

What Is Mental Illness?

Richard J. McNally

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An Epidemic of Madness?

1

Nearly 50 percent of Americans have been mentally ill at some point in their lives, and more than a quarter have suffered from mental illness in the past twelve months.¹ Madness, it seems, is rampant in America.

These startling conclusions emerged from the National Comorbidity Survey Replication (NCSR), a study involving psychiatric interviews with a sample of more than nine thousand adults. Studies in other countries, for their part, seem to confirm the high level of mental illness in America. Consider two recent psychiatric surveys done in China and Nigeria. Both indicated that about 4–5 percent of the population had a mental disorder during the previous year, compared with 26 percent of people in the United States.² Remarkably, Americans seem more vulnerable to breakdown than people in impoverished, often chaotic regions of the globe. Does affluence somehow breed mental disorder?

The NCSR surveyors interviewed adults, not children. But they did ask subjects when their problems began. They found that half of those who had suffered from mental illness developed their disorder before the age of fourteen, and three-quarters of them had fallen ill by the age of twenty-four.³ Mental disorders, then, strike much earlier in people's lives than many would have guessed.

The NCSR also found that most people do not receive treatment in a timely fashion, if at all.⁴ For example, for those with

mood disorders, the delay from illness onset to first professional contact ranged from six to eight years. For those with anxiety disorders, it ranged from nine to twenty-three years. The reasons for delay are unclear. Some people may fail to recognize their problems as symptoms of treatable mental disorders, whereas others may worry about the stigma of being labeled “crazy.” Furthermore, among people who had a mental disorder during the previous year, 59 percent went untreated. The NCSR researchers interpreted these findings as indicating a “profound unmet need for mental health services.”⁵

Yet strangely enough, despite the vast number of untreated individuals, nearly one-third of all mental health visits involve problems too mild to meet criteria for any psychiatric disorder.⁶ So in addition to the many cases of unmet need, we seem to have many cases of “met un-need,” as the psychiatric epidemiologist William Narrow called it.⁷ This would seem to imply that distressed people experiencing ordinary problems of living are consuming scarce resources needed by those with serious problems such as schizophrenia and depression. If so, then we have the worst possible situation: those most in need of treatment do not receive it, whereas those least in need do.

Of course, not all psychological troubles signify mental disorder. Mental health professionals often provide helpful guidance to people whose distress arises from difficulties in everyday life. People seek counseling for relationship problems, difficulties at work, or loneliness. Moreover, people whose mental illness has gone into remission may still require counseling to ensure sustained recovery. For example, therapists can help patients with a history of bipolar disorder adhere to medication regimens and cope with life stressors that might otherwise trigger a relapse into depression or mania. In this sense, not everyone who sees a therapist necessarily counts as a case of met un-need.

The NCSR interviewers also asked subjects who did seek help about the kind of treatment they received. The results were disturbing. A mere one-third had received pharmacological or psychological treatments of demonstrated efficacy. That is, only a minority had received treatments that controlled clinical trials had shown were actually better for reducing psychiatric symptoms than a pill placebo or no treatment at all.⁸ Few received an antidepressant drug for serious depression or cognitive-behavior therapy (CBT) for panic disorder. In fact, nearly one-third of all mental health visits involved spiritual healers, practitioners of “alternative” medicine, and others offering nonmainstream treatments such as past-life regression therapy. As Thomas Insel, the director of the National Institute of Mental Health (NIMH) put it, “mental health care in America is ailing.”⁹

So we’ve heard the claims that half of America has suffered from *mental disorder*, but what exactly do we mean by the term? Nearly all clinicians and researchers today follow the definitions and diagnostic guidelines of the American Psychiatric Association (APA) as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).¹⁰ According to the DSM, mental disorders are behavioral or psychological syndromes, clusters of co-occurring symptoms, which cause significant distress or interfere with a person’s ability to function in everyday life, or both. Symptoms of mental disorders arise from a presumptive dysfunction within the mind (or brain). That is, something has gone wrong within the person. Normal emotional distress arising from ordinary difficulties of living, such as anxiety about losing one’s job in an economic downturn, does not signify mental disorder. Likewise, behavioral problems that conflict with social norms, such as criminal activity, do not indicate mental disorder. Although some criminals are mentally ill, committing crimes is insufficient to justify a diagnosis of mental

illness. Very few murderers are insane. People can be bad without being mad.

Mental disorders vary greatly in terms of type and severity. Schizophrenia, for example, involves a psychotic “break with reality,” marked by hallucinations, delusions, and difficulty functioning in everyday life. For example, a man with paranoid schizophrenia who has delusions that his coworkers are plotting to poison him is likely to have difficulty functioning at work. Other disorders, such as snake phobia and alcohol abuse, produce less suffering and impairment. A woman with a snake phobia may avoid camping outdoors but otherwise experience minimal interference in her family or work life. The DSM-IV provides explicit criteria for objectively diagnosing each mental disorder. Therefore, when epidemiologists announce that half of America has suffered from mental illness, they’re playing by the rules. The problem, however, is that the rules themselves may be faulty. Does our system of diagnosing mental disorders fail to distinguish normal human suffering from genuine mental illness? Or are we really getting sicker?

Consider major depressive disorder. People with this condition suffer from unremitting sadness, an inability to experience pleasure, or both. They also typically lose their energy, appetite, and ability to sleep or concentrate on daily tasks. Suffering from guilt and hopelessness about the future, they often contemplate suicide. When depressed people also have a hard time controlling their impulses or suffer from unrelenting, intense anxiety, they are at high risk for attempting suicide.¹¹

Evidence indicates that major depressive disorder has been striking an increasingly larger proportion of each successive generation.¹² This implies that Generation Xers are at greater risk than are Baby Boomers, who, in turn, are at greater risk than those born during the Great Depression or earlier. Perhaps younger cohorts are less resilient to ordinary life stressors than are older co-

horts, who lived through the Depression and World War II. Younger groups may be more psychologically minded and more willing to admit symptoms than older ones. Of course, some members of older cohorts may have forgotten previous episodes of depression. Some depressed members of older cohorts may have died prematurely, perhaps by suicide. These factors would diminish the apparent rate of depression in older versus younger segments of the population.

