DSM, Psychotherapy, Counseling and the Medicalization of Mental Illness: A Commentary from Allen Frances

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Let us start with two important disclaimers. First, I will be identifying the many ways that the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) system has been detrimental to psychotherapy and how the fifth edition (*DSM-5*; American Psychiatric Association [APA], 2013) will make the current situation even worse. However, this does not mean that I consider *DSM* diagnosis irrelevant to psychotherapy and counseling, nor do I believe that psychotherapists and counselors should neglect learning about diagnosis. I do not trust therapists who focus their contact with the client exclusively around the *DSM* diagnosis. Hippocrates believed that it is more important to know the person who has the disease than the disease the person has. Nevertheless, I also do not trust therapists who are completely free-form, impressionistic and idiosyncratic in their approach to clients. *DSM* diagnosis is only a small part of what goes into therapy, but it is often a crucial part. We need to know what makes each person different and unique; on the other hand, we also need to group clients with similar problems as a way of choosing interventions and predicting the treatment course.

The second disclaimer relates to the proper roles of medication, psychotherapy and counseling. The *DSM* has promoted a reductionistic medicalization of mental illness that, in combination with misleading drug company marketing strategies, has created a strong bias toward treatment with medication and against treatment with psychotherapy and counseling. I am greatly disturbed by the resulting enormous overuse of psychotropic drugs among both adults and children, many of whom do not need psychotropic drugs and would do much better without them. However, we must be equally alert to the fact that many people who need medication do not receive it. Psychotherapists and counselors are important gatekeepers who should recognize when medication is needed and when it is not. It makes no sense to be for or against medicating clients. It is crucial that medication not be used carelessly, but also essential to realize that it is sometimes absolutely necessary.

I will offer a brief history. Before the publication of the *DSM-III* (APA) in 1980, psychiatric diagnosis was a subject of little interest or importance because it was unreliable and not particularly useful for treatment planning. The *DSM-III* marked a sudden and dramatic change—it made diagnosis a major focus of clinical attention and the starting point of all treatment guidelines. Its provision of clearly defined criteria allowed for reasonably reliable diagnosis and for targeting specific symptoms that became the focus of treatment. The *DSM-III*'s influence exceeded all expectations, in some ways useful, but also with a significant defect. The prevailing mental health approach before the *DSM-III* was the well-rounded biopsychosocial model. At that time, clinicians conceptualized symptoms as arising from the complex interplay of brain functioning, psychological factors, and familial and social contexts. Perhaps without intention, the *DSM-III* downgraded the psychological and social factors and promoted undue emphasis on the biological factors. The *DSM-III* was advertised as "atheoretical" and neutral, usable by practitioners of all professional orientations. To some small degree, this

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was true; yet the *DSM-III*'s emphasis on purely descriptive psychiatry strongly favored biological treatments over cognitive-behavioral treatments. This bias proved to be irrelevant and eventually destructive to family and psychodynamic therapies. The descriptive *DSM-III* method focused attention on surface symptoms in the individual and ignored both deeper psychological understanding and the social and familial contexts. Clinicians often adopted a symptom checklist approach to evaluation and forgot that a complete evaluation must account for psychological factors, social supports and stressors.

In addition to its considerable impact on the mental health profession, the *DSM-III* also significantly affected the pharmaceutical industry. Drug companies benefited greatly from the *DSM-III* approach, particularly since 1987 when Prozac established the template for promoting blockbuster psychiatric drugs. Pharma realized that the best way to sell pills is to promote disease-mongering. Their marketing campaign offers the misleading idea that mental disorders are underdiagnosed, easy to diagnose due to chemical imbalances in the brain and best treated with a pill. The marketing targeted psychiatrists first, then primary care physicians and, since 1997, the general public. In the United States and New Zealand, drug companies have successfully bullied the government into allowing direct advertising to consumers on television, in print and on the Internet. Use of medication has skyrocketed as a result of these billion-dollar marketing budgets, turning us into a pill-popping society. This increase in drug use is great for Pharma shareholders and executives, but often inappropriate for clients and terribly costly to the economy. More than $40 billion a year are spent on psychiatric drugs. Most of these (80%) are prescribed by primary care doctors with little training or interest in psychiatric diagnosis or treatment, while under strong pressure from patients and drug company representatives, and after only seven minutes of evaluation on average. During the last decade, many drug companies have received enormous fines (e.g., one fine was $3.3 billion) for illegal marketing practices, but they continue because the rewards are so great.

