American Medical Psychiatry: A Contemporary Case of Lysenkoism

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In a 2005 publication Robert Spitzer, the psychiatrist who spearheaded the APA's official paradigm shift to unsullied medicine, admitted that the false positive problem in psychiatry has proven to be insoluble. A symptoms-only approach to the problem of psychiatric diagnosis, although consistent with medical reasoning, ignores *background* and is thus blind to adversity and to the false positive problem. I argue that recognizing the reality of adversity, which can only be ascertained via dialogue and which ineradicably includes first person subjective components, cannot be assimilated to either medicine or science. Indeed the psychiatrist-patient encounter, in contrast to the physician-patient encounter, is nothing *but* social interaction, dialogue, and interpretation. The difference is so obvious and dramatic that it is hard to see how the claim that the psychiatrist-patient encounter is a *medical* encounter can be presented seriously. Recognizing the reality of adversity shifts the subject matter from medicine and science to something else entirely. I argue that the APA's paradigm shift at the end of the 1970s should be understood sociologically, i.e., in terms of the profession's adaptation to external threats and demands that were too powerful to ignore. I end by arguing that it is barely possible that the *DSM-5* Task Force's insistence on applying medical reasoning to all aspects of life may have created an enduring backlash among the non-medical mental health professions.

In a 2005 publication (Zimmerman and Spitzer) on the topic of psychiatric diagnosis, Robert Spitzer, the guiding spirit of the *DSM-III* revolution, admitted that the false positive problem in psychiatry has proven to be insoluble. He also noted that the problem and its insolubility is not a topic that commands much interest or discussion in psychiatry. He reasoned as follows: (a) it is unrealistic to overlook the possibility that the patient's "clinically significant" distress or social disability may be the result of adversity the patient has faced or is facing, and (b) there is no objective, scientific method for determining if the patient's reaction to adversity is or is not warranted, justified, proportionate, and so on. In short, a mental disorder diagnosis must be an arbitrary conclusion, meaning a conclusion that is not reached on the basis of objective scientific evidence. The fact that a patient may be judged to meet the criteria for this or that mental disorder diagnosis is irrelevant because the issue of whether the adversity the patient has faced justifies the symptoms or entitles the patient to the symptoms is not addressed merely by noting that the patient's symptoms fulfill the listed criteria for this or that mental disorder. Notwithstanding his admission that deciding whether or not a person has a mental disorder is arbitrary, Spitzer expressed no doubt that some people do suffer from a mental disorder. Evidently he is not impressed by the argument that a concept that does not lend itself to distinguishing between true and false positives on the basis of objective evidence cannot claim to be designating something that has an independent existence of its own. Presumably he thinks there is something to discover as opposed to something to judge or have an opinion about (contrast discovering the cause of type 1 diabetes to deciding that a painting is a masterpiece or that Joyce's *Ulysses* is or is not pornographic). He said he hopes that future discoveries in evolutionary psychology will shift what are now arbitrary decisions to evidence-based scientific decisions (I consider this grasping at straws, see Jacobs, 2010). But note that he does not elide the issue of adversity in a person's life and its connection to "symptoms." By admitting that adversity cannot realistically be overlooked he has de facto, as I will discuss, turned away from the position he was so instrumental

ushering in, namely the position that that the subject matter of psychiatry is medical conditions that announce their presence exclusively as far as anyone can tell by producing troubling social behavior (such as complaining of feeling depressed).

