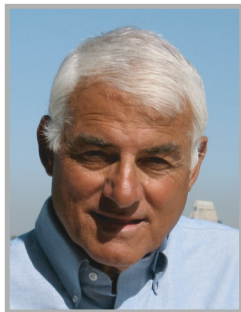
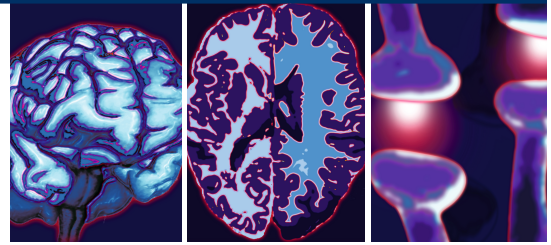


INTERVIEW

The limits and uses of descriptive psychiatry



Allen Frances*: Allen Frances is the professor emeritus and former chair of the Department of Psychiatry and Behavioral Science at Duke University (NC, USA), and he was the chairperson of the DSM-IV task force. Frances has wide-ranging clinical experience with mood disorders, anxiety disorders, personality disorders and schizophrenia. He is also the author of *'Saving Normal'* and *'Essentials of Psychiatric Diagnosis'*.

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Q What initially drew you to psychiatry?

I was drawn to psychiatry immediately at university. The combination of intellectual interest, the opportunity to understand myself better and the possibility to develop strong relationships with patients in a way that may be helpful to them really appealed to me.

Q What do you view as the highlight of your career?

What I have enjoyed the most, and where I think I have been the most useful, is in treating patients. Second, I have also thoroughly enjoyed teaching both trainees and medical students. Third, the opportunity to undertake research has been a highlight. Committee meetings were certainly the aspect that I enjoyed the least!

Q You have worked & published in a wide variety of psychiatric fields: what changes have you seen in these fields over your career?

I think the psychiatric world has developed enormously powerful tools to understand the workings of our brains, cells and DNA.

Over my career I have observed a remarkably exciting revolution in our basic science knowledge base. Unfortunately, this has had little to no impact on clinical practice. By this I mean that we have slightly different drugs from those that were introduced 50 years ago; however, they are no more effective, instead they merely have different side effect profiles. In addition, despite extensive research, we still have no biological tests to diagnose mental disorders and we lack a fundamental understanding of the various causes of a range of psychopathologies. There is a distressing disconnection between the basic science and clinical art in psychiatry. This should not be too surprising as the same problems that occur in this field are occurring throughout all the medical specialities. We understand a lot more about normal physiology than we do about pathological functioning and it is much easier to make a basic science breakthrough than to translate it into clinical advances. For example, the war against cancer has been ongoing for 40 years, and for the most part is being lost; more has been achieved by restricting smoking than

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through all the research conducted. As the brain is by far the most complicated concept in the known universe, the translational problems that exist in all of medicine are exponentially more of an obstacle in psychiatry and it seems probable that there will be no sudden breakthroughs. Instead, there will be slow, detailed, step-by-step processes over many decades to try to better understand the field.

Q Do you think the changes needed to aid this are close by or will it be a long process?

I think that there is tremendous overpromising of the impact of science on clinical practice and it would be wise to be cautious in predicting giant breakthroughs in the future. I believe current projects are oversold. Barack Obama's brain mapping initiative is an ambitious and useful attempt to better understand the causes of psychopathology; however, it is unlikely to yield immediate understanding. The 1990s were hailed as the decade of the brain and we learned a great deal about brain functioning; however, this did not carry over to aid us in better understanding how to help patients. I think that, although we should certainly be advancing research enterprise, we should not be ignoring the current needs of patients.

Q You write extensively on the issues surrounding psychiatric diagnoses; what do you view as the main issues & how do you think the psychiatric world needs to deal with these?

Descriptive psychiatry is a very limited tool because the conditions described are heterogeneous in their presentation and their response to treatment. In addition, there are almost certainly multiple causes for each condition so, for example, there will not be one type of schizophrenia but instead hundreds. As we gradually tease out the different pathways that lead to a final common descriptive presentation – just as there will be hundreds of breast cancers rather than one – there will be hundreds of causes of schizophrenia. I think that it is easy to criticize descriptive psychiatry; however, so far it has been impossible to replace it. So the current medicine is old, imperfect, subject

to human error and subjective; however, it is very important in clinical practice as it is the best and only tool we have to label patients and to find treatments for them. I think that the future will bring greater understanding but in very small and slow steps. My concern lies in the overselling of research, which allows large institutions to ignore their responsibility for the current and desperate needs of patients, who are very ill served by mental health systems, which are disorganized, underfunded and have resources that are badly misallocated. We need to do research that is absolutely essential for the future. However, we cannot allow the hopes of the future to distract us from the needs of the present. Patients, especially in the USA, are in desperate need for better care that doesn't necessarily require increases in knowledge – we know how to treat them we just don't have the funding sources and levels of organization necessary to provide decent community care and housing. As a result, a million psychiatric patients are in prison in the USA due to nuisance crimes that could have been easily avoided had they been given the opportunity to access treatments and places to live. I sometimes fear, having watched the trajectory over the course of the last 45 years, that patient care has been poorly attended to and I think the lesson is that the research is not going to bail us out in any quick way. I think that certain institutions think they can provide answers by devoting themselves exclusively to research and turning into brain institutes rather than mental health institutes. By doing this, they are eliminating all other types of research: outcomes research, treatments research and health services research. I think focusing on these areas offers a false promise that distracts from the kind of work that needs to be done to improve a lot of existing patients' quality of life.

