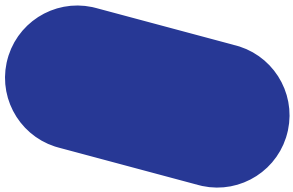
# Overdiagnosed, overtreated

For decades psychiatrists have argued over the boundaries between pathology and normality. Are we any closer to an answer? BY TRISTAN BRONCA



**What is a mental illness?** The standard answer is that it's a pathology of the brain. Conditions such as anxiety and depression are often described in terms of "chemical imbalances." The person suffering doesn't have any more control over it than they do a bad headache. Suggestions otherwise are not only old-fashioned, they're insensitive and wrong. "Those people aren't sad," the retort goes, "they're sick."

It's an oversimplified example, but it's one that goes straight to the framework upon which contemporary psychiatry is built: Mental illnesses are primarily *biological*. They are like other illnesses.

Except they aren't. Psychiatrists have long understood that the biological lens is too reductionistic to bring to bear on an organ as complex as the brain. The "chemical imbalance" cliché may appeal to science but, in the words of McGill University psychiatrist Dr. Joel Paris, "it's not very scientific." Psychiatrists have waited for years for neuroscientific findings that could justify their diagnoses—chemical markers that point to something in the body or brain that causes the symptoms. They haven't materialized. It'd be nice if there were a neat distinction between someone who's sad and someone who's sick, but it's not that simple.

## 'MEDICALIZATION'

The term "medicalization" originated in the field of sociology in the 1970s. It refers to the idea that over time, variants of human behaviour come to be defined as diseases in need of treatment. Nowhere has this concept been more consequential for clinicians than in the publication of the Diagnostic Statistical Manual (DSM), often referred to as the "bible of psychiatrists."[1]

[1] This phrase is revealing, given the DSM's lofty aim to be the final word on the categories of mental suffering. But even the authors say they don't think it'll ever meet that goal. "The DSM will always be provisional. . . . It's not biblical. It's not on stone tablets," former American Psychiatric Association research chief Dr. Darrel Regier is quoted as saying in Gary Greenberg's *The Book of Woe*. But as Greenberg writes, that explanation isn't good enough for many people. "After all, the DSM didn't save the profession, and become a bestseller in the bargain, by claiming to be only provisional."

Until 1980, the DSMs were, in the words of one very prominent psychiatrist, "obscure little books that no one much cared about or read." Today, the most recent of those "little books" is a nearly 1,000-page brick that guides decisions that have a massive impact on people's lives. "Things like who is considered well and who is considered sick; what treatments are offered; who pays for it; who gets disability benefit; who is eligible for mental health, school vocational and other services; who gets to be hired for a job, can adopt a child, pilot a plane, or qualifies for life insurance; whether a murderer is a criminal or mental patient; what should be the damages awarded in lawsuits; and much, much more."

Those are the words of Dr. Allen Frances who chaired the publication of the DSM-IV in the 1990s. His predecessors on the DSM-III, published in 1980, were on a mission to make psychiatric diagnosis systemic and reliable. "(They) saw themselves as a vanguard pushing the field towards the rest of medicine and away from the previously dominant psychoanalytic and social models," Dr. Frances wrote. But such a shift meant reducing diagnoses to a series of checklists. It meant a risk of diagnostic inflation. Dr. Frances and his cohort were keenly aware of that risk when crafting the next version of the DSM.

Despite their efforts, diagnoses blew up following the publication of the DSM-IV. Rates of attention deficit disorder in the U.S. tripled. Autism diagnoses increased 20-fold. Rates of bipolar disorder in children increased 40-fold. Dr. Frances detailed all of this in his book *Saving Normal*, which he described as "part *mea culpa,* part *j'accuse,* part *cri de coeur.*'"

As the consultations started on the DSM-5 (the publisher of the DSM did away with the Roman numerals for the fifth version), Dr. Frances became deeply worried that diagnostic inflation might become hyperinflation. The boundaries of pathology were expanding into otherwise normal behaviour. He was concerned that grief over the death of a loved one might become "major depression," that forgetfulness in old age might become "minor neurocognitive disorder," that immaturity might become "ADHD," and that overeating might become "binge eating disorder." He made it his mission to speak out against that, and his criticism became a guiding force that shaped the DSM-5.

Nevertheless, the categories of mental illness continue to broaden and the question of where precisely those boundaries ought to lie—between normality and pathology—remains very much an open one. But it's not just a question that concerns academics and DSM authors. When you get right down to it, the people drawing that line are almost always family doctors.

## WHAT DOES A DIAGNOSIS MEAN?

In a *Psychology Today* blog published last year, psychologist Jonathan Shendler explained the "circular logic" at play in mental health diagnoses.