Adversity is a word (concept) that does not fit easily or at all into a medical or scientific framework of thought. Spitzer surely realizes this. It only makes sense to say that a *person* has faced or is facing adversity, so it would seem that all of the conceptual and linguistic apparatus of medicine and science becomes immediately irrelevant when what is at issue or under discussion is at the person-level and not the body/organism level. The adversity a person has faced or is facing cannot be adequately/realistically described from an external, third person perspective. Adversity cannot be described impersonally and objectively. Description depends upon first person disclosure. Third person access to first person experienced adversity depends upon dialogue; third person observation by itself cannot be adequate. Adversity connotes a first person, subjective component that cannot be overlooked. Since third person access to first person experienced adversity depends on disclosure and dialogue, depiction of adversity can always be amended during the course of real time dialogue or at any point after at the discretion of the informant. Since disclosure depends on social interaction and dialogue, the informant may say different things to different interlocutors. Since speech must be interpreted, the original interlocutor's understanding of what was said may diverge from the understanding of others who read the transcript or watch the videotape. Since the informant's description of adversity will frequently include reference to or connote or imply what could be called "symptoms," it is unnecessary and indeed misconceived to think of symptoms as an effect that is independent of the cause of the symptoms. For example, describing death of a loved one as a horrifying loss that left the informant alone and bereft in the world can hardly be considered a cause that is independent of its effects. In short it is misconceived to think that cause-effect reasoning is applicable here, and if this is the case then the subject matter falls

outside of scientific explanation, i.e., no impersonal causal process is involved, so no impersonal causal process can be discovered.

Small wonder that medical psychiatry shies away from endeavoring to surface, through dialogue, the patient's exposure to adversity (and related considerations: situation, predicament, history, background, backstory…). As soon as adversity and related considerations are allowed on stage the jig is basically up in so far as the claim that the subject matter at hand is medicine or that scientific research and explanation are pertinent. Once adversity and related considerations begin to be discussed there is no hiding that what is primarily occurring is social interaction, disclosure, dialogue, interpretation, interviewing, and so on. It will be apparent that no disclosure can be considered definitive in the sense that there is nothing left to say that might be pertinent, that the specific clinician as interlocutor and interpreter of what the patient says plays an active and irreproducible role in what emerges in the interview, that whether the patient is entitled to his "symptoms" given the background he reveals is an unabashedly ad hoc moral interpretation on the part of the clinician or anyone else who has access to the transcript, that the clinician's written summary of a series of interviews or sessions has basically the same relation to what the client literally said as a book review has to the book reviewed, and so on. In short as soon as adversity and related considerations are allowed on stage it is more than apparent that the encounter between psychiatrist and patient is anything but a medical encounter. Unlike the physician-patient encounter, in the psychiatrist-patient encounter there is nowhere to go except more talking. The psychiatrist can prescribe drugs, but that does not except in a circular ex juvantibus sense bear on what was the matter in the first place (see for example Moncrieff, 2008). Healy (2012) emphasizes that the sponsoring pharmaceutical companies themselves both strongly influence if not de facto create the definition of psychiatric disorders and develop assessment of treatment measures that are designed to favor the effects of the drug they wish to promote. In numerous publications (e.g., 2000) Healy has pointed out that unambiguously positive indications of treatment outcome, like returns to work or discharge from hospital,

have been rejected by the entire psychiatry-Pharma-NIMH-FDA complex in favor of rating scales. The use of rating scales permits claims of treatment "success" in randomized, placebo controlled drug studies on the basis of what may be clinically insignificant statistical differences between active drug and placebo group. Large, multi-site drug studies which enlist hundreds or thousands of subjects allow very small rating scale differences between active medication group and placebo group to reach statistical significance. The outcome measure of note is almost always the supposedly blinded assessment of the researcher who administered the drug and asked about side effects throughout the course of the typically very short drug treatment study. Quality of life measures are frequently administered but rarely reported. Adverse drug effects are under scrutinized and under reported. Since the pharmaceutical industry itself is primarily in charge of the design, execution, interpretation, and promotion of drug studies, hanky panky has basically run riot (e.g., see Cohen and Jacobs, 2010, and Jacobs and Cohen, 2010).

