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Dangerous New Psychiatric Bible (DSM-5) Finalized for 2013

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This is the saddest moment in my 45 year career of studying, practicing, and teaching psychiatry. The Board of Trustees of the American Psychiatric Association has given its final approval to a deeply flawed DSM-5 containing many changes that seem clearly unsafe and scientifically unsound. My best advice to clinicians, to the press, and to the general public -- be skeptical and don't follow DSM-5 blindly down a road likely to lead to massive over-diagnosis and harmful over-medication. Just ignore the 10 changes that make no sense.

Brief background. DSM-5 got off to a bad start and was never able to establish sure footing. Its leaders initially articulated a premature and unrealizable goal -- to produce a paradigm shift in psychiatry. Excessive ambition combined with disorganized execution led inevitably to many ill-conceived and risky proposals.

These were vigorously opposed. More than 50 mental health professional associations petitioned for an outside review of DSM-5 to provide an independent judgment of its supporting evidence and to evaluate the balance between its risks and benefits. Professional journals, the press, and the public also weighed in -- expressing widespread astonishment about decisions that sometimes seemed not only to lack scientific support but also to defy common sense.

DSM-5 has neither been able to self correct nor willing to heed the advice of outsiders. It has instead created a mostly closed shop -- circling the wagons and deaf to the repeated and widespread warnings that it would lead to massive misdiagnosis. Fortunately, some of its most egregiously risky and unsupportable proposals were eventually dropped under great external pressure (most notably 'psychosis risk,' mixed anxiety/depression, Internet and sex addiction, rape as a mental disorder, 'hebephilia,' cumbersome personality ratings, and sharply lowered thresholds for many existing disorders). But APA stubbornly refused to sponsor any independent review and has given final approval to the 10 reckless and untested ideas that are summarized below.

The history of psychiatry is littered with fad diagnoses that in retrospect did far more harm than good. Yesterday's APA approval makes it likely that DSM-5 will start a half or dozen or more new fads which will be detrimental to the misdiagnosed individuals and costly to our society.

The motives of the people working on DSM-5 have often been questioned. They have been accused of having a financial conflict of interest because some have (minimal) drug company ties and also because so many of the DSM-5 changes will enhance Pharma profits by adding to our already existing societal overdose of carelessly prescribed psychiatric medicine. But I know the people working on DSM-5 and know this charge to be both unfair and untrue. Indeed, they have made some very bad decisions, but they did so with pure hearts and not because they wanted to help the drug companies. Their's is an intellectual, not financial, conflict of interest that results from the natural tendency of highly specialized experts to over value their pet ideas, to want to expand their own areas of research interest, and to be oblivious to the distortions that occur in translating DSM-5 to real life clinical practice (particularly in primary care where 80 percent of psychiatric drugs are prescribed).

The APA's deep dependence on the publishing profits generated by the DSM-5 business enterprise creates a far less pure motivation. There is an inherent and influential conflict of interest between the DSM-5 public trust and DSM-5 as a best seller. When its deadlines were consistently missed due to poor planning and disorganized implementation, APA chose quietly to cancel the DSM-5 field testing step that was meant to provide it with a badly needed opportunity for quality control. The current draft has been approved and is now being rushed prematurely to press with incomplete field testing for one reason only -- so that DSM-5 publishing profits can fill the big hole in APA's projected budget and return dividends on the exorbitant cost of 25 million dollars that has been charged to DSM-5 preparation.

This is no way to prepare or to approve a diagnostic system. Psychiatric diagnosis has become too important in selecting treatments, determining eligibility for benefits and services, allocating resources, guiding legal judgments, creating stigma, and influencing personal expectations to be left in the hands of an APA that has proven itself incapable of producing a safe, sound, and widely accepted manual.

New diagnoses in psychiatry are more dangerous than new drugs because they influence whether or not millions of people are placed on drugs -- often by primary care doctors after brief visits. Before their introduction, new diagnoses deserve the same level of attention to safety that we devote to new drugs. APA is not competent to do this.

So, here is my list of DSM-5's 10 most potentially harmful changes. I would suggest that clinicians not follow these at all (or, at the very least, use them with extreme caution and attention to their risks); that potential patients be deeply skeptical, especially if the proposed diagnosis is being used as a rationale for prescribing medication for you or for your child; and that payers question whether some of these are suitable for reimbursement. My goal is to minimize the harm that may otherwise be done by unnecessary obedience to unwise and arbitrary DSM-5 decisions.