Yet clinical researchers believe that these factors cannot explain the rising incidence of depression over time; the phenomenon appears genuine.¹³ The increase is so dramatic that it strains credulity to imagine that it is entirely due to faulty memory and other artifactual causes. Indeed, only about 2–3 percent of people born before 1915 developed the disorder, despite having lived through the Great Depression and World War II.¹⁴ In contrast, about 20 percent of those born between the late 1950s and the early 1970s have had depression.¹⁵ During the past century, depression has been striking people at increasingly younger ages.

But why? Social trends in recent decades may have increased stressors while diminishing the capacity of people to cope with them. Our society has become increasingly individualistic; we are now more likely to be “bowling alone” than with others.¹⁶ Loosening of social bonds, aggravated by increased geographical mobility, may diminish the support systems vital for coping with the problems of everyday life. Social relationships may not be sufficient to ensure emotional health, but they are a necessary part of it.¹⁷ Factors that disrupt these relationships may foster depression, especially among people genetically at risk for the disorder.¹⁸

Anxiety also has been increasing across generational cohorts. The psychologist Jean Twenge noted that researchers have administered the Taylor Manifest Anxiety Scale to groups of college students for many decades.¹⁹ This questionnaire asks respondents

whether statements such as “I feel anxious about something or someone almost all of the time,” and “I am a very nervous person,” apply to them. For each generation, Twenge calculated the median score (that is, the score dividing the top 50 percent of the students from the bottom 50 percent). She found that the typical college student in the 1990s was more anxious than 71 percent of college students in the 1970s and more anxious than 85 percent of college students in the 1950s. In other words, students scoring at the median (50th percentile) in the 1990s would have scored at the 71st percentile had they attended college in the 1970s and at the 85th percentile had they attended college in the 1950s. The typical college student in the 1990s would have looked neurotic in the 1950s. Similarly, the average schoolchild in the 1980s scored higher on standardized measures of anxiety than did the average child psychiatric patient in the 1950s.

Twenge believes that people born in the 1970s, 1980s, and 1990s encounter stressors seldom experienced by those born earlier.²⁰ About half of them come from broken homes, and many never knew their fathers. Younger cohorts work more hours, deal with higher housing costs, and experience far more geographic mobility, which, in turn, erodes stable networks of social support.

Studies of clients in university counseling centers are consistent with this trend. The proportion of students seeking help for complex clinical problems has increased since the late 1980s, and the number of suicidal students has tripled.²¹ There has been an “extraordinary increase in serious mental illness on college campuses today,” says Richard Kadison, chief of mental health services for students at Harvard University.²² He cited a 2001 survey of directors of university counseling centers in which 85 percent reported an increase in “severe” psychological problems over the course of the previous five years. Kadison warned parents that nearly half of students today will experience a depression so serious that they will

be unable to function, and that about one in ten will become suicidal. Between 25 and 50 percent of students in campus counseling centers take antidepressants.²³ This high rate of medication use is consistent with the kinds of problems students encounter today. The challenges that students of earlier generations faced, such as adjusting to being away from home, confusion about future careers, and conflicts with roommates, no longer dominate the picture. Serious depression, preoccupation with committing suicide, and self-injurious behavior, such as cutting and burning oneself, are far more common than in the past.

A major survey published in 2008 confirms the observations of Kadison and others. The National Epidemiologic Study on Alcohol and Related Conditions (NESARC) involved face-to-face psychiatric interviews with a representative sample of more than 40,000 Americans. In one NESARC report, the authors focused on subjects aged nineteen to twenty-five.²⁴

In this sample, 2,188 subjects attended college and 2,904 did not. Among college students, 46 percent had at least one mental disorder during the previous twelve months. Twenty percent of the college students met criteria for either alcohol abuse or dependence, and about two-thirds of these problem drinkers were dependent on alcohol. More than 10 percent had suffered from a mood disorder during the previous year, usually major depression or bipolar disorder. Anxiety disorders occurred in nearly 12 percent of college students. The NESARC interviewers diagnosed personality disorders—severe, longstanding interpersonal problems—in nearly 18 percent of the college population. Less than 20 percent of students with a mental disorder had sought treatment during the year prior to the survey.

Young people who are not attending college are not doing any better than their peers in school. Forty-eight percent of this group suffered from a mental disorder during the previous twelve

months. For the most part, the same illnesses afflicted this group as afflicted the college students. Moreover, similar factors influenced risk for psychiatric disorder in both groups. Being foreign-born or a member of a racial or ethnic minority group lowered risk, whereas disruption in social relations, including romantic disappointments, increased risk. As the NESARC researchers observed, this finding underscores the powerful impact of social relationships in the lives of young people. The popularity of Facebook, text messaging, and continual cell phone contact may partly arise to counteract trends for increasing social isolation.

Could this increase in mental illness among students be due to the fact that more young people than ever before are attending college, including those whose mental health troubles would have prevented them from doing so before psychiatric drugs became so widely prescribed? Even though medication may enable them to finish high school and enroll in college, the stress of university life may nevertheless unmask preexisting vulnerabilities.

