientific to have these lists of symptoms. It looked like it came from some wonderful compendium of data, but in fact most of the diagnostic criteria in the DSM were not based on data but instead was developed by experts coming to a mutual consensus about how best to define these conditions. But the actual science behind it was pretty weak in the beginning. Still, the definitions looked like other medical sourcebooks, so that's another thing that made the DSM promote medicalization. Now that I've talked about why it is that the DSM has promoted the possibility of medicalization of false positives, I'm now going to go to the other side and say that the developers of the DSM recognized this

potential and recognized that it was a problem. This has always been a problem that has been recognized by the different people working on the DSM, but when I was working on it during the development of the fourth edition of the DSM in the early 1990's, we took this very, very seriously, the false positive problem. The problem is, unfortunately, that the DSM can be used by anybody, you can buy it off the shelf in regular book stores and on Amazon, anyone can use it to try to diagnose their friends. The idea is that to really use it properly you need to exercise clinical judgment. So we had to figure out what we could do to the DSM and the definitions to prevent them from being misused and result in inappropriate medicalization and false positives. These are some of the mechanisms that we came up with. The first one is that phrase I kept talking to you about, which is this requirement that the disturbance must cause clinically significant distress or impairment.

Let me give you a couple of examples of how this works. Take virtually any disorder like autism, social anxiety disorder, depression. They occur on a continuum. There's no bright line separating normal shyness from social anxiety disorder or being a geeky kid from having a diagnosis of autism spectrum disorder. What we use for that is some decision that when the severity of the symptoms cross a certain point, there's enough harm that justified calling it a disorder. So this clinical significance criterion has a huge job within the DSM in trying to set this boundary between disorder and non-disorder. And this is in contrast to medicine. People have picked on the DSM requirement for distress or impairment as something which makes psychiatry set a little bit ludicrous to some people. For example, in medicine a person is diagnosed with tuberculosis if the person is infected with bacterium *Mycobacterium tuberculosis* whether or not the person is experiencing severe symptoms or impairment in role functioning. The requirement that there be some kind of distress or role impairment is something which is unique to psychiatry. We all recognize that that's a weakness of the DSM and psychiatry, but there's no other way right now to be able to differentiate normal from a disorder.

Now the other mechanism that the DSM has used to try to help differentiate normal from disorder is the idea of considering the context in which the symptoms occur (Figure 11). Take for example the symptom of anxiety. We all know that anxiety is normal. Everybody experiences anxiety at one time or another and it's normal and adaptive to experience anxiety when one is anticipating danger. But if the anxiety occurs in a situation where it doesn't make sense, then we consider it a disorder. So for a

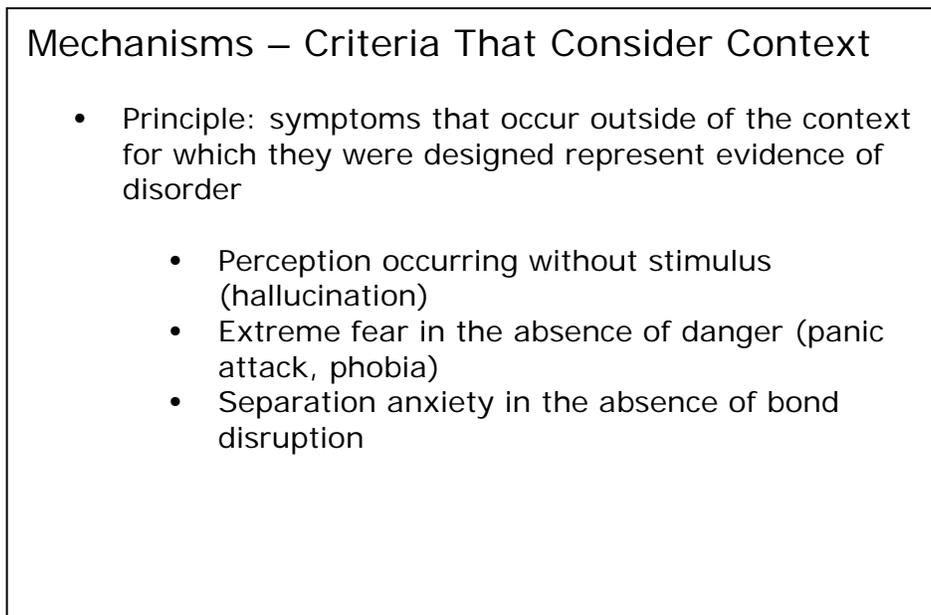


Figure 11

diagnosis like generalized anxiety disorder, the person is anxious all the time no matter what, and they're anxious and worried about insignificant unrealistic things. Somehow in that person their anxiety has become untethered from any appropriate context. So that's a marker in general for when a symptom is likely to be indicative of a disorder rather than just being something part of parcel of normal functioning.

So the way the DSM deals with that, is to require that you look for when the symptom is untethered from its context. Here are three examples

from the DSM that demonstrates this. Take the concept of hallucination: it's obviously normal to have perceptions, but if you're having a perception without an actual stimulus to trigger it, so that the perception is untethered from the context of the stimulus, is what we call a hallucination. Extreme fear in the absence of danger is the core idea of how you diagnose a panic attack or a phobia. And separation anxiety, when it occurs in the absence of a bond disruption, that's again a marker of a disorder, namely separation anxiety disorder.

So DSM tries hard to sort of operationalize common sense to try to help differentiate disorder from non-disorder. There are lots of conditions that are defined in terms of behaviors that may or may not be normal depending on the context. Kleptomania is an example of one such condition. Obviously stealing is not in and of itself evidence of a mental disorder. It can be but not necessarily. So in the definition of kleptomania we know we don't want to be labeling people as having kleptomania if the person is stealing to express anger or vengeance so a criterion has been added to exclude such cases. Sometimes some of our definitions include diagnostic criteria that explicitly bar a diagnosis if there is some contextual circumstance that we know is clearly evidence of a non-disorder, we'll explicitly put it in there. Some disorders require disproportionality of a response. There's a disorder in the DSM called intermittent explosive disorder, which involves recurrent outbursts of verbal or physical aggression. Again, lots of people do that under all different contexts – too much alcohol, just being irritated. But to make this a disorder from the DSM perspective, there is a requirement is that the aggressiveness has to be grossly out of proportion to the provocation. So if such a person driving their car and gets cut off by another driver, that person might get out of the car and start smashing the windshield of the car that cut him off, because that little provocation triggers this out of proportion reaction. A specific phobia by definition pathological fear and avoidance of certain objects or situations. Certain fears and avoidance patterns are justified and would not be considered evidence of

specific phobia. For example, if you're faced with a tiger in front of you and you're feeling frightened, that's normal and would not be evidence of a phobia. If you're feeling frightened and out of control with fear in response to seeing a little mouse on the other side of the room there's an example where the fear that that person has experienced is out of proportion to the actual danger, so that's why we would consider that a disorder assuming the other requirement for a diagnosis would be met, like it causing significant impairment or distress.