"How do we know a patient has depression? Because they have the symptoms. Why are they having symptoms? Because they have depression," he said, summarizing a conversation he had with an advanced psychiatry resident. But psychiatric diagnoses "are merely descriptive, not explanatory." They are labels that describe a group of symptoms. They are not, as with other diseases, the cause of them. "If we speak of generalized anxiety disorder and major depressive disorder as if they are equivalent to pneumonia or diabetes, we are committing a category error."

Rather than provide an etiology,

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**Coming off the drugs may come with side-effects that resemble symptoms of depression—symptoms the medication was meant to ameliorate in the first place.**

psychiatric diagnoses provide a common language from which clinicians determine treatment. This is more important for certain conditions than it is for others. "Schizophrenia and bipolar disorder require specific medications, so you need to make a differential diagnosis," explained Dr. Paris, also author of *The Intelligent Clinician's Guide to DSM-5*. But generally, the less severe the illness the less important the diagnosis.

Yet new criteria have significantly lowered the bar on diagnosis for conditions such as depression and anxiety. With depression for example, once a patient has had five of the nine symptoms for two weeks or more they qualify for a diagnosis. That criteria fails to differentiate between cases that may require treatment and those that are likely to go away on their own, Dr. Paris said. It also doesn't help that very few cases of depression present the same way.

Medicalizing these conditions can also create problems in cases that do require intervention, in that a patient may be set off on a course of treatment that's accessible rather than the one that's right for them. Since therapy is now seen as too lengthy and costly to be done by highly skilled doctors, and because these services aren't otherwise widely available, in many cases the first step after diagnosis is medication.

As Dr. Chris Wilkes, an Alberta-based child and adolescent psychiatrist, put it: "If all you've got is your prescription pad, you're going to use it."

Take antidepressants for example. They're the most commonly prescribed drug for any psychiatric ailment, and their use in therapy is overseen mostly by family doctors. "It's not that they're especially harmful," Dr. Paris said. In fact, most psychiatric drugs, with a few notable exceptions, aren't. "It's that patients get stuck on them, and when they don't work they keep turning the wrench."

When a patient starts a new course of antidepressants, there's a well-documented placebo effect as the patient's hopefulness over the new drug affects their mood. But if that passes, the next step tends to be another drug or a new dosage, and the process begins again. That may be necessary for patients with more severe or protracted symptoms, but the risk/benefit profile can fall out of balance for those with mild or moderate symptoms, especially if other therapies aren't tried first. If at any point patients want to opt out, coming off the drugs may come with side-effects that resemble symptoms of depression—symptoms the medication was meant to ameliorate in the first place.

## PSYCHIATRY'S DEAL WITH THE DEVIL

Antidepressants are big business for pharmaceutical companies. In 2004, as discussions around the DSM-5 were taking place, antidepressants ranked third in pharmaceutical sales worldwide, with $13.4 billion in sales in one year alone. "Big pharma loves the antidepressant market because if everyone gets depressed sometimes then your market is the whole population," said Dr. Paris. "If they stay on them for years, that's billions of dollars."

Dr. Paris and Dr. Frances both suggested that industry has played a major role in driving this trend towards greater medicalization. Companies have "backed off" marketing new psychiatric drugs to doctors in recent years, Dr. Paris said, but he added that may be attributable to the fact that the industry hasn't developed new drugs[2] that are different in meaningful ways from the old ones.

[2] The effectiveness of antidepressants in particular has constantly been questioned. Psychologist Irving Kirsch, an expert on the placebo effect and a critic of antidepressants, wrote in a 2014 piece for the Journal of Psychology that the "serotonin theory"—what most people are referring to when they talk about a "chemical imbalance" at the root of depression—is "as close as any theory in the history of science to having been proved wrong." Kirsch's meta-analysis on antidepressants has influenced official treatment guidelines in the U.K.

Nevertheless, this hasn't stopped companies from redeveloping the same drugs. "A lot of the patients I see in consultation are on the latest antidepressant, even when it's absolutely no different than the antidepressants of 40 years ago—they're just three times the cost," Dr. Paris said. He has several "golden oldie drugs" in his repertoire, These are medications he prescribed when he was a student that he continues to recommend to his students today.

There is also a chicken-and-egg effect with big pharma and medicalization.

Big pharma is not only a cause of medicalization, it's also a product of it.

Before Dr. Harry Zeit opened his psychotherapy practice, he was an ER doctor. His first foray into psychotherapy was as part of a crisis team. He described the patients as being stuck in a "revolving door" where they were put on medication and then back in his clinic six months later following a setback. The physical trauma he saw in the ER was often more straightforward, practised and often resolved in the moment. Working on this crisis team gave him a new appreciation of the complexity of this realm of medicine.