All these studies imply that mental illness is a public health crisis of staggering proportions. But is the epidemic genuine? Not everyone thinks so. As Paul McHugh, former chair of the Department of Psychiatry and Behavioral Sciences at Johns Hopkins University, remarked, “Fifty percent of Americans mentally impaired—are you kidding me? Pretty soon we’ll have a syndrome for short, fat Irish guys with a Boston accent, and I’ll be mentally ill.”²⁵

In fact, recent figures for annual and lifetime prevalence rates for mental disorders seem implausibly high. How could it possibly be true that nearly half of Americans have been mentally ill? If that many citizens were “going crazy,” how could society function at all? The problem here is our understanding of what it means to be mentally ill. When most people think of mental illness, they think of schizophrenia. Schizophrenia is a psychosis characterized

by auditory hallucinations, delusions, social withdrawal, and apathy. Most people with this diagnosis experience severe impairment in occupational and interpersonal settings. Yet only a minority of individuals with psychiatric illness have schizophrenia; its lifetime prevalence is only about 0.5 to 1 percent.²⁶ It constitutes only a tiny fraction of the number of individuals who develop mental disorder. Most suffer from mood disorders, anxiety disorders, and substance abuse or dependence. These problems are serious enough, but with few exceptions, such as bipolar disorder or psychotic depression, they seldom involve a loss of contact with reality.

If we consider, then, that mental illness occurs on a spectrum of severity, the high rates don't seem quite so improbable. Why should mental illness be rare when physical illness is not? After all, nearly everyone catches the flu or develops tooth decay at some point in their lives, and hypertension, diabetes, and obesity are anything but rare in contemporary America. Physical illness runs from the common cold to cancer, and disorders within a medical domain vary in severity, impairment, and need for intervention. Imagine the incredulity provoked by headlines announcing that epidemiologists have discovered that (only!) 50 percent of Americans get sick at some point during their lifetimes. When we lump all mental (or physical) illnesses together, we should not be surprised at high rates. Some mental illnesses are the equivalent of "psychiatric hangnails," as Ronald Kessler, the head of the NCSR, put it.²⁷ Phobic fear of heights, speaking in public, or flying in airplanes might count as examples of these common but less disabling disorders. Hence, public skepticism about an epidemic of mental illness arises partly because laypeople have a much narrower concept of "mental illness" than do mental health professionals. For the latter, "mental illness" means much more than just "psychosis."

Rates of mental illness might also be so high because epi-

demiologists are better at diagnosing disorders in the general population today than in the past. Detecting these illnesses has always been challenging. They have long been a source of shame and stigma, motivating sufferers to conceal their problems. “The mass of men lead lives of quiet desperation,” Thoreau said in 1854.²⁸ Yet despair and its variants are more visible today than ever before, partly because of advances in psychiatric epidemiology.

Epidemiologists have two main missions. In contrast to clinical researchers, who study patients in treatment, epidemiologists study large, representative samples from the population in an attempt to obtain unbiased, generalizable knowledge about the incidence, prevalence, and risk factors for disease. Epidemiologists can also provide valuable information about the need for treatment. Without accurate estimates of how many people need services, health care policy becomes little more than guesswork.

Then there’s the question of cost. How can we possibly manage to pay for treating all these people? Advocates for the mentally ill argue that psychiatric disorders are just as real and no less deserving of health insurance coverage than are physical disorders. To be sure, debate abounds regarding insurance coverage for nonpsychiatric illnesses, too. But that controversy concerns the type and extent of coverage, not whether the condition is, indeed, a genuine medical illness deserving of *any* coverage.

These arguments convinced Congress. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires group health care plans involving more than fifty employees to provide insurance coverage for all mental disorders at a rate no less than that for other medical conditions.²⁹ It updates the previous Mental Health Parity Act of 1996 by extending coverage to substance abuse and dependence disorders. If a health care plan pays 80 percent of the cost of nonpsychiatric medical costs while

the patient pays the rest, then the law requires the plan to pay for 80 percent of the cost of treatment of a mental disorder, too.

But there is a downside: claims that mental disorders are both common and serious may provoke backlash. On the one hand, advocates stress the equivalence of mental and physical disorders, arguing that schizophrenia, bipolar disorder, and other mental illnesses are biologically based diseases of the brain, and at least as devastating as cancer, heart disease, and other uncontested medical diseases. On the other hand, they cite alarming statistics confirming the very high prevalence of mental disorder in the population, underscoring the extent of unmet need. When those who foot the bill consider these two points together—severity and prevalence—a backlash seems inevitable, especially in a climate of shrinking health care dollars. As the psychiatrist and epidemiologist Darrel Regier pointed out, “Some major media commentators identified such high rates as indicating a bottomless pit of possible demand for mental health services.”³⁰

Health care plans provide coverage for *medical* conditions, and psychiatric disorders qualify as medical disorders. Yet these plans provide coverage only when there is “medical necessity.” Can it be, then, that many disorders in the community are insufficiently severe and do not require professional treatment? Perhaps epidemiologists have counted people whose conditions are so mild that treatment is unnecessary. If so, then the prevalence data overestimate the magnitude of treatment need. If epidemiologists were to count only clinically significant disorders when they estimate prevalence, would this reduce widespread skepticism about implausibly high rates as well as provide a more realistic guideline for health care planning?

Let’s look at major depressive disorder. To be diagnosed with this disorder a person must experience either sadness or loss of pleasure for most of the day for only two weeks in addition to

reporting four other symptoms (for example, fatigue, sleep disturbance, concentration problems, and diminished appetite). Most people who seek professional help for depression have been suffering far longer than only two weeks. In contrast, those who have experienced recent hardships, such as the loss of a loved one, may wind up qualifying for a diagnosis of major depression even though their condition is expectable and may abate over time without need of any professional intervention.

William Narrow, Darrel Regier, and their colleagues revisited large epidemiological data sets to investigate this issue.³¹ They counted cases of disorder only when the person's condition met criteria for "clinical significance." They defined a case as "clinically significant" only if the person told the interviewer that he or she had mentioned the problem to a health care professional, took medication for the problem, or said that it had interfered with life "a lot."

These criteria are not ideal. It is tough to know what subjects might have meant when they said the problem interfered with their lives "a lot." The social context is missing. Unfortunately, these are the questions asked in the original research, and Narrow had to have some systematic way of distinguishing between disorders with and without clinical significance.