Another important thing is many of our symptoms may be considered normal depending upon the age of the patient. Separation anxiety is normal in a two year old. You would not make a diagnosis of separation anxiety disorder in a two year old experiencing anxiety when separated from his parents if it's within what you normally would see in a two year old in that circumstance. So the definition of separation anxiety disorder in the DSM specifically requires that the separation anxiety be developmentally inappropriate given that person's age. This is also true for ADHD. There's a clause in the diagnostic criteria for ADHD stating that it's normal for kids at a certain age to have trouble sitting still. You have to make a judgment that the symptoms are out of proportion to what you'd expect for a child of that age. Enuresis, which is bed wetting, is another good example. It would be ridiculous to label a four year old as having enuresis because the capacity to hold one's urine overnight isn't developed until age five, so you wouldn't make the diagnosis if it's developmentally inappropriate to do so.

Another strategy that the DSM uses is to require a symptom to occur in multiple contexts. So ADHD requires the symptoms to occur in two or more different settings. The reason this requirement is important is that if the symptoms are indicative of a problem in the individual as opposed to be a problem specific to a certain context you wouldn't expect them to be evident in only one setting. If it's at school and not at home, it makes you wonder whether the real problem is with the school – there's something

about that schooling that's really not stimulating enough. Therefore the requirement for it to occur in multiple settings. That's a marker of validity that it's not a false positive. Another example is requirement for some disorders of a degree of discrepancy between the patient's belief system and external reality. What I mean by that is there is a condition called body dysmorphic disorder where a person is preoccupied with what they believe to be a defect in their appearance. If somebody has a birth defect that makes them deformed and they're embarrassed and preoccupied about it we wouldn't consider that a disorder, because their reaction is realistic and something you'd expect given the context. The requirement in the definition of body dysmorphic disorder is for the concerns to be excessive and unrealistic – for example, if somebody walks into your office saying that they are horribly embarrassed by this defect and you look at them and you can't see it at all, they look fine to you, that's the marker that it is disorder.

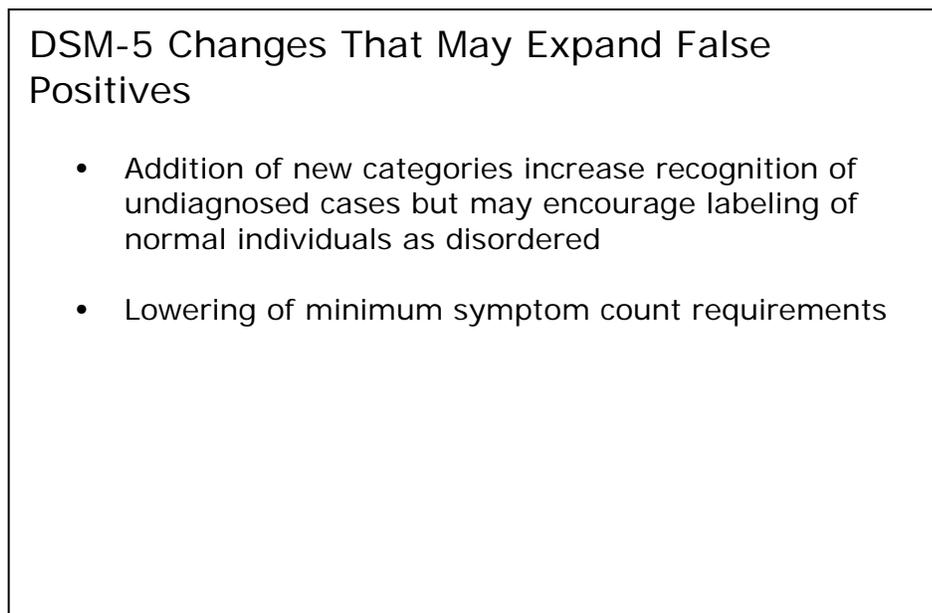


Figure 12

I'm sure people here are somewhat aware of the concerns about the process of DSM-5 development. There were lots of criticisms at the time concerning the possibility that the DSM was expanding the risk of false

positives rather than reducing them (Figure 12). I just gave you a whole bunch of strategies used in the DSM to try to keep the false positives under control, but at least some of the criticisms leveled against DSM-5 concerned changes that might have expanded false positives. Any time you add a new category to the DSM, those are the situations that carry the biggest risks of increasing false positives. Basically when you add a new category to the DSM, cases that were previously undiagnosed in prior editions of the DSM, will now be diagnosed and labeled as a new disorder. So obviously if some proportion of these cases were normal in the first place, then you're going to be increasing false positives.

One of the ways the DSM makes diagnoses is to have the clinician count up the number of symptoms that are present and if the number of symptoms is at or above a certain level, the diagnosis is given. If, however, the required number of symptoms is lowered, you're going to potentially increase false positives. So let me give you a couple of examples of where that happened in DSM-5. There is a new disorder that was added called social communication disorder. This is the definition: persistent difficulties in the social use of verbal and nonverbal communication. So this would include people who have difficulties in the nonliteral or ambiguous meaning of language which might make it difficult to understand jokes, inferences, etc. There is the risk here that people who are just socially awkward but within the normal range, what I might call a geeky child; could now be mistakenly labelled as having social communication disorder. The thing that helps define this as a disorder is the requirement that it results in functional limitations.

