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Controversies in Psychiatry and DSM-5: The Relevance for Social Work (*Occasional Essay*)

Jill Littrell & Jeffrey R. Lacasse

This essay addresses recent controversies surrounding the forthcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*—the first major revision of the *DSM* since 1994), as well as questions regarding the safety and efficacy of psychotropic medications discussed in the public domain. Mental health professionals across a wide range of professions have signed a petition to the *DSM-5* Task Force protesting changes in the new edition, and critiques of psychiatric medications are increasingly disseminated in the media. These issues have particular relevance for children in foster care, who receive diagnoses and medication at high rates. The general public is increasingly exposed to information on these topics through the media; as advocates and clinicians, it is important that social work practitioners be informed regarding these issues.

Controversial issues in psychiatry are relevant to social workers because they provide the majority of mental health services in the United States (Cohen, 2003; Mechanic, 2008). The controversy over revisions in the upcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) has been widely discussed in newspapers and by the Public Broadcasting System's *NewsHour*. The efficacy of antidepressants has been questioned on *60 Minutes,* when Lesley Stahl (2012) interviewed Irving Kirsch. Recently, a petition (Open letter to the *DSM-5,* 2011) launched by the Society for Humanistic Psychology and several other American Psychological Association (APA) divisions, was posted on the Web (http://www.ipetitions.com/petition/dsm5). This essay will begin with some background on what prompted the petition and why Allen Frances, co-chair of the fourth edition of the *DSM* (*DSM-IV*), has become a self-professed crusader. The relevance of the controversies in psychiatry to indigent children and children in foster care will be reviewed here as well. Concerns about the problematic addition of new diagnoses and the narrowing of diagnoses elsewhere for the *DSM-5* will be discussed. A brief overview of the controversy regarding antidepressants will be presented. Finally, some thoughts regarding how social work can respond will be proffered.

The Petition

The petition (Open letter to the *DSM-5,* 2011) asks the *DSM-5* Task Force to reconsider its intention to loosen and expand the criteria for a variety of diagnoses. According to Frances (2011c), this petition has been signed by more than 5,000 mental health professionals and 17 different mental health professional organizations. Frances (2011b) earlier had urged colleagues to sign the petition.

The petition to the committee developing the *DSM-5* follows earlier attempts by Frances to prevent the American Psychiatric Association from "falling off a cliff" (Greenberg, 2010). Frances (2010), concerned about the proliferation of new diagnostic labels, published an article in the *Los Angeles Times* questioning whether "normality is an endangered species." Before this, Frances (2009) published an article in *Psychiatric Times* urging caution in the development of criteria for various proposed disorders and decrying the unintended consequences of the manner in which the *DSM-IV* criteria were stated, which led to the epidemic rise in the diagnoses for attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorders, and bipolar disorder. In an interview, Frances explained his activism, "Kids getting unneeded antipsychotics that would make them gain 12 pounds in 12 weeks hit me in the gut. It was uniquely my job and my duty to protect them. If not me to correct it, who? I was stuck without an excuse to convince myself" (Greenberg, 2010).

The particular issue of children receiving antipsychotic medications is connected to the rise in the diagnosis of pediatric bipolar disorder. Although the diagnosis of pediatric bipolar is not in the revised *DSM-IV* (*DSM-IV-R*), no age restriction was placed on the adult diagnosis in the *DSM-IV-R*. When Harvard University's Joseph Biederman and colleagues began publishing articles reporting that children, many of whom had been previously labeled as conduct disorder or ADHD, met criteria for bipolar disorder, the diagnosis of pediatric bipolar took off (Littrell & Lyons, 2010a). Whereas it had been assumed that bipolar disorder never emerged until late adolescence or adulthood, by 2004 it was the most frequent diagnosis for children (Blader & Carlson, 2007). A similar increase in bipolar spectrum diagnoses was witnessed for adults as well, according to Moreno et al. (2007).