The only way to sidestep the glaringly moral-interpretive issue concerning to what extent the patient's background justifies or entitles her to her distress or quirks or social difficulties is to make up supposedly discrete mental disorders conceived as idiopathic medical conditions defined exclusively on the basis of "symptoms" and to essentially turn a blind eye to adversity and related considerations. Although no actual medical discoveries bearing on psychiatric diagnosis occurred between *DSM-III-R* and the publication of *DSM-IV,* the APA officially banished psychogenesis from existence in *DSM-IV* (see the definition of primary mental disorder in *DSM-IV,* p. 165). A careful reading of the *DSM* offers only the barest suggestion that psychiatric patients have faced conditions of living that are worth remarking upon. This is of course entirely in keeping with the position that psychiatric disorders are in fact impersonal medical conditions, presumably endogenous neurological flaws. If adversity is acknowledged, as in PTSD and Adjustment Disorder, it is none the less taken for granted that the suffering individual is literally sick or disordered, since according to medical reasoning it would be absurd to argue that the suffering person's experience of adversity

entitles him to his distress or social difficulties. It may be perfectly ordinary to say that a bereaved person is entitled to grief, but this is not medical reasoning. From the perspective of medical reasoning "entitled to" is a foreign and absurd idea; the body is never entitled to fail to function as desired and expected. It does not matter what situation an individual might be in, the pancreas for example is never "entitled to" produce less insulin than in needed to maintain good health. Diabetes cannot be excused by circumstances; it is always considered disease. If medical reasoning is applied to people, not just to organisms, then there can be no excuse for distress or social difficulty regardless of circumstances. This why PTSD and Adjustment Disorder are considered mental disorders, and this is why the *DSM-5* Task Force is inclined to reduce the bereavement exception from two months to two weeks (it was a year in *DSM-III)*---distress or disability that does not quickly remit is disease or disorder regardless of circumstances. This is medical reasoning.

It can be highly serviceable to think about the operation of the body/organism without considering *social* circumstances, but it is never serviceable (valid, realistic, useful…) to think about a person and social behavior minus social circumstances. The two subject areas---the organism and the person---are in different realms. Different forms of reasoning are required and apt in one realm but not the other. The recent debacle on the part of the *DSM-5* Task Force concerning eliminating the bereavement exception excited so much lay and professional outrage became it is intuitively obvious to practically everyone not on the *DSM-5* Task Force that, at least when it comes to bereavement, the reasoning that applies to the body/organism does not apply to the person. Social behavior of course may be distorted or disabled by disease (e.g., precipitous drop in blood sugar level may bring about strange and unwarranted behavior), but it certainly will not do to consider deviations from normatively expected and desired behavior in general as brought about by idiopathic medical disease and by so doing terminate the usual interest when speaking about a person in background, circumstances and so on. It is legitimate to suspend person considerations when physical evidence reveals that a causal disease or disorder

explanation is called for, but in the absence of such evidence suspending interest in person considerations does the person a great injustice and should be considered a form of violence.

DSM-5 will once again be obliged to diagnose all disorders unique to psychiatry exclusively in terms of first person complaints and third person observations and interpretations of behavior (it would be more precise to say that observations conveyed in words *are* interpretations). Obviously this is not what the authors of *DSM-III* (published in 1980) expected by 2013. Psychiatry has "rejoined medicine" only in name and in *form,* not in substance. The complete failure of psychiatry to become medical in fact since the great leap forward has only inspired intellectual leaders in psychiatry to remark that the problems facing medical psychiatry have turned out to be harder than they looked from the perspective of the late 1970s when the great leap forward was being planned (e.g., Insel, 2009). To grasp why the APA is committed to psychiatry is medicine despite an unbroken record of failure since *DSM-III* was published, it is enlightening to review the situation of psychiatry as a profession in the 1970s. What will come into view is that the reasons that led the leadership of the APA to abandon the Myerian framework of thought at the end of the 1970s continue to prevail today and will continue to prevail for the foreseeable future.