Another new disorder that was added to DSM-5, which has been a real focus of concern, is something called disruptive mood dysregulation disorder, and the normal variant of this is what one might call just called bratty kid. The definition of this disorder is severe, recurrent temper outbursts with persistently irritable or angry mood in between the outbursts. To elevate the requirements for the diagnosis above just being a bratty kid, the diagnosis

requires that the outbursts be grossly out of proportion or inconsistent with developmental level and occur in two out of three settings. Also the number of outbursts required for this is actually pretty high – three or more times a week for at least 12 months. Hoarding disorder is another new disorder in the DSM. Again, whenever you have a new disorder there's the potential for false positives, especially something like this. Lots of people collect all kinds of things and fill their houses with them. As soon as this disorder is added, there's the risk that people who are just simply collectors might be labeled as having a disorder. The actual definition of hoarding disorder focuses not on the collecting, which is inherently normal, but difficulty discarding or parting with possessions. I'm not saying that's necessarily pathological and not normal, but the focus is on this because what makes it a disorder is this combination: difficulty discarding or parting with possessions that results in an accumulation of stuff that clutters the living area so much so that they compromise their intended use. So this is the person who fills their house with so much stuff so they can barely get around. It's not just the person who has trouble throwing things out.

Here's my final example of a disorder that was criticized: binge eating disorder. Binge eating disorder is like bulimia nervosa without the purging and excessive exercise. So it's just the binging. So you get into this blurry thing here about what's the boundary between overeating and being obese and having binge eating disorder, and it was partly criticized because the threshold that was set in the DSM was actually pretty low. Basically a binge once a week for three months was enough to call it binge eating disorder. Even though they do have the requirement that the binge eating causes marked distress, but in this case it's probably not that helpful in keeping normal people out of that.

Now did I mention about the lowering the diagnostic thresholds? There are two examples where DSM-5 lowered the number of symptoms required. Dr. Wakefield already talked a little bit about adult ADHD. So ADHD you

usually think of as a childhood disorder, and it is a childhood disorder, but when you're a child with ADHD and you grow up to be an adult you can be an adult with ADHD. The reason for this new category called adult ADHD is that there are people who weren't recognized as having ADHD in childhood. Even though now ADHD is all the rage, twenty, thirty, forty years ago ADHD was much less recognized; so there really are a number of older people out there who suffered through their childhood with undiagnosed ADHD. They're only being diagnosed now that they're adults. So that's the concept of adult ADHD. But DSM decided to reduce the number of symptoms required for adult ADHD from six out of nine to five out of nine. So clearly when the DSM does stuff like that, they are flirting with the possibility of increasing the risk of false positives. In substance use disorder, there was also a pretty big change. It went from three out of seven to two out of eleven. That's a pretty big drop. A lot of people have wondered about this and there is some evidence suggesting that substance use disorder in DSM-5 may have a significant number of false positives.

The last thing I'm going to talk about is the issue of epidemics in psychiatry. People are talking about an epidemic of ADHD and an epidemic of autism. One of the problems is that it's very hard to know when the actual incidence is increasing versus whether more people are coming into treatment. Autism is a good example. Lots of environmental suspicions about causes of autism including the claim that it can be caused by vaccines come from the fact that all of a sudden out of nowhere the rate of autism has exploded. How much of that is due to the fact that autism is becoming more prevalent versus parents bringing their kids in to treatment with that label because they're more familiar with it? So getting into treatment and all the factors that bring people to treatment make it very difficult to know what is a real epidemic in the sense of an actual increase of prevalence versus an apparent epidemic simply because people are brought in.

Role of DSM in ADHD Epidemic?

- Increase of 42% in rates of children ages 4-17 having ever been diagnosed with ADHD between 2003 and 2011
- Diagnostic criteria for ADHD unchanged from 1994 to 2013
- DSM definition cannot explain increase in rates
- Underscores that factors other than DSM diagnostic definitions largely determine clinical prevalence

Figure 13

Let me just jump to ADHD. There was a study that was done between 2003 and 2011 ADHD that showed cases went up 42% in diagnoses in children ages four to seven (Figure 13). That's a significant increase. But that does not establishing whether or not there is a real increase in the actual prevalence of ADHD. It's almost certainly due to the fact that parents are bringing in their kids more often for help. The point of this slide is to ask if that so, what's the role of the DSM? Well, it turns out that during that period of time, from 2003 to 2011, the DSM criteria for ADHD hadn't changed. It was stable. So from 1994 to 2013, the criteria were unchanged because that was a very big gap between versions of the DSM. My point here is that while the DSM may have something to do with some increases in prevalence rates, clearly something else is going on.

If the definition is unchanged. It really argues that other factors are involved, like parents wanting their kids to get medicated because it's easier to throw medicine at them to get them to behave, or whether they want to give them an edge in testing, or any of a number of other possible reasons why somebody might want to get a diagnosis. So the whole general issue

about what the role of the DSM is in medicalization is complicated because the users of the DSM, whether it's the doctors or the family members or the patients themselves, are often a big driver on coming in for treatment. So I will stop here and we will open it up now for general discussion. Thank you very much for your attention.

Q & A

Dr. Sanders (moderator):

Now let's get started and we'll ask some questions. For the next thirty-five to forty minutes we're going to go through some written questions, and after that we're going to have some live questions and we'll have the mics open for questions. So first question, and this is probably a good question for both but we'll start with Dr. Wakefield. Does the healthcare system of the United States make us more inclined to medicalize everyday problems so that providers can assure getting paid for their work?

Dr. Wakefield:

That's easy to answer (laughter). The answer is obviously yes. In many other healthcare systems in developed countries you don't have this kind of parsing of the diagnosis. In fact, in some countries you don't even have to give a diagnosis for most cases that you treat if you're a psychiatrist, for instance. Or there might be like in France, there are certain special categories which are more expensive which you have to specify, but it's much more open. Because we are so focused on medical necessity and on keeping a certain threshold in place, I think clinicians have overwhelming pressures to diagnose and over diagnose in order to justify helping people that need help. Look, I will bet that many of you in this room have had relationship problems where you have gone to somebody. Relationship problems are not covered under most reimbursement systems in this country; yet that's self-defeating, right? You want to keep a relationship together, that relationship might have children involved. Isn't it self-defeating and foolish? The clinician wants to help, so maybe stretching it a little or interpreting the symptoms so they fit – this partner might have generalized anxiety disorder as a result of the partners arguing all the time. This one looks like they might have major depression and so on. So you will

get these kinds of diagnoses that are out of a pressure for reimbursement all the time.

Dr. First:

My only comment is that unfortunately we know that there is huge pressure in the United States to control healthcare costs, which are exploding, and somehow, unfortunately, for a long time the insurance industry has used this blunt instrument, which is deciding what's a disorder and not a disorder, making it clear what that is and basically forcing clinicians to have to shape things around that. So I think there's no question that our system has helped create this problem.