Not surprisingly, prevalence rates dropped when they counted only cases that were clinically significant. Subjects in this category were more likely to be suicidal and to report impairment in fulfilling their everyday responsibilities, such as missing days from work because of the disorder, relative to cases without clinical significance. Clinically significant disorders are those most likely to qualify as needing treatment under the medical necessity rule.

Even though these criteria revised prevalence estimates downward, the numbers were still quite high.³² If the demand for services is anywhere near the prevalence rate, then "the mental health sys-

tem would have to expand enormously to meet this need, with attendant increases in workforce deployment and overall costs,” as Narrow and his colleagues observed.³³

This attempt to reduce prevalence rates by counting only clinically significant disorders met with vigorous opposition from others in psychiatry and epidemiology. Why should we confine psychiatric disorders only to their most severe expressions if the same restriction does not hold for other medical specialties?³⁴ Dermatologists treat everything from warts to melanoma. Why should matters differ only for psychiatry?

Ronald Kessler agreed that resources for mental health are woefully inadequate to cope with treatment need.³⁵ Yet he criticized Narrow and colleagues for trying to limit the scope of mental disorder. Identifying treatment-worthy problems as only the most severe expressions of mental illness does not solve the problem of unmet need; it merely amounts to an attempt to define it out of existence. Mild problems, he asserted, deserve reimbursable, professional treatment.

To emphasize why, Kessler examined data from a follow-up study of subjects assessed in his original National Comorbidity Survey (NCS).³⁶ Kessler showed that mild problems identified in the original NCS often predicted the emergence of severe ones later. Thus a person who barely qualified for depression at time one wound up suffering from severe depression at time two. Providing early treatment for individuals with mild conditions might prevent the emergence of devastating illnesses down the road. This approach would be cost-effective as well as humane. Among people with recurrent depression, later episodes may be more resistant to treatment than first episodes.³⁷ Because depression may alter the brains of its victims, it is important to intervene early, before the person develops immunity to otherwise effective medications. Kessler also pointed out that many mental illnesses occur on a con-

tinuum with no clear, natural boundary between nondisorder and disorder.

By intervening early, doctors can prevent a condition from developing into a full-blown, potentially intractable disorder. If we wait before a mild condition reaches the severity of “clinical significance,” costs, let alone suffering, might be higher than they would otherwise have been. Similarly, doctors treat precancerous cells before full-blown cancer develops, and they treat high blood pressure to prevent stroke and heart attack. Why not the same for psychiatry? This argument, however, presupposes that mild psychiatric conditions seldom remit without treatment, and that most are destined to get worse. How often this cancerlike model applies to mental disorders is an open question.

Prevalence rates for mental disorder might be so high because lay interviewers overdiagnose mental disorders. Epidemiologists usually hire survey interviewers, not expensive psychiatrists, to conduct standardized, structured interviews. These interviews do not permit clinical judgment to enter the diagnostic process. Hence even highly trained lay interviewers might mistake normal emotional problems for symptoms of mental illness, inadvertently inflating prevalence rates. They might diagnose shyness as social phobia or sadness in response to life’s disappointments as major depressive disorder.

Kessler, however, has dismissed this objection. He points to studies showing that lay judgments and those of mental health professionals usually agree. In some cases, the psychiatrists actually diagnose disorder more often than do trained lay interviewers. If anything, lay interviewers may miss disorders rather than overdiagnose them. This seemingly implies that epidemiologic surveys underestimate the true prevalence of mental illness.

Perhaps the criteria for diagnosing disorders are themselves flawed. In addition to identifying the truly disordered, they may

also pick up false positives—people whose “symptoms” are merely transient emotional responses to the difficulties of everyday life. Even if lay interviewers apply the criteria properly, they may wind up overdiagnosing disorder if the criteria themselves are too inclusive. Indeed, psychiatrists developed diagnostic criteria for distinguishing among mental disorders in clinics and hospitals, not in the community. As Regier and colleagues observed, “The human organism has a limited repertoire of response patterns to various physical, biological, and emotional stresses. Transient changes in blood pressure, pulse rate, body temperature, anxiety, or mood are not always indicators of pathology but of appropriate adaptive responses.”³⁸ As people try to cope with the difficulties of everyday life, their behavior, thoughts, and emotions vary, sometimes in distressing ways. Yet not all of these changes indicate that something is wrong with their mind. No one is happy all the time.

Narrow aimed to estimate the need for professional mental health treatment, not the true prevalence of mental illness in the community. To determine the prevalence of mental disorders independent of treatment seeking is why epidemiologists conduct their studies in the general population in the first place. Moreover, diagnostic status is conceptually unrelated to treatment seeking: many people who do not have a mental disorder seek help from mental health professionals, and many people with a mental disorder do not seek help. Ascertaining the rates of mental disorder and estimating treatment need are related, but distinct, issues. As Jerome Wakefield and Robert Spitzer argued, Narrow’s approach to recalibrating prevalence rates—calling something a disorder only when it has clinically significant consequences—fails to solve the real problem afflicting the field: distinguishing mental disorders from emotional problems that do not signify psychopathology.³⁹ Not all forms of suffering, including intense suffering, signify mental illness. Grief in response to the sudden loss of a loved one does not

suggest mental illness on the part of the bereaved person. Evolution has not designed people to be eternally happy, and mental distress is not equivalent to mental illness. The concept of mental disorder implies that something internal to the person's psychobiology is not functioning properly. Yet our way of diagnosing disorders today ignores the context of suffering, focusing on symptoms, and thereby increasing the risk of classifying people as disordered whose suffering does not arise from mental illness at all.