The Psychiatry Profession Meets the Corporate World and the Government

The most straightforward and convincing answer is to follow the money. I will draw first on what I think is the most respected and most frequently cited analysis concerning why the APA gave up Myerian psychiatry and officially adopted neoKraepelinism in 1980, namely Mitchell Wilson's 1993 piece in *American Journal of Psychiatry.* In preparing this piece Wilson had numerous discussions

with Robert Spitzer and access to documents in Spitzer's possession, and also access to APA archival documents. Wilson's published analysis emphasized psychiatry's *professional* problems in the 1970s and its realpolitik solution to its professional problems. According to Wilson's analysis the APA essentially adapted to demands on the part of external players too powerful to ignore. The adaptation---neoKraepelinism---solved psychiatry's urgent *professional* problems, but at the cost of adopting a framework of thought that is manifestly ill-suited to the subject matter. By *professional* problems Wilson is speaking unambiguously about access to money and external threats to access to money. This is clearly an unflattering view of the APA's decision to develop a revolutionary break with the past, so one has to wonder about it being published in the APA's own house organ. I cannot answer this question, although I can make the observation that Wilson's analysis had no effect on the content of *DSM-IV,* published in 1994, or on any other practical matter as far as I know. Of course this would be consistent with his thesis---what matters most to a profession are professional considerations (individuals may take a stand on principle or conscience, but a professional organization exists to foster the interests of the profession).

The two major external threats to the profession in the 1970s that Wilson identifies are (1) the federal government did not like psychosocial research into the causes of human distress and social difficulties and in consequence federal research money to psychiatry had been declining 5% per year from 1965 to 1972. Unfortunately, Wilson provides practically no analysis of the federal government's antipathy towards psychosocial research. The reason cannot simply be that the Myerian framework did not easily lend itself to epidemiology, as he suggests. If one is writing critically and analytically about the policies of the federal government the topic of politics obviously cannot be avoided, but Wilson says nothing about politics (imagine avoiding political commentary when it comes to discussing federal policies during the 1960s, a period of unprecedented political and social upheaval; however, see Jacobs, 1995). Perhaps Wilson thought the reasons for the federal government's antipathy towards psychosocial research were too obvious to discuss; (2) third party payers, specifically the private

insurance industry and the federal government in its capacity as third party payer, made it clear to the APA that it would no longer tolerate (i.e., continue to pay for) the unstandardized and unreliable nature of psychiatric diagnosis. From the perspective of third party payers reimbursing psychiatrists for treatment put them (third party payers) in the position of paying for something amorphous, an intolerable position, especially as demand for psychotherapy kept growing. There must be accountablility, meaning standardization. In addition, diagnosis must distinguish between real medical conditions and problems in living, which should not be covered under medical insurance. The Myerian emphasis on the psychosocial causes of distress and disability, its acceptance of a fuzzy and basically non-existent boundary between personal distress and mental illness, and its narrative (i.e, non-categorical, non-entity) approach to diagnosis were extremely problematic to the federal government as provider of research money into the causes of personal distress and social difficulties and to the private insurance industry and the federal government as third party payers for psychiatric treatment. It is intrinsic to Wilson's analysis that the parties demanding reform were not amenable to persuasion and were too big and important to ignore. The profession of psychiatry was in the position of reform or suffer severe consequences. The solution was abandoning the Myerian framework and adopting a conventional medical disease framework. In Wilson's view (and mine) the cost was high---the profession essentially abandoned a realistic framework of thought for its subject matter---but the *professional* reward was survival and growth.

There were other important contributions to psychiatry's shift to a conventional medical framework of thought that Wilson does not discuss, namely the growing competition for the psychotherapy dollar from non-medical professions and the FDA's demand for distinct clinical entities in order to approve new drugs (Mayes and Horwitz, 2005). With regard to the latter, it could be argued on historical grounds that the FDA's requirements from psychiatry in terms of identifying distinct clinical entities were lax enough to continue with the Myerian framework of thought. But the Myerian framework was incompatible with aggressively

promoting psychiatric problems as genuinely medical and therefore requiring drug treatment to address the actual cause of the problem. This position not only rendered psychiatrists immune to competition from the non-medical psychotherapy professions but opened the floodgates to the largess of the pharmaceutical industry. Over time the influence of the pharmaceutical industry on how psychiatric drug treatment research is conducted and on basic concepts of what is really the matter with people who seek psychiatric care has grown so large that it could be argued that the profession has de facto become an arm of the pharmaceutical industry (Cohen and Jacobs, 2010; Jacobs and Cohen, 2010).