Dr. Sanders:

This question kind of goes along with the last one. Discuss how health insurance has contributed to medicalization. For example, increased treatment with medications rather than more evidence-based treatments that require longer treatment sessions and treatment trajectories to be successful. Dr. First, I'll give you first shot at that one.

Dr. First:

That's a general issue, the push towards medication. Part of it is the insurance companies are favoring it. It's very difficult to get coverage for psychotherapy. It's not so hard to get your GP covered to give you Prozac. That fundamental bias in the insurance system is clearly going to put pressure on people to favor treatment with medication rather than with talk therapy. So, you're right. This insurance system is clearly pushing treatment into a certain direction. It's inherently more medical. You can see psychotherapy works for the disorder depression, but it also works for grief and sadness. It's a much broader thing. You don't give pills to somebody who is not disordered. By making pills the only option for many people, of course you're going to be pushing people into being given a medicalized label.

Dr. Wakefield:

I would just add that I agree with everything that Dr. First said, but I would add to that that the pressure for evidence-based practice, which is a reasonable one in some regards, also leads to the conclusion that--at one point it led to the conclusion that pharmacological interventions had been studied better, could be administered in a more research anchored way, in a more clear-cut way, and the idea was out there that we have to bring psychotherapy around to that level of precision. How many sessions for how long fit this particular case? You've got to titrate the psychotherapy like you would titrate a medication. This is a little unrealistic, but we've heard it even within the last year from one of the heads of the NIMH. So I think that has been pressuring things, but the reality is that in almost every area psychotherapies, multiple psychotherapies, have been shown to be just as effective as medication. The reality is this is a kind of stranglehold that the pharmacological producers and the system have on clinicians pressuring them in a certain direction, when in fact the efficacy of treatment is known to be equal to, or better in some instances with psychotherapy. At this point, where evidence isn't all in, you can argue it, but it seems to me an unjust bias of the system at this point.

Dr. Sanders:

Next question. I'm going to add a little bit on to this question, so my apologies to the writer. Do you anticipate better tools for diagnosis in the near future, e.g. MRI with enhanced uptake in specific areas of the brain? And in terms of biomarkers, psychogenomics, and other strategies for diagnosis and treatment, how much do you see that influence in the near future or distant future?

Dr. First:

I can't tell you how much I wish I could give you an answer that we are just around the corner with being able to use these kinds of tools. We are unfortunately very, very far away. It's a little counterintuitive. You see brain scans and you think, for example, that we know that patients with schizophrenia on average have certain brain findings compared to normal. It doesn't help you when you're diagnosing an individual. There are people who are pushing for the use of neuroimaging claiming it helps, but right now, unfortunately, all the things you mentioned – brain imaging, biomarkers – they were desperate during the development of DSM-5 to get a biomarker included in the diagnostic criteria for disorders in the DSM. There's only one biomarker that appears in the diagnostic criteria for a condition in the DSM and the diagnosis that has it is narcolepsy, which is not a mental disorder. Actually, in the criteria for narcolepsy there is a cerebrospinal fluid assay for hypocretin that's low in narcolepsy. We would like biomarkers for every condition. Unfortunately, diagnostically useful biomarkers simply don't exist. The hope is that in my lifetime we'll have that, but we're still very far away. That would really change things. I think that the reliance on subjective symptom reporting, may contribute to over diagnosis – if we had really good biomarkers to help us know what's a disorder versus a non-disorder; not that that solves the problem, but that would help a lot. With regard to Dr. Wakefield's perspective, if you look at harmful dysfunction, a biomarker could be useful for indicating the presence of dysfunction. If you actually had an objective marker that would be really helpful, but we don't have that. I think that would help with this problem, but the lack of the tools keeps us there.

Dr. Wakefield:

I agree that there's no biomarker information that isn't so fuzzy that it does more harm than good when you use it for diagnosis as of now. Some day we may have that. Mike was absolutely right that the biomarker will help

tell us perhaps if there is a dysfunction inside. But you're still going to need the clinical criteria to tell you if it is a harmful dysfunction. We know of many biomarkers in physical medicine for which there is something wrong with something, but only 1% of all those cases have any clinical disorder. So – there's no magic here. You're going to always be looking at the meaning of the biomarker in that individual's life to draw your final conclusion about whether there is a disorder. I guess the harm component is whether it actually has an impact on the person's life.

Dr. Sanders:

We may actually have to still talk to our patients? (Laughter). This question is directed to Dr. Wakefield. Could you say more about psychological justice and why this justifies intervention of the kind you described and does not merely explain it?

Dr. Wakefield:

I didn't have time to say it all, but you can see where I'm going. I said that I find our current reimbursement system to be self-defeating and somewhat cruel. How could it ever be expanded? What would be the argument by which it might be expanded? And if you look around at arguments, there are various possible arguments but one has been successful. There is one argument out there for extending medical treatment beyond medical necessity that has been unbelievably powerfully successful, and that is injustice in terms of our economic system. If you look at Supreme Court rulings – I'm going by the discussions of the justices, and in this case, interestingly, especially the female Supreme Court justices – where they discuss why it is that it is essential for the medical system to provide contraceptive technology to women, for instance, and other reproductive benefits that have to do with regulating reproduction that has nothing to do with disorder. Contraception is not about disorder. So why is that? And if you look at the various opinions that they've put forward, the reason, it turns

out, that's given is in terms of justice. And I'm not going to go on a riff here about John Rawls and how it fits with medicine and so on. I think it's very interesting, but how theories of justice could fit in here. I've written something about that, but the point is, the rationale is, that if our system is such that we construct it in a way that opportunity, the opportunity to partake and to advance yourself, is foreclosed under a wide variety of circumstances that we can help you out of, then we owe it to individuals to help them. And women in particular, in a system like ours where there is equal involvement in occupational careers and equal interest in success, equal benefit of the system to having everybody involved, the argument has been by these justices that that justifies on nonmedical grounds the essential nature that medical insurance must cover these kinds of provisions for women.

Now, just taking that without going into it further, I mean I see that as an analogous argument to the one I'm mounting for mental health. I see psychological properties that are normal variants that are extremely disadvantageous. I try to give a couple of examples, such as inability to engage in mass communication in our mass communication society which we're not evolved in, and so on. But you can see many of them – ADHD, inability to gain an unnatural level of stillness in school and focus beyond what children are probably evolved for, but some are talented at it and some aren't. All these things have become crucial to our culture's demands on people in terms of economic involvement and success, ultimately including the education, of course. But they're not medical problems because what they are is they are part of the normal curve that we have to some degree excluded. So they're not medical necessity strictly speaking. What I see is an analogous argument for extending a reimbursement at least to those areas where as a society we make it difficult for people to succeed. So I hope that answers the question in the way that it was asked in terms of what my rationale is and expanding on the notion of psychological justice. Psychological justice is providing the opportunity to develop those

psychological properties that we demand of people to have opportunity in the society we've constructed.

