Book

Boundary disputes

It's not easy being a psychiatrist, and I should know because I am one. On the one hand, people come to see us unhappy because their neighbours are vile, lonely because their marriage is without affection, or worried that their child is about to be excluded from school for behaving badly. We sympathise, but after the consultation will inform the general practitioner that there is no evidence of mental disorder, and recommend a social worker, solicitor, marriage guidance counsellor, or some classes in more consistent parenting. Yet, on the other hand, those who think that psychiatry is about more than managing people with well defined disorders, such as psychosis, major depression, or autism, and who devote their careers to demonstrating that mental disorders lie on continuums, and that restricting ourselves to treating just the severe end of the spectrum is rather like a cardiologist announcing she will only deal with malignant hypertension, are often castigated for extending the boundaries of mental health disorders and medicalising the normal.

These latter psychiatrists are most in the firing line nowadays. Typically, they are caricatured as psychiatric entrepreneurs, at best perversely labelling normal emotions as pathological, and doing so to benefit pharmaceutical companies that are always on the look-out for new diagnoses and hence new markets. And because we are talking psychiatry, it is inevitable that some of the most public critiques of this position come from within our ranks. Psychiatry has many failings, but maintaining a Stalinistic orthodoxy, suppressing dissent, and discouraging argument are not among them. Far from it, we like nothing better than a good row, particularly when aimed at ourselves.

But why is this particular row now the subject of so many books, articles, and reviews criticising the new psychiatric imperialism? The answer is the imminent arrival of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*-5), the latest attempt by the American Psychiatric Association to do the impossible: to classify psychiatric disorder in a logical, consistent, reliable manner—and to do so in a way that satisfies all.

> **"We are seeing the progressive demedicalisation of psychiatry allied to the deprofessionalisation of treatment."**

DSM is not new. We had *DSM-I* in 1952 and *DSM-II* in 1968, but few people paid much attention to it. It was the introduction of *DSM-III* in 1980 that was the game changer. There were compelling reasons for the change. Psychoanalysis seemed to be going nowhere. Biological psychiatry held real promise, mandating a more overtly scientific approach. Psychiatric epidemiology was getting into its stride, and was showing how many people in the community were experiencing mental health problems that never came near the psychiatrist, were associated with substantial morbidity, and were also potentially treatable.

DSM-III achieved a great many things. The reliability with which psychiatrists made diagnoses was transformed. Research blossomed, particularly epidemiology, which required short, sharp, and easily learned criteria that could be administered by non-psychiatrists, rather than the endless years of training mandated by the various analytic schools. And the insistence on rigorous and reliable observation seemed to support a genuinely more scientific discipline. The problem was that the ball did not stop rolling. *DSM-III* was revised, and then came *DSM-IV*, followed by its revision. With each revision the number of diagnoses increased, and there is no reason to believe that this process will be halted with *DSM*-5 (although quite why the Roman numeral is being replaced by the Arabic remains a mystery).

Allan Horwitz and Jerome Wakefield have been persistent critics of the *DSM* diagnostic process. In their 2007 book *The Loss of Sadness*, they provided a cogent argument against the pathologisation of that most normal human emotion, and its replacement by the seemingly unstoppable rise of depression. Others, such as Christopher Lane, have written about how shy kids have been transformed into sufferers from social phobia. And now in *All We Have to Fear*, Horwitz and Wakefield make much the same point about anxiety disorders in general. They spend a lot of time discussing differences between normal anxiety that is part of human experience, such as anyone might feel on being confronted by an armed robber, for example, and pathological anxiety that affects only a small number of people when confronted by a harmless spider. All told, as Marcia Angell, one time Editor of *The New England Journal of Medicine*, wrote in *The New York Review of Books* "it looks as though it will be harder and harder to be normal".

Angell's ire seemed particularly aimed at those psychiatrists fortunate to be identified as "key opinion formers" and the pharmaceutical industry. When one sees the dramatic rise in diagnoses such as attention deficit hyperactivity disorder or juvenile bipolar disorder, it is easy to blame the increasingly aggressive promotions of psychotropic drugs, not least when pharmaceutical companies seem to have actively manipulated the playing field. But that is not the whole story. Autism spectrum

All We Have to Fear: Psychiatry's Transformation of Natural Anxieties into Mental Disorders
Allan Horwitz, Jerome Wakefield. Oxford University Press, 2012
Pp 304. US$29·95.
ISBN 9780199793754

For **Marcia Angell's "The Illusions of Psychiatry" in *The New York Review of Books* (July 14, 2011)** see http://www.nybooks.com/articles/archives/2011/jul/14/illusions-of-psychiatry