Q What is the psychiatric world's responsibility to the patient with regard to these issues?

I think we have a general misallocation of resources where patients with mild symptoms are being markedly overtreated, receiving diagnoses and distressing medication treatments that are likely to do them more harm than good. At the same time, we

have terrible underfunding for people with moderate-to-severe problems. Psychiatry is at home and does its best with people with a certified psychiatric illness. We can be reliable in diagnosing them and very effective in treating them, in fact our results compare favorably with other medical specialties. The problem that has arisen over the last 30 years is that there has been an extension of psychiatric diagnoses towards milder and milder conditions that blur imperceptibly with normality so that diagnosis becomes unreliable and hard to distinguish compared with problems that occur in normality. Whereas it is very easy to distinguish people who are severely ill, in these milder conditions the treatment response rate is less attributable to the treatment because the placebo response rate among the moderately ill is so high it approaches the response rates for actual treatment. We need to be cognizant of the fact that drugs will appear to have good response rates in patients who are not sick because placebo response rates are approximately 50% or more. What is emerging is that there are people receiving medicine that they do not need with harmful side effects, who are being given diagnoses that are stigmatizing and reduce their opportunities, which results in negative attributions from others. At the same time, there are people who cannot get an appointment for months or do not have a place to live and get into trouble because they were not cared for appropriately.

Q Having chaired the DSM-IV task force, what do you view as the key changes in the DSM-5 & how will these affect the psychiatric world?

I think the differences in goals were substantial. They were very ambitious with regards to change, whereas we were very modest in our ambitions. With regards to the method, we were meticulously careful. Finally, with regards to results, we added only two diagnoses and hoped these would not result in any substantial increase in the rates of psychiatric disorders. DSM-5 has been adventurous in adding new diagnoses that will have very high base rates in the general population and in reducing thresholds for existing diagnoses that are already being overused and leading to excess medication,

whereas in DSM-IV, we aimed to stem the tide of diagnostic inflation. For example, childhood bipolar disorder was rejected by DSM-IV, but has still increased 40-fold over the last 20 years because it was being pushed as a way of explaining disruptive behavior in children. This led to an enormous interest in psychiatric medication in children, which was largely unresearched, and although we have no indication of treatment being effective, we have every indication of harm and danger because, on average, children gain 10% of their body weight in just 3 months. The experiment undertaken with DSM-IV was to try to have a very restricted system and the results of the experiment showed that even with that effort, people were being convinced that they were unwell, and doctors were being convinced that they should be diagnosing more and giving out medication more leniently. DSM-5 has opened the floodgates by offering new targets for excessive diagnoses and potentially harmful treatments.

Q Do you have a proposition for a better approach for future revisions of the DSM?

I think the main causes of diagnoses inflation and excessive treatments are multiple; there will not be one solution. The diagnostic system is too important now to be left in the hands of one small group of psychiatrists who have an intellectual conflict of interest to expand their own areas of expertise. We need to introduce careful vetting of new diagnoses, as we do with new drugs. In psychiatry, new diagnoses are more dangerous to people than drugs: people can be subjected to medication they didn't need whereas new drugs seem to have similar side-effect profiles that more or less represent the drugs in existence. We are very careless in allowing diagnostic changes that will include millions of new patients. So, one thing that needs to be done is the implementation of a new system that aims to provide a safe and scientifically sound document. It needs to be more scientifically based and more restrictive to reduce the risk of overdiagnosis and overtreatment. I think we need to stop the influence of drug companies in the process, I believe they should not be allowed to market directly

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to the consumers. In fact, I personally do not think they should be allowed to market to doctors. Currently, they are selling medicines like you would with any product, and patient welfare is not the highest priority, so drug companies need to be controlled. I think insurance companies tend to expect diagnoses on the first visit. Psychiatric diagnoses take a great deal of time and effort. Patients often get better on their own without intervention and without diagnoses. It would be much better if patients were given 1–2 months of evaluation, especially in those cases where care is not urgent, to allow time to heal and when natural resiliency has brought a person back to a more stable level. One should not be making a diagnosis based on the most challenging day of a person's life. The insurance companies should change their policy to allow the evaluation period to stretch over several visits rather than requiring an immediate diagnosis for reimbursement. Finally, people need to be aware that life's problems, disappointments, difficulties and anxieties are part of the human existence and not all of these are mental disorders. There is not a pill for every problem and the problems of life are not necessarily chemical imbalances that require a solution.