Dr. Sanders:

Dr. First, the next question is directed to you. Thank you for your thought-provoking talk. If over diagnosis is not an issue rooted in the DSM, but a misuse or misunderstanding of the text by clinicians, why is there so much misuse, understanding especially given the DSM's role in making psychiatry more medical?

Dr. First:

Well, the problem with the DSM is that it's a book that you buy and you use. There's a limit to what the DSM can do to make sure it's used well. Everything I talked about were our attempts to build into at least the definitions to try to make people do less stupid things, smarter things. But the bereavement exclusion, which unfortunately was eliminated to Dr. Wakefield's and my chagrin, but that was there to try to prevent clinicians from making the wrong diagnosis. Let's say a person comes in to his doctor saying that his spouse died and the person seems depressed. A stupid thing to do would be to say oh, they have major depression give them medication. The smart thing is to say wait a minute, this is normal grief. Putting it in as a criterion is a way to put a red flag up to remind the clinician to do the right thing and think smartly.

The problem is people still do what they want to do. ADHD is a good example. People will write down a diagnosis because that's what they think they want to do, they need to do, and they don't read the diagnostic definitions that carefully. I'm not saying the DSM has nothing to do with the risk of over diagnosis. Every time you add a new diagnosis there is a risk. I'm not saying everything in there is perfect and changes could be leading to over diagnosis including getting rid of the bereavement exclusion. So there were things that were done in DSM-5 that still could be improved in the

future. I still believe that the best solution is some kind of educational effort. Unfortunately, you don't have to take a test to be allowed to use the DSM. You use it because you want to use it. If there was maybe some kind of greater educational effort in residency programs about how to properly use the DSM including training about false positives. I mean there are things that could be done to reduce the problem. But it's got to be done on the user level, not the book level. There is a limit to what the book can do to get people to behave better.

Dr. Wakefield:

I think there is a slight point of disagreement here. I do agree with Dr. First's account of how DSM tries to prevent false positives because these are smart folks who are clinicians. They can see certain obvious objections. The people who write out these definitions are not philosophers. They're not conceptual analysts. They haven't been trained in the notion of necessary and sufficient conditions. It's much easier, of course, to come up with necessary conditions. Well, to have an anxiety disorder you have to have intense anxiety. What about all the conditions that make it sufficient that distinguish it from all the range of circumstances where you have intense anxiety but it's not a disorder? Well, that's not so easy. Yes, it's true, that if it's out of proportion to the actual danger – that helps. But guess what? Your smoke detector goes off when the fish is frying in the oven. It goes off out of proportion to the actual fire in your apartment and that's good. There are some areas of life where we biologically have been selected to be overresponsive. We are anxious, vigilant creatures. I was once in a pool at my mom's house in Boca and a snake jumped into the pool with me. I could see right away that it was a garter snake. It's harmless. I discovered I could fly (laughter). It was amazing. I was like out of the pool straight up in the air off to the side. So, that fear response to snakes doesn't stop for a moment and say uh, is this a dangerous thing? How proportionate is my fear to the snake? In other words, this is an Aristotelian vision, that reason regulates all

of our other emotions and so on. There's a certain truth to that in a way, but on the other hand when it comes to psychiatry you've got to look beyond that.

It seems to me that Michael has made very good points about this, but saying that there are some good things in DSM doesn't, I think, undermine the many objections one can bring. There are still many, many, many serious problems there. I wish I could go through his slides and give you the other side of these various disorders, the things that they didn't do that were left that are stupid. Also there's another kind of point to be made. The fact that the diagnostic criteria stayed constant during a certain period and diagnosis went up does not mean the DSM is not part of the fault. That's just a fallacy. What it means is that DSM diagnosis as written on the page interacted with something else. The fact that it could happen was made possible by the DSM criteria. The fact that pharmacological, that direct-to-consumer advertising exploited that over that period, the fact that parents came in and physicians could exploit that easily during that period. There are a lot of factors which interact with these criteria. If the criteria are broad enough, yes you can interact with them in a way that gives rise to this huge false positives problem even while the criteria stayed the same. It does take time also for the possibility of exploiting criteria to become known, understood by clinicians and percolated out, and for the motivation to be there, such as support of alternative education, special education, and so on.

Dr. Sanders:

Dr. Wakefield, you beat me to it: direct-to-consumer. And I have one more question, one of the more popular questions we had. I want to talk about the direct consumer prescribing and you brought that up and that was one of the questions. Dr. First, what are your thoughts on that? Do you think that had an effect as well? Direct-to-consumer advertising by the pharmaceutical industry?

Dr. First:

I think the direct-to-consumer advertising is a disaster. We're one of the only countries in the world that allow that. If I were president – I'm not debating tonight – I would roll that back in a second. I think one of the big problems with direct-to-consumer advertising, though, is the healthcare cost related to pushing people away from using generic drugs in favor of using more expensive newer drugs for which there is no evidence of superiority. It does have some impact here because, like Dr. Wakefield kind of hinted about this, what is bringing the parents and people into their doctors to ask for treatment? Like social anxiety disorder. Social anxiety disorder--several SSRIs like Prozac got approved for social anxiety disorder. It wasn't Prozac, it was Zoloft I think. That drug company went to town running ads, putting in ads a self-report checklist based on the DSM definition. Do you have this? If so, see your doctor. People come to the doctor and doctors are busy, especially if you're a GP. They just write the prescription. There's no question that the pharmaceutical industry for their own financial reasons has definitely had a huge impact on the medicalization by manipulating the consumers to see their problems in a way that is medical. So I agree. I think that's only part of the problem. Although the advantages of direct-to-consumer advertising are minimal, it does potentially uncover unrecognized cases by encouraging undiagnosed cases to seek treatment.