As Dr. Zeit pointed out, the research into pharmaceuticals for mental health has really sapped resources that might be better spent on holistic solutions. That's not only because holistic solutions tend to be more expensive and time-intensive, but because they don't really fit with psychiatry's *modus operandi*. "Despite increasing evidence that quick fixes do not lead to lasting or meaningful results, governments increasingly turn to cheaper, quicker models of care," Dr. Zeit said. "Unfortunately, those choices do nothing to reduce the prevalence of suicide, depression, and anxiety, which continue to rise." What Dr. Zeit finds even more concerning is that these models do very little to address trauma: the violence, addiction, revictimization that are at the root of many of the most severe forms of mental illness.

There's a pull towards medicalization because its solutions feel sturdier and more expedient, as opposed to variable and messy.[3] The latter don't really fit in the existing medical paradigm, even though the emerging consensus is that they more closely reflect the realities of mental illness. This tradeoff gave psychiatry "a certain pedestal," one that Dr. Zeit freely admits he enjoys, as his colleagues do. "But it lets a lot of people off the hook from creating system changes that can really make a difference," he said. "There's a certain madness in continuing to invest heavily in models like medication and manualized therapy, which have failed in other countries."

[3] In terms of treatment, more medicalization means medication and maybe some short-term cognitive behavioural therapy (i.e., the things doctors do now), while a move away from it will require long-term counselling, lifestyle changes, social supports for struggling families, housing, nutrition, etc. (i.e., things that are understood to be outside the boundaries of medicine).

## MEDICALIZATION AS A POSITIVE DEVELOPMENT

Dr. Frances is sensitive to accusations that his critiques of the DSM might be interpreted as "anti-psychiatry." One of his motivations in raising the alarm on the DSM-5 was the fear that diagnostic hyperinflation would over-extend psychiatry beyond its capacity to meaningfully diagnose or treat. If that happened, patients may lose trust in the profession, which he argued would do far more to discredit the field than his arguments could.

"There's no doubt in my mind that neuroscience is crucial," Dr. Zeit said, referencing elements of the biological framework on which psychiatry relies. "But I feel a kind of heartbreak that medicine hasn't found a way to take in new information easily. It's not difficult to suppress certain symptoms with medications, but it is immensely more difficult to establish or modify the deep brain circuits that regulate physiology and emotion that lie at the core of every so-called mental illness."

While all the doctors interviewed for this article fall on one side of this tug-of-war, the divide in the profession at large likely falls closer to the middle. Earlier this year the *Medical Post* surveyed about 200 Canadian doctors and asked whether they thought certain mental illnesses were overmedicalized. Only 53% said yes.

Underdiagnosis can have serious consequences as well. Perhaps the best example is the historical treatment of autism, a condition that is today among the top three or four mental health conditions considered overdiagnosed. "Early infantile autism" was first identified by an American psychiatrist named Dr. Leo Kanner in 1943. By 1950, Dr. Kanner had become the world's leading expert on the condition, fielding referrals from as far away as South Africa. His diagnostic criteria was incredibly narrow, however. According to journalist Steve Silberman, who told the story in his 2015 TED Talk "The forgotten history of autism," Dr. Kanner once bragged that he had turned away nine of 10 kids referred to his office as autistic by other clinicians without a diagnosis.

Revered though he was, Dr. Kanner had some ideas about the condition that were misguided. For example, he took a dim view of the prodigious abilities these children seemed to possess in math, music and science, saying they were simply regurgitating what they had heard their parents say. As a result, autism became a source of shame and stigma for families.

Much of that changed with the work of Dr. Hans Asperger. The Vienna pediatrician ran a residential school and clinic where autism was understood "as a diverse continuum that spans an astonishing range of giftedness and disability." He called the kids "his little professors" and consulted them closely in developing his curriculum. It created a model for understanding the condition that was inclusive and less stigmatizing.

Whatever your opinions about the prevalence of autism spectrum disorder in the population, the shift Dr. Asperger initiated in the field was an important one. Activists lobbied to see the changes reflected in the DSM-IV and when that happened, the number of diagnoses soared. But as Silberman explained, it wasn't a bad thing. It allowed patients access to services they needed, and crucially, it managed to capture a broad range of variances in the human experience that are typically lost by trying to distill a singular diagnosis.

