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Battle in Print: *Psychiatrists and drug companies are thoroughly redefining normal behaviour*

Christopher Lane

For almost three decades, routine behaviours such as shyness, solitude, and defiance have been classed as symptoms of full-fledged disorders, with names as overwrought as ‘social anxiety’, ‘avoidant personality’, and ‘oppositional’ disorder.

All three of these conditions became mental illnesses in 1980, when the American Psychiatric Association approved the third edition of its massively expanded *Diagnostic and Statistical Manual of Mental Disorders*. The *DSM-III*, now the bible of psychiatry, is invoked daily in courts, prisons, schools, insurance companies, emergency rooms, and doctors’ offices on every continent. In the same highly influential edition, ‘dawdling’, ‘procrastination’, and ‘intentional inefficiency’ became symptoms of ‘passive-aggressive personality disorder’; ‘disobedient, negativistic, and provocative opposition to authority figures’ epitomised ‘oppositional disorder’; and the introverted individual morphed into a person with mild psychosis whose symptoms included being aloof, being dull, and simply ‘being alone’ (DSM-III: 329, 63; Spitzer 1978).

To open the *DSM* at almost any page is to find similar jaw-dropping lists of normal traits that are understood, chapter and verse, as evidence that half of us have some form of mental disorder, an almost-equal number of us are depressed, and as many as one person in five now suffers from a particular anxiety disorder such as ‘social anxiety’ (Stein et al. 1994: 408).

But if you look at this story from several interlocking angles - including the DSM task forces that created the disorders and the drug companies that branded them through clever marketing - the picture looks far less impressive and plausible. Massive effects, including the fate of blockbuster drugs, stemmed from closed-door meetings in the 1970s among handpicked friends, colleagues, and ‘kindred spirits’ (Spitzer, quoted in Wilson 1993: 404). The chair of the task force later manipulated the maths so that the ‘illnesses’ (112 of them newly established in 1980, with 58 more arriving in 1994) would appear more common. Almost overnight, patients were said to experience ‘introverted personality disorder’ if they lacked vitality, had ‘deficits in . . . spontaniety (*sic*)’, were generally unenthusiastic, and exuded ‘minimal introspectiveness and awareness of self’ (Millon 1978). The *DSM* proclaims even greater numbers of us to be mentally ill if we have only a handful of friends, don’t get along with our parents, accept jobs involving minimal contact with others, and generally are either ‘humorless or dull’ (DSM-III: 310).

Given this ‘hodgepodge’ of ‘scattered, inconsistent, and ambiguous’ assertions and impressions - an assessment by one of the *DSM-III*’s own task force members (Millon, quoted in Spiegel 3.1.2005: 59) - it is all the more astonishing to note that this small group of self-selecting American psychiatrists also built a sweepingly ingenious consensus: the new anxiety and personality disorders

stemmed not from psychological conflicts or social tensions, but rather from a chemical imbalance or from faulty neurotransmitters in the brain.

Deeply hostile to psychoanalysis and other psychodynamic approaches to mental conflict, the experts found ways to apportion run-of-the-mill concerns to hereditary, genetic, or simple chemical dysfunctions (too little serotonin, dopamine, or norepinephrine in the brain - the same criteria apply to amazingly varied problems). In this way, the psychiatrists closed the door on any far-reaching discussion of culture, environment, family dynamics, or even the mind. Apparently, individual therapy was no longer needed to work through conflict; people were suffering from biomedical disorders for which the experts and the drug companies had rapid and painless pharmacological solutions.

Before long, the media reported these radical changes with breathless excitement. In 1994, at the height of giddy media coverage of Prozac, *Newsweek* asked its American readers if they were 'Shy? Forgetful? Anxious? Fearful? Obsessed?', then presented them with a simple cure ('How Science Will Let You Change Your Personality with a Pill'). The neuropsychiatrist Richard Restak was quoted as announcing proudly: 'For the first time in human history, we will be in a position to design our own brain' (quoted in Begley 7.2.1994: 37).

Unfortunately, the research leading to *DSM-III* was far less scientific than one might think. The psychiatrists' case studies sometimes boiled down to just one patient who had been treated by the person advocating the disorder. The discussions also focused less on the lasting consequences of the psychiatrists' momentous decisions than on how to reward the work of allies, and on who should get credit for plucking a term out of a dictionary. Even that could have bizarre, unpredictable effects. One expert defined 'masochism' as follows: 'Oh, you know what I mean, a whiny individual . . . the Jewish-mother type' (quoted in Talan 11.3.1986: 7). Others thought 'passive-aggressive disorder' should be identified by such clear pathological signs as 'feels misunderstood' while displaying a 'negative attitude (chip on shoulder)' and 'ineffectiveness in social and occupation interaction' (Fielding 1978; Hyler 1977b). Meanwhile, patients suffering from 'avoidant personality disorder' were logged as symptomatic if they either had 'not learned to drive a car, or would suffer the inconvenience of public transportation in a situation where a private automobile is available' (MacKinnon 1978). I'm still scratching my head over the last alternative, for private car use would surely signal the greater avoidance of other people.