If Wilson's analysis is taken seriously then it is appropriate to think of American medical psychiatry primarily as a sociological phenomenon rather than primarily as a bona fide scientific research endeavor and an applied science medical practice. Certainly there are research and practicing psychiatrists who fully believe that psychiatric problems are genuine medical diseases (based on biological faults, dysfunction, etc.), but that is beside the point. The point is that the existence of such beliefs among a minority of psychiatrists in the 1970s was not the main reason that the APA refashioned itself as a conventional medical specialty (i.e., diseases and medicines). A year after Wilson's paper was published, comments and rejoinders were published in the Letters to the Editor section (March, 1994), including a rejoinder from Robert Spitzer (Spitzer and Williams, 1994). What is noteworthy is that none of the published commentaries and rejoinders even acknowledged Wilson's major thesis, which was that the APA was basically pressured into dropping the Myerian framework by external players in the mental health industry, players whose interests were political and financial, not scientific or clinical. The closest Spitzer (Spitzer and Williams, 1994) came to actually addressing Wilson's thesis was to admit that the majority of diagnostic categories in *DSM-III* lacked sufficient reliability data; the bulk of diagnostic categories included in *DSM-III* were present because clinicians needed them (to get reimbursed, although Spitzer is content not to complete the sentence). Having published Wilson's basically sociological analysis, the Editors declined to further honor it by demanding that published comments actually address and presumably

attempt to refute his main thesis. What I want to emphasize is that the professional literature has largely followed suit---in the main there is no mention of the financial and political forces that in effect demanded a conventional medical paradigm in psychiatry. It is only a slight exaggeration to say that American medical psychiatry is a case of Lysenkoism, with the qualification that political and financial forces as opposed to exclusively political forces were operant. The overarching point I want to make is that attention to political and financial influences at work in shaping contemporary American medical psychiatry should have the effect of de-mesmerizing reactions to the unceasing stream of propaganda projected from the psychiatry-Pharma-NIMH complex.

Conclusion

In medicine, first person complaints and/or third person observation of the body or behavior can serve as a *clue* to further investigation and diagnosis based on physical evidence (McHugh and Slavney, 1988). In psychiatry, in the realm of primary mental disorders, first person complaints and third person observations (of social behavior, which are actually interpretations) only lead to further talk in so far as diagnosis (what is the matter?) is concerned. It is misleading, not to say a farce, to call what occurs between psychiatrist and patient a medical encounter once actual medical disease has been ruled out on the basis of physical examination and negative physical evidence. The psychiatrist as a physician can prescribe drugs, but even if the drugs bring about a certain amount of relief from some features of the patient's complaints without too great a cost in physical and psychosocial adverse effects, this does not show that a genuine medical condition was the problem in the first place (Moncrieff, 2009). It would be a somewhat different matter if psychiatric drugs were actually curative, but this is not the case (a frank admission of this can be found in a 2009 paper by the current head of NIMH, Thomas Insel); indeed it is not even the case that psychiatric drugs

routinely outperform placebo in industry controlled drug treatment studies, despite industry control of all aspects of the study, including interpretation of outcome data. This is not even to mention adverse drug effects. I cannot emphasize too strongly that adverse drug effects are not the focus of psychiatric drug treatment studies and are given short shrift (see Jacobs and Cohen, 1999). In the absence of positive physical evidence that the patient's problem is really a medical condition, calling and treating the patient's difficulties a medical condition invalidates the person *as such* and should be considered a form of violence. This form of violence has become accepted as normal in American society. The consequences of invalidating the person qua person are limitless.