The problem may lie in the DSM itself. Continuing a tradition inaugurated in 1980 with the appearance of the third edition of the psychiatric "bible," the current version defines each discrete disorder by its symptoms, not by its causes. Although this approach has been immensely successful in many ways, some experts believe that this purely descriptive approach to defining mental disorders has outlived its usefulness and may be blocking further progress.⁴⁰ Yet there are good reasons that the descriptive approach took over the field, its now-apparent limitations notwithstanding. It emerged in response to a crisis of legitimacy that struck psychiatry in the 1960s and 1970s.

The debate about the apparent epidemic of mental illness could not have occurred had the APA not entirely transformed diagnostic practice in 1980 with its publication of DSM-III.⁴¹ The third edition of the diagnostic manual specified explicit diagnostic criteria for each disorder, essential for the conduct of objective, structured interviews integral to modern epidemiology. The first two versions of the DSM provided only brief, narrative descriptions of mental disorders, not explicit descriptions of symptoms and the number needed for a person to qualify for a diagnosis.

Consider the DSM-II definition of *inadequate personality disorder*. According to DSM-II, "This behavior pattern is characterized by ineffectual responses to emotional, social, intellectual and physical

demands. While the patient seems neither physically nor mentally deficient, he does manifest inadaptability, ineptness, poor judgment, social instability, and lack of physical and emotional stamina.⁴² Given this vague description, how could we ever be sure whether someone truly suffered from inadequate personality disorder? As it turns out, the DSM-III committee didn't even try to provide a specific, objective set of criteria for this one. A victim of its own terminal vagueness, inadequate personality disorder was consigned to the dustbin of psychiatric history.

Few psychiatrists worried very much about diagnostic disagreement in the years prior to DSM-III's publication. Interest in scientifically rigorous diagnostic criteria was minimal. The subfield of psychiatric diagnosis was an intellectual backwater that attracted little professional attention, and for good reason. Until the discovery of drugs effective against psychotic symptoms, doctors could do little more than provide custodial care for patients by confining them to large asylums and experimenting with physical interventions, such as prefrontal lobotomy.⁴³ Getting the correct diagnosis becomes important only given the availability of specific treatments that are more effective for one disease than for another. If nothing seems to work, diagnosis does not count for much. The discovery of effective medications for treating psychotic symptoms, such as hallucinations and delusions, and for treating mood disturbances changed things. Once phenothiazines became available for schizophrenia and lithium for manic-depressive illness, diagnosis began to matter because it suddenly had treatment implications.

The hegemony of psychoanalysis during psychiatry's postwar pinnacle of prestige likewise acted to downgrade the importance of diagnosis. During the 1940s and 1950s, increasing numbers of psychiatrists worked outside the asylum, treating troubled individuals in long-term psychodynamic psychotherapy. Under the sway of Freud, therapists regarded symptoms as idiosyncratic symbols of

unconscious conflicts, not straightforward indications of specific illnesses. Because the meaning of a symptom varied from patient to patient depending on the individual's psychic conflicts, diagnosis was irrelevant. The goal was to understand and treat the unconscious source of the problem, not to assess symptoms to arrive at a correct medical diagnosis. Moreover, if psychoanalytic psychotherapy were the treatment of choice for anyone who sought help, getting the diagnosis right would have no bearing on treatment.

Psychoanalysis may have been a part of modernism's cultural avant-garde in the 1920s, but it had long become the core of mainstream outpatient psychiatry by the 1960s. As with so many other established bastions of authority, psychiatry received fierce criticism. Even members of the discipline attacked its legitimacy as a medical specialty. "Antipsychiatrists" such as David Cooper and R. D. Laing held that seriously mentally ill people were undergoing an inner voyage of discovery. As Laing put it, "We can no longer assume that such a voyage is an illness that has to be treated."⁴⁴ He regarded psychosis as more of a breakthrough than a breakdown. The antipsychiatrists viewed schizophrenia as an expectable, adaptive response to an insane world, often blaming the patient's family as the source of the disturbance. Psychiatric disorders were not medical diseases but consequences of unjust social, political, and economic conditions.

From the perspective of the twenty-first century, these views seem quaint and naïve, and they never gained much traction within psychiatry itself. However, they did manage to foster suspicion about the medical credentials of the field within American society. Indeed, the belief that psychiatry did not treat real diseases diminished its capacity to flourish. The popularity of the acclaimed film *One Flew over the Cuckoo's Nest* indicated just how widespread negative views of the field had become by the 1970s.

The psychiatrist Thomas Szasz has long sought to undermine

psychiatry's legitimacy as a medical specialty.⁴⁵ Proclaiming that mental illness is a myth, not a disease, he argues that conditions such as schizophrenia fall outside the jurisdiction of medicine. People called "schizophrenic," he acknowledges, may behave oddly, but their behavior reflects problems in living, not symptoms of a disease. He argues that the concept of mental illness is an oxymoron because illness can only affect the body, not the mind. If scientists were to discover that brain pathology causes schizophrenia, then that would qualify the disorder as a neurological disease, not a mental illness.

Contrary to what many people think, Szasz is not an antipsychiatrist. He does not object to contractual psychotherapy whereby clients voluntarily seek help and advice from psychiatrists when they experience problems in day-to-day life. Rather, he objects to the loss of liberty associated with involuntary hospitalization and treatment. Like the antipsychiatrists, however, Szasz has had little impact within psychiatry itself other than raising awareness about the ethics of involuntary treatment. Indeed, the evidence that schizophrenia is associated with brain pathology is undeniable.⁴⁶ Yet psychiatrists have not concluded that schizophrenia no longer counts as a mental disorder whose treatment should be the responsibility of neurology. Psychiatrists are not dualists who consider their province to be treatment of a disembodied mind unrelated to dysfunction of the brain.

Social scientists likewise challenged the medical legitimacy of psychiatry in the 1960s and 1970s. The sociologist Thomas Scheff held that people who get labeled "mentally ill" begin by breaking certain unwritten rules in public settings.⁴⁷ There is no law against mumbling to oneself in public, but doing so violates implicit social norms and counts as a kind of rule breaking. Those who violate such rules are labeled mentally ill, and their behavior gradually conforms to the label imposed on them. In this regard, social forces

transform minor deviance into full-blown “mental illness.” Again, society is the main culprit, not some disease process within the person.