For mild to moderate psychiatric problems, psychotherapy and counseling are just as effective as medication, and their effects are much more enduring. Most people taking medication would probably have been better off had they received psychotherapy or counseling. Unfortunately, psychotherapy and counseling suffer from two great disadvantages in their competition with drug treatment. Drug companies are enormously profitable industrial giants with billion-dollar budgets to push their products. In contrast, the mental health field is more of a nickel-and-dime, mom-and-pop operation with absolutely no marketing punch. Insurance companies further tilt the playing field by consistently favoring medication management over psychotherapy and counseling based on the mistaken assumption that it will be cheaper. In fact, brief treatments are often much more cost-effective because their effects are lasting, whereas medication may be necessary for years or a lifetime.

The medicalization of mental illness has had a dire impact on our clients and our society. Twenty percent of the population regularly takes a psychiatric drug, many for problems of everyday life more amenable to watchful waiting or psychotherapy and counseling than to drug treatment. It is astounding that there are now more overdoses and deaths from prescription drugs than street drugs. The tremendous societal investment in psychiatric drugs also misallocates resources much better spent on terribly underfunded social investments. Would it not be better for children to have smaller classes and more gym periods than for so many of them to be on pills for ADHD?

In preparing the *DSM-IV* (APA, 1994), we attempted to hold the line against diagnostic inflation and the medicalization of normality; however, we failed. During the past 20 years, the United States has experienced fad epidemics of ADHD, autism and bipolar disorder. We were conservative in writing the *DSM-IV*, but failed to anticipate or prevent its careless misuse under external pressure, particularly drug company marketing and the requirement of a psychiatric diagnosis for clients to qualify for school services and disability benefits. The quick fix is to give a diagnosis, but often this does more harm than good in the long run. Inaccurate diagnoses are easy

to give but hard to remove. Often they haunt the client for life with stigma, unnecessary treatments and reduced expectations. Making an accurate diagnosis requires really knowing one's client, which may take weeks or even months. In uncertain situations, it is better to underdiagnose than overdiagnose a symptom pattern, and better to be safe than sorry.

The *DSM-5* will considerably increase medicalization and may turn our current diagnostic inflation into hyperinflation. Overdiagnosis transforms normal grief into major depressive disorder, normal temper tantrums into disruptive mood dysregulation disorder, normal forgetfulness of old age into minor neurocognitive disorder, poor eating habits into binge eating disorder, and expectable worry about physical symptoms into somatic symptom disorder. It also further loosens the already far too slack criteria for attention deficit disorder and contains a completely confusing definition of autism. Experience teaches that whenever the diagnostic spigot is unrestricted, drug company revenues increase, and less funding is available to support psychotherapy and counseling visits.

The *DSM* is only one guide to diagnosis—it is not a bible or official manual of diagnosis. The *DSM* codes that clinicians routinely use for reimbursement are in fact all International Classification of Diseases, Clinical Modification (*ICD-CM*) codes that are available for free on the Internet. *DSM-5* is one suggested way to arrive at an *ICD-CM* diagnosis, but it is not the only or best way. Other more reliable guides to psychiatric diagnosis are available. Therapists do not have to buy or use the *DSM-5* unless they work for an institution that requires it.

Receiving a psychiatric diagnosis can be a turning point in a client's life. An accurate diagnosis can lead to an effective treatment plan; an inaccurate diagnosis can lead to side effects, stigma, high costs, reduced opportunities and needless suffering. Severe and classic presentations require quick diagnosis and immediate intervention, usually including medication. Milder, equivocal presentations allow for and require a more cautious approach. Therefore, watchful waiting or brief counseling is usually best.

Conflict of Interest and Funding Disclosure
The author published two books that critically review the DSM-5*, titled* Saving Normal *and* Essentials of Psychiatric Diagnosis*.*

References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.