Think of depicting a bereaved patient's problem without reference to the patient's loss and without including any information concerning the nature, quality, and importance of the relationship between the patient and the deceased as far as the patient is concerned and what it means to the bereaved patient that the deceased is gone. This is not even a parody of the official line the APA has taken to grasping the patient's problem (i.e., a symptoms-only formulation of the patient's problem). It is true that Axis IV exists, but its use is officially optional (*DSM-IV-TR,* pp. 27 and 37), the patient's history beyond one year ago is regarded as usually irrelevant, and finally and most importantly the overall point of the manual is to advance the idea that mental disorders are impersonal medical conditions, albeit idiopathic medical conditions (see the definition of primary mental disorders). Although Axis IV continues to be included in the manual, psychogenesis was officially banned beginning with *DSM-IV,* which sends a clear message concerning the importance of psychosocial history-taking, as does the fact that Axis IV is optional. The person is considered the host of an idiopathic medical condition that announces its presence exclusively via behavioral symptoms (that is, complaints of psychological distress and/or troubling or disappointing social behavior). Considerations that would ordinarily pertain to understanding a person's thinking, feeling, and behavior are considered irrelevant because psychiatry is medicine and identifies and treats medical conditions. Meanwhile all disorders unique to psychiatry are identified without benefit of

biological information or evidence of any kind. Nothing of a non-linguistic, interpretive nature has any bearing whatsoever on psychiatric diagnosis. Yet patients are informed they are suffering from a genuine medical illness and prescribed drugs in the spirit of being directly treated via drugs for what is really the matter with them as opposed to some narrative that is much closer to the truth. When adversity is acknowledged, as in PTSD and Adjustment Disorder, the distressed person is considered literally mentally disordered *because* she is distressed. It makes sense in medicine to see persistent bodily distress or functional disability as disorder, but discussion of the individual as a person must recognize that a person is responsive to important developments in his life as he sees it. Evaluations such as whether or not a tragedy has occurred and what feelings and behaviors tragedy does and does not entitle a person to are ad hoc moral-interpretive evaluations, not medical science. Medical reasoning cannot sensibly be applied to discussion of a person per se. The realm of person discussion cannot be replaced with medical reasoning. Pretending it can on the basis of a combination of professional self-interest, profit seeking, and political expediency can be called Lysenkoism.

Is there any hope for reform? As I write this chapter there is widespread lay and professional dismay and alarm concerning various *DSM*-5 Task Force recommendations. Numerous professional mental health organizations are threatening to boycott *DSM*-5 (this is actually practicable because by treaty the ICD trumps the *DSM,* although I don't think most mental health professional realize this). The Chair of the *DSM-IV* Task Force, Allen Frances has publically opined (as part of his larger mea culpa, as I see it), that the APA can no longer be trusted to be the official owner of psychiatric diagnosis in America. He has not come right out and said that the APA has been purchased by the pharmaceutical industry (although numerous others have), but he keeps making the point that *DSM-5* Task force recommendations will create a new bonanza for the pharmaceutical industry while putting many people in danger. Reform is not in the interests of the major players in the mental health industry. This means that reform can only be brought about by persistent pressure, threat, and disruption

from below, i.e., from the vast majority of mental health professionals who are not psychiatrists and who presumably do not have a vested interest in medical dominance of the mental health industry. Is there any possibility that the present widespread disaffection with how the APA is handling its de facto mandate to create an official diagnostic manual for everyone else will persist and develop once *DSM-5* is published in 2013? The historical record shows that the non-medical mental health professions have been content to permit an organization whose interests are undisguisedly self-promoting to call the shots for the entire industry. This is probably based on the fact that everyone wants to bill medical insurance and the insurance industry is not likely to turn to non-physicians to create an official system of *medical* diagnosis. Is there a way out of this? A way out will only materialize if there is sufficient pressure from below. The outlook is dim but large changes do occur when widespread disaffection passes a certain threshold.

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