Scheff popularized the view that what counts as a mental disorder varies according to social circumstances. Yet he had little impact on mainstream psychiatry. He was never very clear about the social norms whose violation earns someone a label of mental illness. Although psychotic behavior surely violates norms, there is more to psychosis than merely mumbling in public.

Psychiatry’s crisis as a legitimate medical specialty culminated in a controversy ignited by the social psychologist David Rosenhan’s provocative article in *Science* in 1973 titled “On Being Sane in Insane Places.”⁴⁸ Rosenhan and seven other psychiatrically normal individuals got themselves admitted to inpatient psychiatric units at twelve different hospitals. Each complained of a single symptom: auditory hallucinations of a single word: “thud,” “hollow,” or “empty.” During the intake interview and their inpatient stay, averaging nineteen days, the pseudopatients behaved normally and complained of no further symptoms. One received a discharge diagnosis of schizophrenia, whereas the others received a discharge diagnosis of schizophrenia in remission. The failure of the psychiatrists to detect the sanity of the pseudopatients led Rosenhan to conclude, “We now know that we cannot distinguish insanity from sanity.”

Rosenhan’s study implied that social context was far more important than symptoms themselves in the diagnostic process. An insane context, such as an inpatient psychiatric unit, drastically colored how staff interpreted the behavior of patients. Rosenhan’s study amounted to a critique of the *validity* of psychiatric diagnosis. Valid diagnostic criteria correctly identify those with the disorder and exclude those without the disorder. Validity, in turn, requires diagnostic *reliability*. If the diagnostic criteria for a disorder are reli-

able, then two clinicians who interview the same patient should arrive at the same diagnosis. If the diagnostic criteria are vague, rendering them subject to idiosyncratic interpretation by different doctors, then they will be unreliable. The validity of a diagnosis presupposes its reliability. We must be able to measure phenomena reliably before we can investigate their causes and treatments. Reliability, by contrast, does not presuppose validity. Indeed, the reliability of the discharge diagnoses in the Rosenhan study was remarkably high. Seven of the eight pseudopatients received a diagnosis of schizophrenia in remission, whereas the other received a diagnosis of schizophrenia. But the validity of the diagnoses was abysmal; none of the pseudopatients actually had schizophrenia.

Many other studies on the reliability of psychiatric diagnosis conducted during the 1960s and 1970s were not encouraging. In one study, American and British psychiatrists who viewed videotaped interviews with patients differed dramatically in the diagnoses they assigned.⁴⁹ The same patient might receive a diagnosis of schizophrenia from one doctor, a diagnosis of manic-depression from another, and a diagnosis of personality disorder from a third doctor. Worse yet, disagreement occurred even at the level of symptoms. For example, after viewing one of the videotaped interviews, 67 percent of American psychiatrists noted that the patient had delusions, whereas only 12 percent of British psychiatrists did so. Not only were the diagnoses vague, but the criteria for identifying symptoms were, too.

The strangest episode leading to the diagnostic revolution embodied in DSM-III was the disappearance of homosexuality as a psychiatric diagnosis by democratic vote of APA members.⁵⁰ In DSM-II, homosexuality appeared among “sexual deviations”—a category including syndromes such as necrophilia, pedophilia, and sexual sadism. Psychoanalytic doctrine held that homosexuality was rooted in unconscious infantile conflicts induced by a cold, reject-

ing father and an overprotective mother. Helping the patient uncover and resolve these conflicts would presumably cure his homosexuality.

Gay activists strongly objected to this characterization, and they began to stage protests at APA meetings in the early 1970s. At the 1970 meeting, activists disrupted a session on the treatment of homosexuality, seizing the microphone and denouncing aversive techniques for altering sexual orientation. Disruptions occurred the following year, and activists demanded the removal of homosexuality from the DSM-II. To placate the activists, the APA scheduled sessions to allow gay speakers to present their point of view. Dr. Anonymous, a hooded and cloaked gay psychiatrist, gave the most riveting presentation. He revealed that more than 200 APA members were homosexual, and that this group, the Gay Psychiatric Association, met secretly each year at the annual APA conference.

In the fall of 1972, the Columbia University psychiatrist Robert Spitzer attended the annual conference of the Association for Advancement of Behavior Therapy (AABT). Behavior therapists had developed Pavlovian conditioning techniques designed to help homosexual patients who sought to change their sexual orientation. One method involved showing the patient pictures of men engaging in homosexual activity and then delivering painful electric shocks to the patient's forearm as he fantasized about the men in the pictures.⁵¹ Another method, orgasmic reconditioning, required patients to masturbate in the privacy of their homes while engaging in homosexual fantasy and then switch to heterosexual fantasy prior to orgasm. Behavior therapists have long ceased any attempt to "treat" homosexuality, influenced by the AABT president Gerald Davison, who criticized the ethics of the practice in his 1974 presidential address.⁵² Yet in 1972, attempts to change sexual orientation were still occurring, and for this reason, more than one hundred

gay activists caused a disruption at the conference. After the protest, Spitzer lingered behind to speak with the organizer of the demonstration. They discussed their respective views on homosexuality as a form of mental illness. The conversation ended with Spitzer promising to arrange a meeting between the activists and the APA's Committee on Nomenclature and to schedule a panel on homosexuality at the next APA convention.

The panel included a gay activist as well as psychiatrists on both sides of the debate regarding the APA's position on homosexuality. Spitzer also received an invitation to attend the secret meeting of the Gay Psychiatric Association at APA. He was impressed by these high-functioning psychiatrists, individuals who were not at all distressed by their sexual orientation. The obvious mental health of the gay psychiatrists convinced Spitzer that homosexuality per se was not a mental disorder.