As more children and adults were labeled bipolar, the use of atypical antipsychotics escalated. Domino and Swartz (2008) documented the rise in the use of atypical antipsychotics for both children and adults. Most recently, Comer, Mojtabai, and Olfson (2011) documented

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an increase in the use of atypical antipsychotics for the treatment of anxiety disorders. As the addictive liability of tranquilizers has received attention, an atypical antipsychotic, Seroquel (quetiapine), is now being used for insomnia (Sinaikin, 2010).

While Comer et al. (2011) documented the rise in the use of atypical antipsychotics, others have documented the deleterious impact of the atypicals. In February 2011, Ho, Andreasen, Ziebell, Pierson, and Magnotta (2011) published their findings of brain volume reduction given the use of antipsychotic medications (both older neuroleptics and the new atypicals). While the Ho et al. study did not use random assignment to conditions, and thus causality could not be inferred from their data, the researchers cited animal work with the same findings, where random assignment was observed. After 27 months of dosages in the therapeutic range for people, there was an 11.8–15.2% reduction in the parietal lobe and a reduction in total weight of brain volume (Konopaske et al., 2007, 2008). Brain tissue volume decrement is only the latest recognition of the devastating impact of the atypical antipsychotics. Atypicals are associated with weight gain that does not plateau, high levels of blood lipids, and increased risk of diabetes (Goodwin & Jamison, 2007, p. 846), as well as osteoporosis (Kawai & Rosen, 2010). Although the atypicals were initially believed to be free of movement disorder risks, the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study, a large government-funded study, revealed that the atypicals, like older neuroleptics, can cause movement disorder (Casey, 2006). Additionally, the Food and Drug Administration (FDA) has issued a warning regarding Seroquel's capacity to induce cardiac arrhythmias and sudden death (Wilson, 2011).

Relevance to the Child Welfare System

Children covered by Medicare and Medicaid are more likely to receive prescriptions for antipsychotics than privately insured children. High proportions of foster children are being medicated with antipsychotics and polypharmacy (dosReis, Yoon, Rubin, Riddle, Noll, & Rothbard, 2011; Littrell & Lyons, 2010b), which is costly (Leslie & Rosenheck, 2012). This is particularly troublesome given that few medications are FDA-approved for children. State Medicaid programs allow for more office visits when there is a severe diagnosis, and Supplemental Security Income (SSI) eligibility is easier to obtain with a severe diagnosis, both of which probably contribute to the increase in severe diagnoses and heavy medications (Littrell & Lyons, 2010b). Recently, push-back on these issues has occurred. On December 1, 2011, U.S. Senator Tom Carper held a hearing on the report of the U.S. Government Accountability Office (GAO) investigating medication of foster children. In several states, doses were found that exceeded the maximum levels approved by the FDA. Across states, 0.11–1.33% of children were being treated concurrently with more than five medications. According to the GAO panel, "Our experts also said that no evidence supports the use of five or more psychotropic drugs in adults or children, and only limited evidence supports the use of even two drugs concomitantly in children" (GAO testimony, 2011, p. 14).

Concerns regarding prepsychosis. In addition to concerns about the rise in atypical antipsychotic medication use for children, Frances (2011a) also expressed concern about the inclusion of a prepsychosis diagnosis in the impending *DSM-5*. Frances reported that attempts to identify those individuals who would later become psychotic have yielded high levels of false positives (see Thompson, Nelson, & Yung, 2011). Antipsychotics have failed to prevent the emergence of psychosis in high-risk groups (Marshall & Rathbone, 2011; although the salubrious Omega-3 fatty acids have demonstrated efficacy in preventing the emergence of psychosis in those at high risk—see Amminger et al., 2010). Frances fears a new diagnosis of prepsychosis could result in many more individuals being stigmatized and placed on ineffective medications with severe adverse effects. Social worker researchers should endeavor to identify social factors that prevent the emergence of psychosis in those who are at risk so that prevention strategies can be developed.