But never mind. After the DSM task forces had completed their work, the relabelling of our emotions advanced with lightning speed. Anxiety Disorders clinics soon sprang up at universities across Britain, Canada, and the United States to research and treat the problem. Public relations firms were hired to hype ambiguous data and to raise the profile of the new disorders. Marketing departments spent tens of millions of pounds and dollars blurring the lines between chronic and routine problems so that both would strike us as debilitating conditions. In the United States in particular, wide-eyed health 'reports' in the media dutifully chronicled every sound bite and 'video news release' the drug companies sent them. *Psychology Today* dubbed social anxiety the 'disorder of the decade' in 1993 - just three years into the decade in question - and quoted a representative of the National Institute of Mental Health as warning that excessive shyness is 'one of the worst neglected disorders of our time' (*Psychology Today* 7.8.1993: 22). Partly as a result, almost two hundred million prescriptions for depression are filled each year in the United States alone; and more than five thousand North Americans begin a fresh course of treatment for Seroxat/Paxil every

day.

One reason for the skyrocketing diagnoses is that doctors and psychiatrists require a very low burden of proof. They say social anxiety disorder runs the gamut from stage fright to paralysing fears of criticism and embarrassment. (The most common nightmare scenario is eating alone in a restaurant, with fear of hand-trembling a close second and avoidance of public toilets third.) And if those criteria sound vague and implausible, consider that the *DSM* definition also includes, as symptoms of this disorder, *anticipated* concern about saying the wrong thing and of being stumped when asked questions in social settings - fears that doubtless afflict almost everyone on the planet (*DSM-III-R*: 241). Assessing these elastic guidelines, we can readily grasp why the 'illness' is so widely diagnosed, but it's harder to say why so many take the diagnosis seriously, much less accept its judgement of mental debility.

One explanation lies with the drug companies. The year after SmithKline Beecham (later GlaxoSmithKline) received approval from the US Food and Drug Administration to treat social anxiety with Seroxat/Paxil, the drug company spent a cool \$92.1 million promoting the disorder and the drug pushed to treat it - \$3 million more than Pfizer spent in a year on Viagra, a pill grossing over a billion dollars in the same period (Levitt 2001: 6). SmithKline hired a Madison Avenue agency to promote its ubiquitous advertising campaign, 'Imagine Being Allergic to People . . .' And it distributed among doctors and anxious patients a 'reliable screening tool' that would enable self-diagnosis, if necessary, by helping a person to gauge the severity of a response to these statements: 'I am afraid of people in authority', 'I am bothered by blushing in front of people', 'I avoid going to parties', 'Being criticised scares me a lot' (SmithKline Beecham 1999: 14). If you need to ask, 'To whom are these never, or rarely, matters of concern?' you have already missed the point.

In this extreme vision of mental health - which even a member of the *DSM-III* task force acknowledged induced in him 'an Alice in Wonderland feeling' (Frosch 1978) - routine fears and anxiety are easily pathologised and then medicated away, apparently without any of the many nasty side effects plaguing those who take - or are trying to come off - antidepressants. But if we can represent ordinary traits in this way, without any psychological inflection, why not add an even greater range of human traits and emotions, such as envy, joy, or common unhappiness? Indeed, when so many routine behaviours are viewed as disorders, is it possible to live a 'normal' life without hitting up against one or more of them?

The short answer is no. The *DSM* and the drug companies have narrowed healthy behaviour so dramatically that our quirks and eccentricities - the *normal* emotional range of adolescence and adulthood - are now problems we fear and expect drugs to fix. Gone are the days, apparently, when we could value exuberance *and* shyness, as well as a vast repertoire of similar moods. Nor are we citizens who sometimes need to be alone, justifiably concerned about our world. Our afflictions are chronic anxiety and personality or mood disorders; our solitude is a marker for mild psychosis; our dissent a symptom of oppositional disorder; our worries, chemical imbalances that drugs must cure.

The biomedical turn in psychiatry has transformed our expectations of the individual in society so dramatically that we now tend to believe that active membership in community activities, cultivation of social skills (becoming a 'people person' in American lingo), and development of group consciousness are natural, universal, and obligatory aims. We think the adjustment should be painless rather than a cause of unease, and sometimes even profound discontent. We tend,

moreover, to attach such import to the attainment of these goals that psychiatrists are now licensed to regard as ill those manifesting even vaguely nongregarious behaviour.