Dr. Wakefield:

This is a good example where DSM interacts. I don't think Dr. First would disagree with this. So the DSM, as he pointed out, creates a set of criteria; like with depression it's nine symptoms and you have to have five out of those nine symptoms. So that's a pretty good threshold. But the symptoms differ in their severity, or what I call patho-suggestiveness. They differ in how much they suggest a pathology versus a normal reaction of sadness and they just consider them all equal. Then big pharma comes in and says well look, we can present ads with the five most non-patho-

suggestive symptoms and that's going to suggest to all the people out there that when they're sad they should come in and see their physician. Look, if you're feeling sad, you've lost interest in stuff, you're having some insomnia, your appetite is less, you're having trouble concentrating – those are all general distress symptoms when things go wrong in your life. They're not suicidal ideation. They're not psychomotor retardation. They're not marked role impairment where you're lying in bed unable to function. But you can orient ads, and this is what the pharmaceutical industry does and they don't think they're doing anything wrong. They're saying the psychiatrist told us this is a disorder, so we're just trying to use that to help people. If DSM were more careful about that, it seems to me, there wouldn't be that ease of use where you could create ads out of weak symptoms that then have this very broad kind of encompassing quality. So here's a case that illustrates the interaction of maybe insufficiently incisive criteria with other actors that can use that. It's exploitation, but it's using what's there.

Dr. Sanders:

So you would suggest that the pharmaceutical companies know how to market and they know that medications with the letters PQXY and Z sell better than some more scientific terms and that medications in purple packages sell better (laughter). That might be true. This was a popular question. I think because we ran out of time in your lecture and presentation – there were several questions of this kind – about the over diagnosis of depression. How do you differentiate appropriate sadness due to a life circumstance from clinical depression? Isn't this a huge gray area? I think we just didn't have time to get to that in your presentation. I'm going to let both of you comment on that and then we're going to go to a live mic after that.

Dr. Wakefield:

It follows on what I just said in a way. It's too huge to go into all. It is a gray area. But here's what we do know. We do know from many, many studies that with normal grief, people weren't clinically coming in or anything. They were relatives of people who had just been lost, studying that sequelae ... that it includes many of the weaker symptoms I was just distinguishing. I call them the general distress symptoms of depression as distinct from the patho-suggestive or serious symptoms of depression. So as it turns out, those general distress symptoms are extremely common in reactions to loss, reactions to stress. Now, you can do research on this. And I've done research on this. I've probably done more studies on this than any other person alive. It turns out if you have people that only have those weaker symptoms, they are not anything like all the rest of the people that come under major depression that have one or more of those stronger patho-suggestive symptoms. For instance, the classic quality of depression, of major depression, is recurrence. You're likely to have recurrences. Another quality is likely a much higher rate of suicide attempts. There are others. Development of generalized anxiety, there are a lot of other markers, predictive markers, the most powerful kind. You can study the people who have only the weaker symptoms that qualify under DSM, but they have only the weaker symptoms and guess what? So far we've gotten it to a three. We did a one-year follow-up and a three-year follow-up. On the three-year follow-up those with weaker symptoms do not look different than the general population of those who never had major depression, whereas the people with major depression look radically different. They have very high rates just as we believe all along, they have very high rates of all of those markers follow-up outcomes. So the research is fairly clear.

How do you distinguish? You look at the environmental context. Dr. First pointed that out. We both worked on that. It's critical it's left out of DSM in many places. You look at the context. You look at the person's history and

you look at the actual quality of the symptoms rather than counting the way the DSM suggests you should. The quality of the symptoms matters and if you email me I can send you some papers or research on this. So there is a lot of research supporting the fact that there is an over diagnosis going on here.

Dr. Sanders:

Dr. First, any thoughts?

Dr. First:

Dr. Wakefield and I have had a little disagreement. It's true that in epidemiologic samples when you apply these criteria, you see the criteria lead to individuals being overdiagnosed by those conducting the study interviews, according to Dr. Wakefield. Whether this actually translates to people being overdiagnosed with depression in the real world, coming to doctors, asking for help, and getting inappropriate unwarranted treatment, that's unknown. I think you've got to be careful. I'm not saying there's not a problem. From this statement, people are imagining there are millions of people out there taking medicine they don't need. That would be, I think, too much of a stretch to know the answer to that question.

Dr. Wakefield:

I agree we don't know the answer to that question. It is true that clinically by far the most people that are seen are classified under other scales not using that division I just described as mild or moderate, not severe. We know that antidepressants don't even work all that well with that group or at least it seems that. So, if you do careful studies, not the kind of cross sectional study remembering all your symptoms through your life, but you follow people asking them every few years what happened this year so they've got fresh memories and so on. The current criteria in DSM for major depression apply to apparently more than half of the entire population at

some point between about ages 18 and 30. There's nothing in the conceptualization of this disorder that ever suggested that, it just looks like we are massively potentially overdiagnosing. But Michael is absolutely right. We have not done the studies to show in terms of who comes in clinically what percentage there are false positives and aren't. We just don't know any of that yet.

Dr. Sanders:

We're going to switch gears to some live questions. If you have a question, please raise your hand or come to the mic and please tell us your name so that we can reference you.

Audience:

Hi. Thank you very much. My name is Jeff Byrnes. This is directed toward Dr. First. So you gave us some very helpful clarifications in a kind of rough defense of the DSM and the clarifications are something like look, not everything listed is a disorder. Not everything is outlined concretely but there is room for clinical interpretation, and even when criteria don't change you might see an uptick in people seeking help. But even if that works as a defense of the text, I mean I wonder if that doesn't provoke the cultural question. If people see a text that could play Linnaeus to all mental phenomena, it can encode everything, and that even in the interpretive work it can only be done by a kind of priesthood of people who know about these things, it seems like the text or the culture around the text could be feeding into this kind of problem.

Dr. First:

Well, I think you're right. Let me just give you a little anecdote. I worked very intensely on DSM-IV, the one that we were very careful about false positives. The next crew of people who took over the DSM-5, interestingly enough they didn't care that much about false positives. In fact,

when issues were raised to them about potential false positives, several of those working on the manual actually said, well, it's not our job to worry about how it could be misused. My response is the opposite. You're right; we now created a tool which is easily misused. The DSM and the APA have a responsibility to do whatever they can to make the book as abuse-proof as possible, however difficult that is. My point about the rates going up, you know the point that there's a limit to what we can do. That's not the core of the problem. I'm not saying we are absolving ourselves of any responsibilities, or washing our hands of it and saying we're going to just put the manual out there, and simply say that it's the clinicians' responsibility to use it right. I think we do have a responsibility to not put in stupid disorders, to not put in really low thresholds. We do the best we can. I sort of want it both ways.