Limiting diagnoses without drug treatments. Ironically, the *DSM-5* Committee on Autism Spectrum Disorders has suggested more stringent criteria. Dr. Fred Volkmar, director of the Child Study Center at the Yale School of Medicine, forecasted that the new criteria would disqualify many of the individuals who are currently being treated. Consumer advocates have protested the tightening of criteria for autism spectrum disorders, fearing the loss of insurance coverage of nonpharmaceutical treatments (Carey, 2012). Since social workers provide services to the developmentally disabled, this change could limit the ability of social workers to serve their clients.

Controversy about the efficacy of antidepressants. The questionable use of antipsychotics is only one of the latest controversies in psychiatry. Speaking more broadly, Thomas Insel, current director of the National Institute of Mental Health (NIMH), reflected, "The unfortunate reality is that current medications help too few people get better and very few people to get well" (2009, p. 704). In *Anatomy of an Epidemic*, Whitaker (2010) examined each category of psychotropic medication in turn. He contrasted current outcomes of psychiatric disorders with outcomes for these same disorders prior to the advent of drugs. Surprisingly, not only are current outcomes not any better than those prior to drugs, but for major depression and for bipolar disorder, current treatment seems to contribute to chronicity. Whitaker's book was reviewed in *New York Review of Books* in the summer of 2011 by Marcia Angell, the former editor of *The New England*

Journal of Medicine. Angell pointed out the lack of data on long-term outcomes with psychiatric medications; placebo-controlled trials, often sponsored by industry, evaluate outcomes after only 8 weeks. Moreover, there are no definitive tests for any of the diagnoses in the *DSM*. Angell did not disagree with Whitaker's conclusions (Angell, 2011a, 2011b, 2011c).

An exchange between Angell and several psychiatrists (i.e., Oldham, Friedman, Nierenberg, and Carlat) later was published in the *New York Review of Books* (2011c). In response to Angell in the exchange, Oldham argued that depression is undertreated and that psychiatry, as a whole, has never argued that "chemical imbalances are causes of mental disorders or the symptoms of them" (Angell, 2011c, p. 82). Friedman and Nierenberg, in response to Angell, argued that physicians in other areas of medicine treat before they understand the conditions they are treating. Also, in response to Angell, Carlat cited Turner and Rosenthal's (2008) defense of antidepressants, who wrote, "When considering the potential benefits of treatment with antidepressants, be circumspect but not dismissive" (p. 51).

The Larger Context

The subtext of the current controversies refers to corruption in the process of the writing of the *DSM-5*. The obvious "elephant in the room" behind the rise in psychiatric diagnoses is the unhealthy relationship between academic psychiatry and the pharmaceutical industry. U.S. Senator Charles Grassley's Finance Committee investigated the degree to which prominent psychiatrists who set standards for practice are paid by industry, revealing that several had failed to disclose the extent of their financial ties to drug companies (Harris & Carey, 2008). Others have decried the influence of pharmaceutical houses in medicine (Bremner, 2011; Elliot, 2010; Sinaikin, 2010). This potential for influence extends to *DSM-5* task force members, many of whom have financial ties to the pharmaceutical industry (Cosgrove & Krimsky, 2012).

Angell (2005) has published extensively on the broader issue of the pharmaceutical industry and purveyors of devices influencing students in medical school with biased information. Most of the clinical trials in this country are funded by industry, and only positive findings are published (Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Given the rampant ghostwriting by industry in medical journals (Lacasse & Leo, 2010), industry-funded studies are sometimes best regarded primarily as marketing efforts rather than truth-seeking endeavors. How is the reader of journal articles to know when these influences are or are not present? The ramifications of this commercial influence on the interrelated practice of diagnosis and treatment by social workers are difficult to quantify, but certainly our profession must wrestle with these issues.