1) Disruptive Mood Dysregulation Disorder: DSM-5 will turn temper tantrums into a mental disorder -- a puzzling decision based on the work of only one research group. We have no idea how this untested new diagnosis will play out in real life practice settings, but my fear is that it will exacerbate, not relieve, the already excessive and inappropriate use of medication in young children. During the past two decades, child psychiatry has already provoked three fads -- a tripling of Attention Deficit Disorder, a more than 20-times increase in Autistic Disorder, and a 40-times increase in childhood Bipolar Disorder. The field should have felt chastened by this sorry track record and should engage itself now in the crucial task of educating practitioners and the public about the difficulty of accurately diagnosing children and the risks of over-medicating them. DSM-5 should not be adding a new disorder likely to result in a new fad and even more inappropriate medication use in vulnerable children.

2) Normal grief will become Major Depressive Disorder, thus medicalizing and trivializing our expectable and necessary emotional reactions to the loss of a loved one and substituting pills and superficial medical rituals for the deep consolations of family, friends, religion, and the resiliency that comes with time and the acceptance of the limitations of life.

3) The everyday forgetting characteristic of old age will now be misdiagnosed as Minor Neurocognitive Disorder, creating a huge false positive population of people who are not at special risk for dementia. Since there is no effective treatment for this 'condition' (or for dementia), the label provides absolutely no benefit (while creating great anxiety) even for those at true risk for later developing dementia. It is a dead loss for the many who will be mislabeled.

4) DSM-5 will likely trigger a fad of Adult Attention Deficit Disorder leading to widespread misuse of stimulant drugs for performance enhancement and recreation and contributing to the already large illegal secondary market in diverted prescription drugs.

5) Excessive eating 12 times in 3 months is no longer just a manifestation of gluttony and the easy availability of really great tasting food. DSM-5 has instead turned it into a psychiatric illness called Binge Eating Disorder.

6) The changes in the DSM-5 definition of autism will result in lowered rates -- 10 percent according to estimates by the DSM-5 work group, perhaps 50 percent according to outside research groups. This reduction can be seen as beneficial in the sense that the diagnosis of autism will be more accurate and specific -- but advocates understandably fear a disruption in needed school services. Here the DSM-5 problem is not so much a bad decision, but the misleading promises that it will have no impact on rates of disorder or of service delivery. School services should be tied more to educational need, less to a controversial psychiatric diagnosis created for clinical (not educational) purposes and whose rate is so sensitive to small changes in definition and assessment.

7) First time substance abusers will be lumped in definitionally in with hard-core addicts despite their very different treatment needs and prognosis and the stigma this will cause.

8) DSM-5 has created a slippery slope by introducing the concept of Behavioral Addictions that eventually can spread to make a mental disorder of everything we like to do a lot. Watch out for

careless overdiagnosis of Internet and sex addiction and the development of lucrative treatment programs to exploit these new markets.

9) DSM-5 obscures the already fuzzy boundary been Generalized Anxiety Disorder and the worries of everyday life. Small changes in definition can create millions of anxious new 'patients' and expand the already widespread practice of inappropriately prescribing addicting anti-anxiety medications.

10) DSM-5 has opened the gate even further to the already existing problem of misdiagnosis of PTSD in forensic settings.

DSM-5 has dropped its pretension to being a paradigm shift in psychiatric diagnosis and instead (in a dramatic 180 degree turn) now makes the equally misleading claim that it is a conservative document that will have minimal impact on the rates of psychiatric diagnosis and in the consequent provision of inappropriate treatment. This is an untenable claim that DSM-5 cannot possibly support because, for completely unfathomable reasons, it never took the simple and inexpensive step of actually studying the impact of DSM on rates in real world settings.

Except for autism, all the DSM-5 changes loosen diagnosis and threaten to turn our current diagnostic inflation into diagnostic hyperinflation. Painful experience with previous DSMs teaches that if anything in the diagnostic system can be misused and turned into a fad, it will be. Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and 'behavioral addictions' will soon be mislabeled as psychiatrically sick and given inappropriate treatment.

People with real psychiatric problems that can be reliably diagnosed and effectively treated are already badly shortchanged. DSM-5 will make this worse by diverting attention and scarce resources away from the really ill and toward people with the everyday problems of life who will be harmed, not helped, when they are mislabeled as mentally ill.

Our patients deserve better, society deserves better, and the mental health professions deserve better. Caring for the mentally ill is a noble and effective profession. But we have to know our limits and stay within them.

DSM-5 violates the most sacred (and most frequently ignored) tenet in medicine -- First Do No Harm! That's why this is such a sad moment.