Q Recently, you wrote about how the International Classification of Diseases (11th revision) should learn from the DSM-5. In your opinion, what is there to learn & how does the psychiatric world deal with the possible confusion that arises if the two differ from each other?

DSM-5 was very overfunded; the expenditures on it were over US\$25 million, whereas the DSM-IV cost only US\$5 million. WHO has almost no resources devoted to International Classification of Diseases 11th revision (ICD-11) and, as a result, it is being done on a shoestring. It would be a much better world if less was spent on DSM-5 and more spent on ICD-11. I think the major lesson to be learned is experts in any area cannot be trusted to control the diagnostic inflation in their own area. In my 40 years of working with experts, the universal experience is that they always want to expand their area and, unfortunately, the ICD has even less central guidance than

the DSM-5, as it allows groups of experts to make decisions that seem logical to them given their setting but would actually be disastrous when translated to primary care. My concern is that the ICD-11 will follow the same errant path of opening up the diagnostic system to even more excessive diagnoses and excessive treatment unless some concern is derived from the DSM-5 experience, and that this will cause more trouble than help people, and that the consumers are unhappy when mislabeled with having a mental disorders.

Q You have spoken about overdiagnosis & excessive treatment. Do you think the two go hand in hand or do they need to be tackled separately as different problems?

I think what drug companies have learned is that they have to sell the diagnosis as a way of selling the pill. Therefore, disease mongering becomes the major marketing tool and people are made more aware that these conditions exist. So, for example, as a result conditions such as ADHD, a mental disorder, are diagnosed when a child shows the slightest bit of spirit. The rubric of diagnosis of mental disorders is being widened to include human feelings and behaviors that are a perfectly normal part of life, and this widens the market of the drug companies. Therefore, the effort to reduce excessive treatment can succeed only if we make it clear that excessive diagnosis is part of the problem – and I think that the two really have gone hand in hand. I think psychotherapy as a response to excessive diagnosis is less dangerous, especially brief psychotherapies, rather than long-term medication treatments. I believe the biggest problem at this point is not controlling expenditure for psychological treatments, but rather controlling expenditures for medication treatments.

Q Looking forward, what changes are you hoping to see in the field of psychiatry?

In my opinion, the main thing that needs to be done for the future is advocacy for patients who are being ignored by the system, those who are severely ill, and warning patients and carers of the importance of

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becoming an informed consumer: they need to be asking doctors questions. A diagnosis is a turning point in a person's life and is as important as choosing a spouse or your house, and it shouldn't be carelessly made after a 5–7 min experience with a doctor where one receives a diagnosis and a sample of pills. Getting a diagnosis is very serious and should be taken seriously by all concerned parties. We need to warn consumers and educate them. Additionally, we need to re-educate doctors: they've been excessively quick to make diagnoses based on very limited contact information and the diagnostic process is time consuming, there should be watchful waiting, advice giving and time for natural healing given before making diagnoses. The whole enterprise needs to be shifted away from questionable diagnoses and people need to be allowed to recover on their own by giving them time. We also need to provide and care for the underserved. It is absolutely shameful to have a million psychiatric patients in prison; this harks back to two centuries ago before the effort to provide moral care begun, which started in France and spread quickly to England before coming to America. There was a revolution that lasted 200 years towards understanding mental illnesses and treating it in a humane way, and the current situation is a bad regression to a shameful neglect of the needs of existing patients. I am looking forward to the research that is emerging and hoping that it gradually will be incorporated into our ability to diagnose more accurately and treat more effectively. However, I'm concerned that while we are waiting for that we are failing to meet the needs of the patients that we are currently responsible for.

Q Do you have any closing comments or messages for our readers?

I think what has disturbed me most in the last 30 years is the reduction of psychiatry to a reductionist biological model that devotes relatively less attention to psychological and

social contacts, which are so important in every psychiatric illness, even in the most severe illnesses. I think that psychiatrists do not spend enough time with patients and this reduces their ability to get to know patients, resulting in a reflex effort to solve every problem with medication. I've seen far too much polypharmacy; drugs once started are very hard to take patients off and too many patients are receiving combinations. We have more deaths in USA from prescription drugs than we do from street drugs. We see excessively high doses of a number of different medications given conjointly, sometimes by one doctor, sometimes by several. I think most problems occur because of prescription habits, I think if we are to have less time with patients we need to learn to use that time not just to evaluate response to medication and side effects but also to improve patients lives through the doctor–patient relationships – we shouldn't be reducing evaluations to DSM diagnoses. Hipocrates said: "It is far more important to know the person the disease has than what disease the person has." We need to understand not just the symptoms that are present but the psychological factors that contribute toward it. I would hope for a psychiatry that goes back to a biopsychosocial model that is more patient centered rather than diagnosis and medication centered.

Disclaimer

The opinions expressed in this interview are those of the interviewee and do not necessarily reflect the views of Future Medicine Ltd.

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A Frances is the author of two books that criticize DSM-5: 'Saving Normal' and 'Essentials of Psychiatric Diagnosis'. A Frances has no other relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript apart from those disclosed.

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