

Psychiatry's Footling Psychosis: Why the DSM is damned, drugs don't work and Kraepelin is kaput

We think we think with our brains. But personally I think with my feet. That's the only way I really come into contact with anything solid. I do occasionally think with my forehead, when I bang into something. But I've seen enough electroencephalograms to know there's not the slightest trace of a thought in the brain.

Jacques Lacan

This gnomic utterance from Jacques Lacan, the famously incomprehensible French psychoanalyst, as much as any other prognostication, illustrates the state of disarray in psychiatry, the worst crisis in a century that brought great progress and order to a previously bleak discipline.

To understand this, one needs to head back to the *fin de siècle* era when German psychiatry led the way. Emil Kraepelin, the prudish Pope of the speciality, produced the first workable classification. In essence, what Kraepelin did was to make a clear distinction between dementia praecox (later called schizophrenia) and manic-depressive psychosis. The former was a condition from which there was no recovery while the latter was dominated by mood symptoms with full recovery between episodes. In addition, Kraepelin provided a hierarchy of disorders of lesser severity which were 'trumped' by higher order conditions.

Armed with Kraepelin's classification, psychiatrists could now investigate what had been untreatable, if not hopeless illnesses. Slowly but surely the developments came. In the thirties, there were the physical treatments, some ineffective but giving the world ECT, a

truly lifesaving cure in some cases. This was followed by the psychopharmacological revolution of the fifties, providing effective drugs to treat psychosis, depression, mania and anxiety.

Psychiatry had made enormous progress but there was a long way to go.

Which brings us to the present. While we have more disorders, more drugs and more therapies than ever, the degree of confusion, frustration and sense of stasis is widespread. This arises from three factors: the DSM catastrophe; the end of the Kraepelinian era; and the psychopharmacological mess.

In what can only be regarded as an unprecedented triumph of product marketing, the American Psychiatric Association (APA) created a brand that may be as well known as Apple or Coca Cola: the Diagnostic & Statistical Manual or DSM, appearing in various manifestations since 1980 and culminating in its latest incarnation DSM-5 in 2013. The DSM is mostly sold as a little pocket manual so the novice or the professional can easily run a finger along the neat flow chart to settle on one of many disorders, diagnostic features listed in dot point (anticipating the Power Point generation). This of course encourages a cookbook mentality, as opposed to the careful clinical examination by psychiatrist of patient.

The APA made many millions of dollars and can expect the rivers of gold to keep running for some time. The widespread acceptance of the DSM has been attributed to American medical imperialism. This may be questioned; what is more likely is that its anti-scientific impulse is

the selling point to psychiatrists, doctors, psychologists, social workers and other mental health workers. These are the simplistic listing of symptoms, promotion of fashionable conditions regardless of their validity and exponential growth in listed disorders. The latter feature is especially valued by non-psychiatrists. By converting everyday anxiety, grieving or over-eating – amidst many others – into official diagnoses, it provided a gratifying growth in insurance-funded work for the talking professions. The pathologization of daily life is in full flood.

The DSM arose from a gallimaufry of misplaced good intentions, individual enthusiasms, lobby groups (like the Viet Nam veterans), ruthless committee horse trading and, at times, witless ineptitude combined with surging careerism. Swept aside was 150 years of careful clinical observation, a high bar for validity (let alone reliability) of disorders and a belief that sooner or later a treatment for everything would emerge if they just set out the disorders.

While there had been reservations about the earlier editions, for example the cavalier and clinically unconfirmed version of Post-traumatic Stress Disorder (thereby creating another useful acronym PTSD), this was as nothing compared to the veritable storm that preceded and followed DSM-5 in 2013.

If there is no publicity like bad publicity, the marketers of DSM-V have every reason to be pleased. Since its release there has been an outpouring of books damning, from every point of view, the new psychiatric *Britannica*. So intense is the reaction that one can lay bets

as to how long it will be before a revised version is issued. This will not change the difficulties inherent in the system.

While many psychiatrists are prepared to take or leave DSM-V, using those aspects they consider valid and ignoring the rest, a larger epistemological problem looms. Kraepelin is kaput. His great distinction between manic-depressive psychosis and schizophrenia cannot be maintained. A growing series of studies shows that on clinical, outcome and genetic terms there is no real difference but rather a spectrum of symptoms from the purely psychotic to the affective. So to say that the paradigm has shifted is not just to state the obvious; a new program of research needs to be instigated on this basis. And, as would be expected, those of the old school who have an investment in the maintaining the old model are not giving ground easily.

At the lucrative temple of DSM the pharmacological industry should sacrifice a herd of prime beef every day. In a perfect meeting of mutual interests, the DSM creates illness categories for which the companies create suitable drugs, flooding the market with Prozac, Zyprexa and the likes. That these treatments are intended for committee-derived syndromes with little connection to clinical reality makes no difference; the market-driven industry feeds the sacred cow.

Far from providing patients with better choices, the new drugs are no better than the 'classic' psychotropics and, in some cases, distinctly worse. The much mooted lack of side effects has little to recommend. Conferences are now held to discuss the sexual problems caused by SSRIs and treating the metabolic syndromes (gross obesity, high

blood pressure, diabetes) caused by the new antipsychotics is something of a growth industry.

The fact remains that in the last three decades, if not longer, there has not been a single breakthrough in drug treatment, rather than variations on a theme which drug companies will frantically promote until the patent expires, then ignore from then on.

As a Prince of Wales once lamented “Something has to be done” – but what? An ahistorical psychiatry has to remember its hard-fought victories and defend its territory. It is not just another sector of mental health care but a clinical discipline in the medical profession that interacts appropriately with other carer groups. Those in academia need regular reminders that their research is not to enhance their career path but to enhance and improve the speciality. The feckless adherence to the catechism of DSM needs to be put where it belongs – in the junk bin of history – and a consensus reached that is based on clinical realities that have been reified over 150 years. In this regard, the new European classification ICD-11 has some promise – if the DSM contagion can be extirpated.

Areas of therapeutic change are coming. They include TMI, vagal stimulators and deep brain implants. Cognitive behavioural therapy has extended its range to the point that it can now be used for psychotic symptoms, something never envisaged before. But all these modalities require much investment and research before they come into general use.

Much as the Big Man (or Woman) theory of history has been discarded, is it too much to hope that somewhere there is a new Kraepelin (or Kraepelina) who is prepared to lead us out of the present mess? If it all sounds too messianic, it is a reflection of just how bad things have got. On the other hand, there is always the example of the late Lacan, who saw psychosis as arising in his perfectly-shod feet. Perhaps we haven't quite reached bottom yet.

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