That doesn't mean the current line between an autism diagnosis and normality is where it needs to be. Many, including Dr. Frances, argue that too many children fall under the umbrella diagnosis who probably shouldn't—children whom the clinicians we

interviewed affectionately described as "a little odd." But what it does mean is that the right move for determining the criteria for diagnosis is not always away from the bulky middle of the Gaussian curve.

## STIGMA & STRESS

One of the arguments in favour of expanding diagnostic criteria has to do with stigma. Mental illness has traditionally been viewed not only as different but, in some sense, lesser than other illnesses. If you're sick, it's not the same as if you're *just* sad, anxious, or stressed. There's been a long struggle for people to have this kind of suffering validated.

Medicalizing these conditions changes this and according to Dr. Frances, that has certain advantages. "However, I often wonder whether overall, the whole enterprise of finding medical labels and drug 'treatments' for what are often arguably problems of living, actually causes more problems than it solves," he wrote in a 2015 blog.

He explained, quoting British psychologist Anne Cooke: "Thinking of myself as mentally ill might well be a huge blow to my self-confidence. I might conclude that there is little I can do to help myself except to keep taking the tablets. Depending on my diagnosis, I might begin to fear turning into people's image of a mental patient—strange, unable to function and perhaps even potentially violent."

This isn't just a process that goes on in the patient's head. Dr. Jean Wittenberg is a consulting infant psychiatrist at the Hospital for Sick Children in Toronto. He's involved with an American think tank called the Group for the Advancement of Psychiatry where he's been investigating the impact of stigma on distressed and marginalized teenage mothers and their babies. They found that both mothers and babies end up with greater dysfunction as a result of the stigma they experience.

"When they go into a grocery store, they're followed around because people think they're going to shoplift. When their kid acts up on a streetcar, people look at them like, 'what can you expect.' Even healthcare or social services providers start to look at them differently," Dr. Wittenberg told the *Medical Post*. A sense of powerlessness is telegraphed onto them. It becomes an aggravating factor, and it doesn't make much difference if the people in the grocery store or on the streetcar happen to acknowledge the patients may be sick rather than stressed (dubious as that distinction already is). Even after the mothers begin to "get their feet back under them," Dr. Wittenberg's group has found that there are often lasting effects for the child, such as education and health problems.[4]

[4] Such problems are not solely the result of stigma, however. These findings belong to a growing body of research in the field that suggests trauma in one's formative years has important consequences for both physical and mental health. Perhaps the most cited example is the famous Adverse Childhood Experiences study. It found that children who experienced six or more of the study's 10 "life events"—one of a specified varieties of abuse, neglect, or violence—in their first 18 years of life, later experienced a host of other health risks to the point where life expectancy dropped by an astonishing 20 years on average.

"What's behind stigma, in my opinion, is that nobody wants to be mentally ill," Dr. Paris said. He accepted that in certain circumstances, it may improve how the patient is treated. "But nobody is going to put a mental health diagnosis on their resume."

## MORE THAN DYSFUNCTIONING PARTS

The pendulum has begun to swing away from the biological lens toward a more holistic understanding of mental illness.[5] Most guidelines call for a stepwise approach before prescribing medication, even if appropriate supports aren't in place for many patients to access them. According to the World Health Organization, 13% of the global burden of disease is related to mental health, and yet Dr. Wilkes pointed out that Canadian provinces rarely allocate more than 7% to 10% of their health budgets towards it. Even then, services are often disconnected and inaccessible to people who need them most.

[5] Dr. Frances even argues that the term "mental illness" is misleading. "Schizophrenia is not one illness," he wrote in a 2015 blog. "(It) describes a heterogeneous set of experiences and behaviours." Dr. Zeit pointed out that no two depressed people are alike, which in many cases undermines the DSM's utility.

"I think we need to re-frame what we mean by therapy," Dr. Wilkes told the *Medical Post*. "Right now it means seeing a doctor and getting a prescription. It can come to mean music and pets for treating isolation, or activities like walking or biking, or talk therapies." In 2017, Choosing Wisely, the Canadian group campaigning to reduce unnecessary tests and treatments in healthcare, issued 13 recommendations for psychiatry. Eleven of them had to do with medication use, particularly as a first-line intervention or in children.

Mental health is, to quote Dr. Zeit, the product of an interplay between individual stress, environmental stress and genetics. To return to Shendler's example: One's generalized anxiety disorder may be, in a true genetic sense, inherited from a parent who had the same diagnosis. But the clinician is also under some obligation to consider whether that condition has more to do with the fact that the patient was raised by an anxious parent.

Mental illness can't be compartmentalized from the world in which it occurs. Such an insight may help doctors navigate the line between normality and pathology. More importantly, though, it may guide better forms of treatment for people who are more than a series of dysfunctioning biological parts. **MP**