Spitzer soon spearheaded the movement to remove the diagnosis from the next printing of the DSM-II. After several APA committees approved the change, the association's Board of Trustees voted unanimously in favor of declassifying homosexuality as a mental disorder.

Traditional psychoanalysts were enraged. They mobilized their colleagues to support a referendum to decide whether the decision should be reversed. Although both sides of the debate couched their arguments in terms of science, democracy prevailed. The APA voted to determine whether homosexuality is a mental disorder. The poll of APA members indicated that 58 percent favored eliminating homosexuality from the DSM, whereas 37 percent opposed the move.⁵³ Formal democratic procedures seldom answer classification questions in science. Indeed, until astronomers recently voted to kick Pluto out of the planetary solar system, the APA vote to decertify homosexuality as a mental disorder may have been the only instance in modern times. Doctors are disinclined to re-

sort to democracy when considering whether something counts as a disease.⁵⁴

The declassification of homosexuality as a mental disorder pleased political progressives and angered political conservatives. But the democratic process by which the APA resolved the controversy did nothing to encourage the view that psychiatry was a scientific discipline. In fact, it showed that psychiatry had no principled basis for distinguishing mental disorders from other aspects of human functioning. When gay activists challenged psychiatry to explain why homosexuality was a form of mental illness, the field had no good answer.

Treaty obligations with the World Health Organization (WHO) determine when the APA revises its diagnostic manual, and the process for revising DSM was about to begin as Spitzer was successfully resolving the embarrassing public controversy over homosexuality. His interest in diagnosis, his energy, and his skill at mediating bitter disputes in the field earned him the chairmanship of the task force to revise DSM. As the leader of the DSM-III process, he wound up transforming the field of psychiatry.

Spitzer was among a small cadre of psychiatrists, many from Columbia University and Washington University, who were dissatisfied with the abysmal state of diagnosis and with psychiatry's marginal status in modern scientific medicine. If psychiatrists cannot reliably decide who has what disorder—or whether a person has a disorder at all—it is impossible to conduct the research necessary to ascertain the causes and cures for mental illness.

Fortunately, psychiatric researchers at Columbia and Washington Universities had already elucidated “operational” criteria for defining discrete mental disorders as an essential prelude to conducting research on the course of illness, family history, causes, and so forth.⁵⁵ The operational emphasis entailed careful description of

the signs and symptoms of mental disorder, unencumbered by psychoanalytic assumptions about their causes. This descriptive approach precluded speculation about why a person had a disorder. It drew inspiration from Freud's contemporary Emil Kraepelin, whose pioneering work with psychotic inpatients had been eclipsed by the glamour of psychoanalysis.

For assistance revising the manual, Spitzer recruited psychiatrists keen to overhaul the DSM, placing it firmly on a descriptive neo-Kraepelinian basis. DSM-III represented a radical break from tradition, and it encountered stiff resistance from many groups, especially psychoanalysts.⁵⁶ The new approach, though, promised many benefits. By providing clear, explicit descriptions of diagnostic criteria, it allowed clinicians and researchers of diverse theoretical persuasions—psychodynamic, cognitive, behavioral, and biological—to agree, at least in principle, whether someone qualified for a certain diagnosis, even if they could not agree about its causes. DSM-III promised to solve the reliability problem; whether it consistently did so remains a matter of debate.⁵⁷ Suffice it to say, clinicians and researchers could diagnose reliably, as many studies have shown, even if they sometimes failed to do so.

DSM-I and DSM-II did not contain a definition of mental disorder, thereby fostering confusion about the professional bailiwick of psychiatry, as critics noted. To rectify this omission, Spitzer wrote a working definition of mental disorder that appears, with minor modifications, in the current manual:

In *DSM-IV*, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syn-

drome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.⁵⁸

Importantly, this definition answers critics who claimed that psychiatrists classify mere social deviance as mental illness. It specifies that the problem must originate within the person, placing it in the domain of mental health rather than of law enforcement, for example. Moreover, the internal dysfunction must cause the individual suffering or harm. This proviso would presumably justify the exclusion of homosexuality on the grounds that gays comfortable with their sexual orientation suffer no harm other than homophobic discrimination.

Spitzer chaired an interim revision of the manual, DSM-III-R, which appeared in 1987. Allen Frances replaced him as chair of DSM-IV, which appeared in 1994. Another edition of DSM-IV came out in 2000, but this one chiefly updated the accompanying text; it contained few changes to diagnostic criteria.⁵⁹

By enabling reliable diagnosis, the atheoretical, descriptive tradition inaugurated by DSM-III has transformed the study and treatment of mental disorders throughout the world. It has spurred the growth of psychiatric epidemiology, basic research on the cognitive, behavioral, and biological aspects of mental illness, and it has paved the way for the development and evaluation of new psychological and psychopharmacological treatments. As a diagnostic lingua franca, DSM-III and its successors have provided the indispensable foundation for progress.

Yet all is not well in the field of mental health, and the descriptive approach of the DSM may be part of the problem. In other areas of medicine, doctors identify a disease not only by its symptoms but also by its causes (etiology) and the resultant bodily dysfunction (pathophysiology). Symptoms of fever, weakness, and a persistent cough are consistent with the presence of many diseases, and doctors must probe further, conducting additional tests to confirm a diagnosis. In contrast, doctors dealing with mental disorders have traditionally lacked laboratory tests that can illuminate etiology and pathophysiology. However, information about the context of the symptoms and their course can sometimes help distinguish mental disorders from normal emotional reactions. Knowing that a person reporting symptoms of depression has suddenly lost a loved one, for example, provides important context for the practitioner.