Audience:

My name is Brian Lakey. Professor Wakefield, I admire your work on bereavement and diagnosis of major depression; and Professor First, I admire the DSM as a required textbook of my 300 level psych pathology class. The question that I have has to do with many of the premises of the discussion assume that there is a clear criterion for mental disorders to compare diagnoses with. And it seemed to me that Professor Wakefield, you were arguing that in the DSM there's a primary biological cause for all disorders. But in my reading the DSM doesn't actually say that. And in fact it lists stressful life events as an etiological factor for more disorders than there is actually good evidence for. I wasn't clear, actually, on what your opinion was on this, Professor First. In some ways it seemed to me that you were saying if we could find biomarkers then the problem would be solved. So here I'm ranting. The question is can either of you offer a definition of a mental disorder that does not rely upon a primary biological dysfunction?

Dr. First:

I think actually the current definition says biological or psychological, but the key word is dysfunction. It's not required that only biological dysfunctions count. There has to be a dysfunction of some sort. I think we commonly – and part of it does have to do with this decade of the brain. There's been a push, especially in psychiatry, to see things in biological reductionistic terms. But I think that in the current – I don't know how many people here are familiar with RDoC. It's the new NIMH replacement for the DSM in research settings, so to speak, to be used in research with the goal of understanding the functioning of the brain where they've broken down mental disorders into psychological functions that by definition have a neurobiological cause. It sees disorders primarily in terms of their neurocircuitry. That's one way of looking at it. I think the DSM is open to both. I think it would be a mistake to say that everything has a core biological cause. My comment on the biomarkers was more that as a doctor we love biomarkers because people want blood tests to tell us things, so that would help. I don't want to imply that will solve all the problems. I guess given the drought of biomarkers, any biomarker that comes our way I think would be an improvement.

Dr. Wakefield:

First of all let me just say, and I'm not sure but it may be that what you're asking about is actually reflecting ambiguity in the word biological. That is, I personally don't believe that every disorder must go back to a dysfunction that's describable in reductionistic, if you want to use that word, brain/physiological terms. So biological can have two meanings. Biological can mean oh, it's got to be a brain thing that's gone wrong. Or, biological can mean evolutionary biological which means simply something is going wrong at some level that is not doing what it's supposed to do by biological design - - without getting into that whole discussion.

To me, given my view, I know it's often confused, my view is that in principle there could be dysfunctions and therefore disorders purely at the psychological level of how meanings interact, how people reason, and so on, that don't correspond to a brain physiological dysfunction. Now, of course we have Nobel Prize winners like Kandel at Columbia saying, you know, parroting the argument that all mental events are brain events, therefore all mental disorders are brain disorders. That's a fallacious argument. The standard way of refuting it – at least to get you started thinking about it – is the software-hardware analogy, which is that all software runs in hardware, but that doesn't mean that every software malfunction is a hardware malfunction. In fact, most aren't, as we know, and you would waste your money getting somebody to look into your hardware when you have a software malfunction. So if there is emotional belief, desire, programming of some kind, it's conceivable that its parameters could go wrong in such a way that there could be a dysfunction at that level without a dysfunction in any brain physiological process. That's what I would hope.

Now I will say anecdotally that I tried to say this to the psychiatric residents at a nearby medical center in New York and I was met with utter disbelief. I would say more than disbelief. It was incomprehension. That's just simply impossible, they said. Every mental disorder must be a brain disorder. That's what I meant when I said we're living in an era, the brain disease era, where it is assumed. Now how this will all play out, whether every mental disorder is a brain disorder, that's an empirical question, not a philosopher's. As a philosopher you can't just solve that. But I hope that clarifies the point that you were asking about.

Audience:

Thank you both again for two thought provoking talks. My name is Brian Pilkington and I teach philosophy at Aquinas College. I want to push back a little bit on Dr. Wakefield's Rawlsian move. I hope Dr. Sanders will pull me back up the rabbit hole if I go too far. I appreciate the equal

opportunity move and I think I know where you're going with Rawls, but why is it that this medical response is appropriate as opposed to social activism or making arguments in favor of acceptance? So why is it if someone falls within a normal range – and I can see by the nod you know where I'm going – or is disadvantaged by society, why must that person bear the burdens of acceptance as opposed to the rest of us?

Dr. Wakefield:

It's an excellent question and it will vary. I think many of us would say that when it comes to children, I mean this argument has actually kind of been made by people in the field of ADHD. Well, you know, look, in our society kids need to learn this is our educational system, better to give drugs so that they learn and they have opportunity later on. People say this who study ADHD – psychologists and psychiatrists. Many of us would argue that a better solution is social change for God's sake, and change in the school environment.

So I'm not precluding that argument at all. I do believe, you know, a theory of the professions would hold maybe that kind of Aristotelian theory that each profession has an essential goal. I call it the organizing value of a profession, so for medicine it's health. So why should they do stuff having to do with justice? And, that is, every profession also has what I call derived tasks. Due to their skills, their skills define that group as the best one to handle something society wants done. So cosmetic surgery for aesthetic reasons, most of us agree – has nothing to do with the ultimate goals of medicine, of healthcare; but there's nobody else that has those skills, so it's given to medicine. So this is given to medicine, as is contraception and other reproductive health issues that have nothing to do with real disorder. So the answer to your question is once it's established that this is something people are owed, then the medical professions do it because they have the skills.

Is it presumed that we will intervene and train everybody? No. First of all, once it's relabeled – that's the problem. Labeling it a disorder precludes this whole discussion that you're trying to open up. Should we have other options? What if you don't like speaking in public? Should there be other ways? Should we develop ways of helping you that don't involve going through therapy or taking Paxil or whatever? So, I see all these options as open once we are honest. The problem now is that we are dishonest, and I'm giving an analysis of why our intuitions are that these people should be treated even though it's pretty obvious that they are false positives.

Dr. Sanders:

Dr. First, any thoughts on that?

Dr. First:

It's way out of my area.

Dr. Sanders:

Ok. I appreciate the comment and you didn't go down the rabbit hole. But I think in terms of social justice having the right to do something but knowing what the right thing to do is really important. I think that that's really what we want to think about. I could say a lot more but I don't want to interrupt. Next question.

