The New Crisis of Confidence in Psychiatric Diagnosis

Allen Frances, MD

In the early 1970s, 2 highly publicized studies showed that psychiatric diagnosis, as it was then conducted, was unreliable and inaccurate. The first found that British and U.S. psychiatrists came to different diagnostic conclusions when viewing the same patients on videotape (1). The second found that healthy volunteers claiming to hear voices were admitted to psychiatric hospitals for extended stays despite subsequently acting normally (2). Was psychiatry entitled to a place among the other medical specialties when its diagnoses were so random? The response was quick and effective. The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III), published in 1980, featured definitions of mental disorders that, when properly used, achieved reliability equivalent to that of most medical diagnosis. The DSM-III stimulated an outpouring of psychiatric research. In most medical schools, mental health research now ranks behind only internal medicine in National Institutes of Health funding.

Unfortunately, the extensive research has had no effect on psychiatric diagnosis, which still relies exclusively on fallible subjective judgments rather than objective biological tests. Brain complexity makes the translational step from basic science to clinical practice more difficult in psychiatry than in other fields of medicine. Biological findings, however exciting, are never robust enough to become test-worthy because within-group variability cancels out between-group differences. We will be stuck with descriptive psychiatry for the foreseeable future.

Psychiatric diagnosis is facing a renewed crisis of confidence caused by diagnostic inflation. The boundaries of psychiatry are easily expanded because no bright line separates patients who are simply worried from those with mild mental disorders. The DSM-III opened the door to loose diagnosis by defining conditions that were no more than slightly more severe versions of such everyday problems as mild depression, generalized anxiety, social anxiety, simple phobias, sexual dysfunctions, and sleep disorders.

The fourth edition of the DSM (DSM-IV), published in 1994, tried to hold the line against further diagnostic inflation by taking the conservative stance of discouraging all changes and requiring substantial scientific evidence for them (3). Of 94 suggested new diagnoses, the DSM-IV added only 2, but this caution did not prevent the unexpected occurrence of 3 market-driven diagnostic fads. In the past 20 years, the rate of attention-deficit disorder tripled, the rate of bipolar disorder doubled, and the rate of autism increased more than 20-fold (4). The lesson should be clear that every change in the diagnostic system can lead to unpredictable overdiagnosis.

The DSM-5, the recently published fifth edition of the diagnostic manual, ignored this risk and introduced several high-prevalence diagnoses at the fuzzy boundary with normality. With the DSM-5, patients worried about having a medical illness will often be diagnosed with somatic symptom disorder (5), normal grief will be misidentified as major depressive disorder, the forgetfulness of old age will be confused with mild neurocognitive disorder, temper tantrums will be labeled disruptive mood dysregulation disorder, overeating will become binge eating disorder, and the already overused diagnosis of attention-deficit disorder will be even easier to apply to adults thanks to criteria that have been loosened further.

These changes will probably lead to substantial false-positive rates and unnecessary treatment. Drug companies take marketing advantage of the loose DSM definitions by promoting the misleading idea that everyday life problems are actually undiagnosed psychiatric illnesses caused by a chemical imbalance and require a solution in pill form. This results in misallocation of resources, with excessive diagnosis and treatment for essentially healthy persons (who may be harmed by it) and relative neglect of those with clear psychiatric illness (whose access to care has been sharply reduced by slashed state mental health budgets) (6). Only one third of persons with severe depression receive mental health care, and a large percentage of our swollen prison population consists of true psychiatric patients with no other place to go. Meta-analysis shows that the results of psychiatric treatment equal or surpass those of most medical specialties (7), but the treatments must be delivered to patients who really need them instead of being squandered on those likely to do well on their own.

The DSM-5 did not address professional, public, and press charges that its changes lacked sufficient scientific support and defied clinical common sense. It was prepared without adequate consideration of risk–benefit ratios and the economic cost of expanding the reach of psychiatry just when the field is about to achieve parity within an expanded national insurance system (8). I found the DSM-5 process secretive, closed, and disorganized. Deadlines were consistently missed. Field trials produced reliability results that did not meet historical standards. I believe that the financial conflict of interest of the American Psychiatric Association (APA), generated by DSM publishing profits needed to fill its budget deficit, led to premature publication of an incompletely tested and poorly edited product. The APA refused a petition for an independent scientific review of the DSM-5 that was endorsed by more than 50 mental health associations (9). Publishing profits trumped public interest.
The APA has been responsible for the diagnostic system for 100 years, having initially accepted the task when it was too unimportant for anyone else to care. However, the DSM has since acquired perhaps too much real-world influence as the arbiter of who gets what treatment and whether it will be reimbursed; who is eligible for disability benefits, Veterans Affairs benefits, and school and mental health services; and who qualifies to receive life insurance, adopt a child, fly an airplane, or buy a gun.

New psychiatric diagnoses are now potentially more dangerous than new psychiatric drugs. Diagnostic expansions lead to drug company promotions that dramatically increase the use of unnecessary medications, with high cost and potentially harmful side effects. In the United States, we carefully monitor new drug development but do not have an effective system to vet the safety and efficacy of new psychiatric diagnoses. The problems associated with the DSM-5 prove that the APA should no longer hold a monopoly on psychiatric diagnosis. Another mechanism for revising the diagnostic system must be developed.

My advice to physicians is to use the DSM-5 cautiously, if at all. It is not an official manual; no one is compelled to use it unless they work in an institutional setting that requires it. The codes needed for reimbursement are available for free on the Internet (10).

From Duke University, Durham, North Carolina.

Potential Conflicts of Interest: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M13-0997.

Requests for Single Reprints: Allen Frances, MD, Duke University, PO Box 39950, Durham, NC 27710.

Author contributions are available at www.annals.org.


References
5. Frances A. The new somatic symptom disorder in DSM-5 risks mislabeling many people as mentally ill. BMJ. 2013;346:f1580.
Author Contributions: Conception and design: A. Frances.
Analysis and interpretation of the data: A. Frances.
Drafting of the article: A. Frances.
Critical revision of the article for important intellectual content:
A. Frances.
Final approval of the article: A. Frances.
Administrative, technical, or logistic support: A. Frances.
Collection and assembly of data: A. Frances.