Skepticism about the epidemic arises partly from the increase in the number of mental disorders recognized by psychiatry. In a seminal 1972 article that inspired the DSM-III revolution, John Feighner and his colleagues provided explicit criteria suitable for advancing research.⁶⁰ They listed a mere 14 syndromes for which they believed there was good scientific evidence. DSM-III greatly expanded the number of syndromes, coding for 211 discrete mental disorders. DSM-IV further expanded the number to 341 disorders. Has psychiatry actually discovered 327 new forms of mental illness unknown to doctors in 1972?

There are several reasons for the growth in the number of diagnoses. Professional and economic factors required that the discrete entities appearing in DSM-III cover the kinds of problems that psychiatrists routinely encounter in their clinical practice.⁶¹ If the DSM-III were to recognize only the short list of syndromes deemed validated by Feighner and colleagues, then many people treated in outpatient settings would fall outside the scope of reimbursable practice. Something had to change.

Differentiation within existing categories likewise multiplied the number of discretely coded diagnoses. For example, the DSM-III committee divided the DSM-II diagnosis of phobic neurosis into simple phobia, social phobia, and agoraphobia. The DSM-IV committee changed the name of simple phobia to specific phobia, further dividing it into subtypes (for example, fear of fainting at the sight of blood; animal phobia; situational phobia, such as fear of enclosed spaces). In this case, doctors did not discover new disorders so much as make new distinctions within one subtype of an established diagnosis.

More controversial, however, are cases of problems that now fall under the rubric of mental illness but seem rather far removed from prototypical mental disorders such as schizophrenia and major depression. Among these are relatively trivial problems, such as caffeine-induced sleep disorder. Even more controversial are the seemingly expanding boundaries of mental disorders that underscore the problem of distinguishing between the normal range of human emotions and disorder. Critics worry that we are medicalizing more and more of human life. Are we, for example, medicalizing normal sadness, confusing it with the disease of depression? Are we now diagnosing shy people as suffering from social anxiety disorder?

Then there's the question of just who benefits from expanding the definition of mental disorder. The pharmaceutical industry, for one. Mental health professionals, psychotherapists as well as psychopharmacologists, also stand to benefit from an expanded scope of reimbursable disorders. There is money in madness. In contrast, managed-care companies and others responsible for paying the bill favor restricting the scope of disorder.

Money aside, if our diagnostic criteria fail to distinguish between the truly disordered and the normally distressed, studies on the efficacy of treatment will be invalid. For example, clinical trials

on major depressive disorder have yielded placebo response rates that range from 12.5 percent to 51.8 percent.⁶² As many as 50 percent of people recover from depression by swallowing sugar pills for a few months. Given this number, we have to wonder if the diagnostic criteria for this illness are so broad that they wind up including people whose symptoms do not signify the presence of the depressive disease. The diagnostic criteria for major depressive disorder may capture an extremely heterogeneous group of people whose problems have diverse etiologies and pathophysiologies.

Similar problems occur with posttraumatic stress disorder (PTSD). The original diagnostic criteria described a syndrome arising from extreme life-threatening events, such as combat. Current criteria enable individuals to qualify for PTSD who have been horrified by *learning about others* who have been trauma-exposed. For example, citing survey data, one research group argued that about 4 percent of Americans developed PTSD after watching televised coverage of the terrorist attacks occurring on September 11, 2001.⁶³ Yet it is implausible that individuals whose “PTSD” was caused by television have much in common with people whose PTSD arose from personal trauma. Regardless of the PTSD symptoms they acknowledged on a survey, the first group is unlikely to share a psychology with the survivors of terrorist attacks themselves.

In this book I evaluate current attempts to clarify the boundary between mental disorder and mental distress. Unlike other medical issues, psychiatric problems uniquely strike at our very sense of self. As the perimeter of what counts as mental illness continues to expand, people worry more than ever about whether their emotional difficulties signify a serious psychiatric condition, and, if so, what to do about it. Many critics, for their part, accuse mental health professionals of pathologizing normal emotional responses to the stressors of everyday life.

Consider depression. As the psychiatrist Peter Kramer has observed, there is a left-wing perspective and a right-wing perspective on the disorder.⁶⁴ Both express reservations about treating depression, but for different reasons. From the perspective of the left, depression indicates refined intellectual and aesthetic sensibilities. To this way of thinking, treating depression runs the risk of destroying the source of creativity. Would antidepressant medication have blunted the genius of van Gogh, Beethoven, and Virginia Woolf? Less dramatically, others worry that giving pills to poor, disadvantaged people who suffer from depression only masks the social and economic causes of understandable emotional suffering.

From the perspective of the right, people should maintain a stiff upper lip as they struggle against life's adversities. Reliance on medication and psychotherapy runs the risk of undermining the mental toughness and moral fiber of our nation. The upshot is that forces outside as well as inside the mental health field tug at the boundary between mental distress and mental disorder, and, by implication, affect the decision to initiate treatment.

As this book will show, there is no infallible boundary separating mental distress from mental disorder. This does not mean, however, that "mental illness" is nothing but an arbitrary social convention. Far from it. Clinical scientists have provided abundant psychological and biological data that go a long way toward answering the question "What is mental illness?" The results of their labors show that cases of mental illness possess many properties lacking in cases of mental distress. Yet because the boundary between the two is a fuzzy one, social, political, and economic factors often prove decisive when it comes to deciding whether ambiguous cases count as mental illness or mental disorder (I use these terms interchangeably). Decisions about cases straddling the boundary between distress and disorder are not merely semantic quibbles.

They have consequences. Whether someone secures treatment for their suffering often turns on how these matters are decided.

It has become fashionable to trash psychiatry and to bash its “bible,” the DSM. I am not a DSM-basher. I am a clinical psychologist and experimental psychopathologist who served on the PTSD and specific phobia committees of the DSM-IV. I currently serve as an external advisor to the groups responsible for revisiting and revising the diagnostic criteria for panic disorder and for PTSD. I am often critical of trends in psychiatry, but I’m a friendly critic, one who’s keen to make constructive suggestions about the direction of the field and how we understand and treat mental disorders.