Audience:

My name is Steve Williams and I appreciate the presentation. I think you're actually being too kind to the reimbursement system, but I don't want to go there because there doesn't seem to be support for it anymore; but what we're going to go to I don't know. My question is a little more specific, and that is I have become aware lately of a phenomenon called adverse childhood events and heard a fairly cogent presentation on it. I wonder if you're familiar with this sort of new developing thinking. Because it gets at

this issue of the sort of change in DNA, the change in the neuroscience of the brain that if you experience a number of adverse childhood events, your actual biology changes. I don't know if this is a confluence of issues, but I wondered what your thoughts might be if you're aware of it.

Dr. Wakefield:

Are you talking about early trauma?

Audience:

Well, I became aware of it just recently. There have been a couple of new papers published recently. Communities are beginning to adopt this sort of screening – widespread screening. It's fairly limited right now to a few communities to try to get at what happened to children or to adults that causes dysfunction in their life.

Dr. Wakefield:

Absolutely. By the way, there is a fairly large group I find when I'm giving DSM workshops or stuff like that that is upset that DSM-5 did not take adequate account of this new research to define some kind of – not so much posttraumatic, in the sense in DSM – but chronic minor traumas that much of the new literature is looking at. Absolutely, we know – and it's not only there but in genetics as well – we're discovering all sorts of ways we didn't realize by which things can be modified, can be reshaped, as well as the basic discovery some time ago that we grow new neurons and create new neuronal pathways. We're not frozen in our brains after a certain age as they used to believe. All of this has to be addressed, but it isn't yet. And it also raises interesting conceptual questions about disorder. If we're all being shaped to some degree by what happens in our childhood – and some, due to their traumas, are then set for life in certain ways – how does that change how you think about disorder, for instance, or what the boundaries are between disorder and nondisorder? I mean, I think the puzzle and the interest go all

the way back to before most of these new discoveries, to studies like the Dodge study in which he confirmed that a large group of people who were abused in their childhood had a much higher chance of being abusers. But here's what the interesting finding was: the entire effect was explained by the degree to which the early abuse caused the person to have a change in their belief system, their meaning system, that made them believe that things were dangerous and that people would respond violently to them. To those who were early abused and didn't come to believe that, they didn't have higher rates of child abuse later on. To those who came to see the world as dangerous intrinsically, they had higher rates of child abuse later on. This RDoC is partly aimed at this – it's following people longitudinally, developmentally, both normal and traumatized and disordered -- trying to get an overall view of how we are shaped in the long run, which we really don't have a clue about. And after all, to define disorder you have to understand normality. We're not there yet.

Dr. First:

One of the problems with that is the specificity of having these adverse childhood events. One of the disorders proposed for DSM-5 that didn't make it in – and I was in favor of it not going in – was a psychiatric version of fetal alcohol syndrome. The problem was that the original definition seemed to suggest that almost any maternal use of alcohol was enough to cause it and that virtually every kind of behavioral phenomenon in the child was going to be attributed to fetal alcohol exposure. To try to blame the alcohol for this result – mothers who use alcohol when they're pregnant probably have a lot of other risk factors going on and to blame it all on alcohol exposure would be a mistake. So the thing is so complicated that it's one of those things that putting things in a diagnostic system without knowing what's really going on can create a new false positive problem. So you have to be very careful.

Dr. Sanders:

I think it's important that the point you bring up, the number of traumas, can affect people. One of the things we have to be careful of is two thirds of who we are is how our environment affects us, one third is biologic. Different people are resilient in different ways. We know people have different types of genetic makeup in terms of how resilient they are to trauma, so that's why it's a good screening opportunity to review things.

Dr. Wakefield:

One more comment, just to take up Michael's very good point. One problem is our theories become so powerful and compelling that we go into the false positives area. I once was doing a study on conduct disorder and to some of the vignettes I was having clinical judgments about whether a kid had a disorder when he was acting antisocially under certain contextual conditions. I threw into one of the vignettes that the young person had been sexually abused as a child. No matter how rational, no matter what I put into the vignette other than that, at that point in time all these clinicians in training said yes, they must have a disorder. It was their theory that child abuse must cause disorder that made them respond rather than any of the cues, any of the contextual stuff that I put in, that really was more pertinent to whether their behavior was driven by a dysfunction or not. So it's something to think about that we want to get this right instead of again inflating the false positive domain.

Audience:

My name is Joanne Hoganson and I'm here representing Public Health. I'm Director of Nursing at the Kent County Health Department and one of the things that we work with is access to care. I couldn't help but think as I heard you that we in Kent County have a significant access to care challenge, especially around psychiatric needs of adolescents. It does make me wonder if an over-diagnosis may be contributing to filling psychiatric offices and

clinics and in-house treatment when in fact some of those same disorders might be better treated in a support group or in a church youth group or in some other kind of environment, therefore leaving space for those that truly have a disorder. I was just wondering if you had a comment about that.

Dr. First:

My guess is that there is such a shortage of clinicians, even though in theory that may be the case, I think there are so many – if you got rid of some of those cases there would still be a big access problem. The access problem between patients and available clinicians spread out geographically is so huge, I doubt that shifting would make that much of a difference. That's the argument for ADHD. The usual argument against ADHD as being grossly overdiagnosed is actually it's being misdiagnosed. That there are normal children being inappropriately labeled with ADHD but there are still lots of children out there who truly have ADHD and are not getting treatment. So it's a misallocation of resources. So I think in general you're absolutely right. I think that every time a normal person is getting resources and they don't really need it, given how scarce things are, there are all these people out there who really do need it and aren't getting it.

Dr. Wakefield:

I agree. Way back in the old days when community mental health centers were new, they were explicitly put in to help the people be deinstitutionalized, to help support them in the community. But there was a natural trend to treat, by the clinicians as much as anybody else, to treat what some people dismissed as the worry of, well they might have true disorder, they might not, marital problems, all sorts of problems. And we really weren't doing our job. I think that getting clearer on the false positives, I totally agree with what Michael said. There are a lot of people who need treatment who aren't getting treatment. But getting clearer on this problem would help to allocate resources better. Whether it would clear out

the clinics, I'm dubious. Whether it would allocate resources better? Absolutely. And, an embarrassment to all us clinicians, peer counseling for milder problems is remarkably effective even when compared to professional intervention. So peer counseling has not been adequately given its due and used, for obvious reasons.

Dr. Sanders:

One last question. Any more questions? I guess we will enjoy watching the election then. Please join me in thanking Dr. Wakefield and Dr. First. Outstanding. Thank you for joining us and enjoy the Michigan fall that's coming. Hope we'll see you March 27th.



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