Action Strategies for Social Work Professionals

So how should social workers respond to these developments? The APA has not taken a position on the online petition to the *DSM-5* Task Force, although a special e-mail was sent to members to alert them to an article by Rebecca Clay in the February 2012 issue of *Monitor*. Clay (2012) pointed out that most psychologists use the World Health Organization's *International Classification of Diseases* rather than the *DSM*. Indeed, Frances (2011c) has suggested that mental health professionals can defect from using the *DSM* in rendering diagnoses if efforts toward reform are unheeded. The National Association of Social Workers (NASW) announced the petition on its website but has not taken an official position. Given the social justice orientation of our profession and our history of critical engagement with the issue of diagnosis (e.g., Kutchins & Kirk, 1992; Saleebey, 2001), social workers should read and consider signing the petition. On a macro level, NASW should consider entering this debate, particularly regarding the diagnosis of foster children and other vulnerable populations. Practicing social workers should familiarize themselves with the many controversies related to *DSM-5* (only a few of which are addressed here), so that they can apply critical thinking to the question of diagnoses relevant to their practice context. In particular, practitioners should consider whether certain diagnostic labels drive the prescription of psychiatric medications to their clients, and whether other explanations or labels for behavior might instead facilitate the use of effective psychosocial interventions for client problems (e.g., should major depression be diagnosed and antidepressants used in the wake of a major loss? See Horowitz & Wakefield, 2007). While *DSM* clearly serves a valid bureaucratic purpose as a vehicle for reimbursement, these controversies illustrate the debatable science underlying many of the *DSM* categories. Social work researchers should be aware that NIMH now recognizes the problems with *DSM* and that the 21st-century research agenda for studying mental disorders will change substantially to move beyond such *DSM* categories (Insel et al., 2010).

The closely related issue of medication is also important for social work to address, as social workers are involved in psychoeducation and related roles (Bentley, Walsh, & Farmer, 2005). Serving in this role requires considerable preparation, and social work educators should consider this reality when developing curricula; course content on psychiatric drugs should be offered to all clinical students. In clinical practice, social workers should present full disclosure regarding any medication discussed. This requires that practicing social workers be familiar with the efficacy of various medications, including the proportion of people who respond to drugs as compared to general-

ized helping or psychotherapy, as well as the probability of recovering without drugs. To meet our ethical mandate to our clients, this requires that social workers think critically about the source of knowledge about psychiatric drugs and realize the limitations of research produced by the pharmaceutical industry (Gomory, Wong, Cohen, & Lacasse, 2011). Social workers should provide information about withdrawal phenomena and the short- and long-term adverse effects of medications. Mental health practitioners should never instruct a client to stop taking a medication prescribed by a physician. Social workers can, however, provide documentation of the degree of efficacy of medications and their adverse effects. Then the client can make an informed decision when talking with a physician about current medications or have an informed basis for declining a referral for initiating medications (see Littrell & Ashford, 1995, on legal issues). Social workers should also be familiar with evidence-based psychosocial alternatives to medication; for instance, use of behavioral analysis and Vygotsky's methods (Bodrova & Leong, 1996) for helping foster children develop self-control. On a policy level, they should become informed about the issues regarding medicating foster children and advocate for stringent guidelines at the state level. Psychrights (http://www.psychrights.org/index.htm) website describes national protection efforts for children in foster care and specifics in what social workers can do. Finally, social work researchers should more aggressively probe the influence of the pharmaceutical industry on practice (see Stoesz, 2012) and advocate for more integrity in the process of conducting studies and disseminating information. In an era of evidence-based practice, the veracity and objectivity of peer-reviewed research is a deeply important issue (Gambrill, 2012).

With regard to further advocacy, the initial phase is providing documentation of a problem. Hopefully, this essay will alert the social work community to what is problematic about the manner in which we currently conceptualize and respond to human suffering. Our hope is that these issues will be further debated and discussed.

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