The meanings we attribute to shyness, fear, and introspection - for the meanings certainly change (McDaniel 2003: 2-20) - are less at issue here than the broader consequences of our intolerance for emotions we're encouraged to eliminate from ourselves, and indeed to imagine eliminating from other people. Such concerns are not far-fetched. At least one American dictionary now defines *normal* as 'free of any mental disorder' - an outcome that, given the numbers, would seem quite optimistic (Webster's Unabridged, 2nd edition). Meanwhile, neuropsychiatry, seizing on the spurious logic of a 'chemical imbalance' when no perfect 'balance' exists, implies that failing or refusing to strive for that balance means settling for less than optimal brain performance or unnecessary sadness.

The future that psychiatry holds before us is no less worrisome: a group of US psychiatrists is currently meeting to prepare *DSM-V* for publication, most likely in 2011. They have already debated in print whether *apathy* is a bona fide illness (Stephenson 2005) and seem to agree that overuse of the internet and excessive shopping should join poorly controlled anger ('intermittent explosive disorder') and premenstrual tension ('premenstrual dysphoric disorder') as separate mental illnesses.

Without dramatic reform, psychiatry will turn these and many more ordinary emotions and common behaviours into pathologies for which billion-dollar pharmacological treatments are already on tap and merely awaiting prescription. Such changes will put millions more patients at risk, overmedicate the next generation, and send healthcare costs into the stratosphere.

Whether psychiatry desists or continues trying to medicate away our emotions will be decisive for the profession. That there are in all of us drives and fantasies that make us incapable of *complete* adaptation might in fact be the basis for an ethics that helps us live productively and intelligently when we're 'worried well', rather than wasting our energy aspiring to be 'better than well', whatever that actually means. First, however, we'll have to convince psychiatrists like Steven Hyler, a member of the *DSM-III* Personality Disorders committee, who argued for the inclusion of ailments as vague as 'chronic complaint' and 'chronic undifferentiated unhappiness' disorder on the basis that a person suffering from the second of these 'often present[s] a very sad face', and a person experiencing the first inflicts his or her 'persistent and consistent complaining . . . in a high-pitched whining fashion which is especially noxious to the listener' (Hyler 1977a).

Hyler said he was prepared to class among the mentally ill 'persons who heretofore were known by the synonyms "kvetch", "scotch", "noodge", and just plain "neurotic"'. Although the complaints of such people may, he said, be 'of a general nature and include such diverse topics as the weather, the energy crisis, taxes, or the previous evening's track results', the symptoms apparently are unmistakable, not least because they 'include an outlook on life which is characterised as pessimistic'.

Welcome to Steven Hyler's brave new world.

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References

All unpublished correspondence cited above appears courtesy of the American Psychiatric Association in Arlington, Virginia.

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III)*. Washington, DC, APA.

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition Revised (DSM-III-R)*. Washington, DC, APA.

Begley, S. (7.2.1994). 'One Pill Makes You Larger, And One Pill Makes You Small'. *Newsweek*.

Fielding, M. (1978). Unpublished memo on Passive-Aggressive Personality Disorder. 11 November.

Frosch, J. (1978). Unpublished letter to Robert Spitzer. 4 December.

Hyer, S. (1977a). "Chronic Undifferentiated Unhappiness" (CUU) and "Chronic Complaint Disorder" (CCD). Memo sent to Robert Spitzer and the DSM-III Task Force for consideration. 10 May.

Hyer, S. (1977b). Unpublished memo to Robert Spitzer on Passive-Aggressive Personality Disorder. 31 October.

Levitt, L. (2001). *Prescription Drug Trends*. Washington, DC, Henry J. Kaiser Family Foundation.

MacKinnon, R. (1978). Unpublished memo to members of the Advisory Committee on Personality Disorders. 17 May.

McDaniel, P. (2003). *Shrinking Violets and Caspar Milquetoasts: Shyness, Power, and Intimacy in the United States, 1950-1995*. New York, New York University Press.

Millon, T. (1978). Unpublished memo to the Advisory Committee on Personality Disorders. 28 June.

Psychology Today (7.8.1993). 'Disorder of the Decade'. *Psychology Today* 26.

SmithKline Beecham (1999). *New Hope for People with Social Anxiety Disorder*

Spiegel, A. (3.1.2005). 'The Dictionary of Disorder: How One Man Revolutionized Psychiatry'. *New Yorker*.

Spitzer, R. (1978). Unpublished memo to the Advisory Committee on Personality Disorders. 12 April.

Stein, M., J. Walker, and D. Forde (1994). 'Setting Diagnostic Thresholds for Social Phobia: Considerations from a Community Survey of Social Anxiety'. *American Journal of Psychiatry* 151.

Stephenson, M. (2005). 'Should Apathy Be Included in the DSM-V?' *NeuroPsychiatry Reviews* 6.

Talan, J. (11.3.1986). 'Diagnosis by the Book: Controversy over Revisions of the Manual Psychiatrists Use'. *Newsday*.

Wilson, M. (1993). 'DSM-III and the Transformation of American Psychiatry: A History'. *American Journal of Psychiatry* 150.