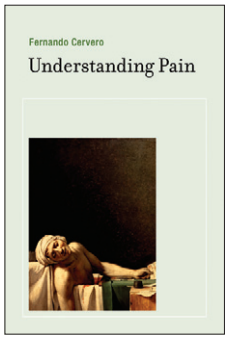
For **Andrew Scull's "Psychiatry's Legitimacy Crisis" in *The Los Angeles Review of Books* (Aug 8, 2012)** see http://lareviewofbooks.org/article.php?id=812&fulltext=1

disorders, such as Asperger's, are also showing similar exponential increases, without the active involvement of pharmaceutical companies. Some parents will prefer to explain their child's problematic behaviours as due to genes or disordered development rather than discord and inconsistent parenting, and can react vehemently to those who suggest the opposite. Andrew Scull, writing in *The Los Angeles Review of Books,* drew attention to the opprobrium that visited Allen Frances, ironically one of the key architects of the *DSM* process, but who came to view his own contribution to expanding the diagnostic boundaries of autism as something he now regrets—"Particularly vocal in online discussions have been the parents of children diagnosed with autism, for whom the loss of the label will mean being deprived of social services and support that is conditional on retaining that status. At times, the vituperation that has rained down on Frances's head has been extraordinary—and indeed it's hard not to form a mental image of families all across the country sticking pins into a Frances voodoo doll."

Horwitz and Wakefield put together a strong intellectual case for what my military friends might call psychiatric "mission creep", albeit weakened by a couple of questionable assumptions that when Cicero talked about anxiety he meant the same as we do, or that it is safe to assume that Hippocrates knew about social anxiety disorder.

But at the same time, I wonder if Horwitz and Wakefield are living in the same world as I am, at least here in the UK, where it is becoming increasingly hard for psychiatrists to treat anything other than the extremes of pathology. Neurosis has practically vanished from the psychiatric clinic. General practitioners will tell you of the struggle it takes to get a good clinical assessment, let alone treatment, for anyone who is not psychotic or suicidal. And when you do, the outcomes are becoming increasingly "depsychiatrised". In the UK, the Increasing Access to Psychological Treatment (IAPT) programme is doing its best, but beyond, and occasionally within it, "wellbeing practitioners" now diagnose on the telephone and self-help as opposed to professional help is in vogue. The voluntary sector, offering more democratic, user-led, and cheaper options now challenges psychiatry across the board. We are seeing the progressive demedicalisation of psychiatry allied to the deprofessionalisation of treatment. It is now possible to seek help for treatment on a Friday, and by Monday be enlisted in treating others with similar problems. This is no longer psychiatry, it is pyramid selling.

Simon Wessely
simon.wessely@kcl.ac.uk



Understanding Pain
Fernando Cervero. MIT Press, 2012. Pp 192. US$24·95.
ISBN 9780262018043

In brief

Book The problem of pain

Few things are as universally experienced and yet incompletely understood as pain. All of us are familiar with it, but centuries of experience and study have failed to produce comprehensive understandings. Pain is ubiquitous but diverse in presentation. It is easily identified but difficult to treat. It can promote function through injury avoidance or become the source of crippling debilitation itself.

In *Understanding Pain,* neuroscientist Fernando Cervero addresses these difficulties surrounding pain. To decode its mysteries while respecting its complexities, Cervero methodically outlines mechanistic understandings and philosophically explores pain's role in human experience. By guiding readers through a history of pain theory, Cervero unearths important ideas: that we process sensory stimuli in complex, sometimes unpredictable, ways; that permutations in processing produce diversity in pain types; that understanding can therefore be found in how the nervous system transforms stimuli into perception.

Importantly, Cervero transcends any simple dichotomous notion of "good" versus "bad" pain and explores areas of uncertainty. Many factors affect pain perception, obstacles complicate its measurement, and historically definitive therapies have proven disappointing. Through discussions about visceral pain, neuropathic pain, and pain modulation, Cervero displays an appreciation of these nuances and achieves a granularity and thoughtfulness required to discuss pain in meaningful ways.

Compared with Cervero's detailed accounts of receptors, pathways, and neural networks, *Understanding Pain* contains less discussion of the sociocultural and behavioural elements of pain. Given the importance of culture, community, economics, behaviour, and non-biomedical factors on pain, the book would have benefited from further exploration of these wider issues. Nonetheless, *Understanding Pain* elevates pain beyond symptom to multidimensional experience. Most importantly, Cervero's book affirms a unifying truth: that we learn about ourselves and our environments in a world marked by many pains—the kinds we rightly seek to eradicate, and the kinds we need to live—and the problem of knowing how to thrive between them.

Joshua Liao
jmliao@partners.org