

**Review: Stuart Kirk and Herb Kutchins, *The Selling of DSM: The Rhetoric of Science in Psychiatry*, Aldine de Gruyter, NY, 1992**

Pages: 270

**Mammon for Souls**

The authors trace the history of the psychiatry's 'Bible', the Diagnostic and Statistical Manual, and it isn't pretty. From the outset, there is no agreed definition of 'mental illness' which give the opposing school of thought under Thomas Szasz endless ammunition against the whole concept of having a DSM.

The character of the main protagonist Robert Spitzer, and main arguments of voting in and out mental illness by plebiscite, also how the field trials of the DSM-III manual were merely user experience studies are most convincing.

On the 'science' of reliability, there is only subjectivity; in the favoured kappa method of comparing actual agreement between clinicians against 'chance' agreement, a ratio of 0.7 is considered 'good'. Rosenhan's malingering study is also mentioned, also, the fact that many practitioners diagnose illness without using all the DSM criteria is damning.

Given the increasingly malevolent grip psychiatry has on society, e.g., injustice to crime victims in the courts, and diagnosing-away people's liberties, this is a critical read to expose its foundations of sand.

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**I) Psychiatric Diagnosis and the New Bible (pp. 1-16)**

Emil Kraepelin attempted to classify, categorise, and describe psychiatric disorders as discrete entities.

From 1975-90, psychiatrists increased from 26-36K, clinical psychologists 15-42K, clinical social workers 25-80K, and marriage counsellors 6-40K.

Psychiatrists are at the bottom of the totem pole of medical specialists.

## **II) The Transformation of Psychiatric Troubles (pp. 17-45)**

Psychotherapists prefer the young, attractive, verbal, intelligent and successful (YAVIS). It has been described as, “purchase of friendship”.

“Mental illness” is really a residual behaviour category.

DSM-I was published 1952.

Reliability: two clinicians independently diagnosing the same illness in the same patient.

Diagnosis agreement is reduced by: different training levels; poorly defined ‘illness’ categories; time between appraisals; earlier diagnosis awareness bias.

$$\kappa = (\rho_o - \rho_c) / (1 - \rho_c)$$

$\rho_o$  = observed diagnosis

$\rho_c$  = proportion expected by chance.

## **III) The Social Control of Error (pp. 47-75)**

‘Progress’ is affirmed by denigrating the past and reinterpreting it as unsatisfactory.

A normal part of ‘problem-making’ is emphasise the negative.

## **IV) Making a Manual (pp. 76-119)**

Robert Spitzer: “I found myself talking to a very angry young man. At that time I was convinced that homosexuality was a disorder.” [p83]

In 1973, 58% were in favour of deleting homosexuality from the DSM, while only 37% voted against it.

Spitzer came up with, “dyshomophilia”.

In DSM-II, psychiatrists began using categories as part of the International Classification of Disease (ICD) system.

DSM-III was compiled from hundreds of experts in 14 communities. It was finished in 1980 after one year's editing.

David Rosenhan, *On Being Sane in Insane Places*, 1973, describes eight pseudopatients which were admitted to twelve hospitals by falsely reporting a single symptom. They remained there from 7-52 days.

Psychologists disagree that, "mental disorders are a subset of medical disorders".

Many disorders are, "obviously acquired through learning experiences."

DSM-III was approved based on "bureaucratic momentum".

Schizophrenia is the pivotal modern psychiatric disorder.

Five "axes" of behaviour are evaluated: Clinical Syndromes; Personality Disorders; Medical conditions; Psychological stressors; and Adaptive function.

## **V) A Careful Look at the Field Trials (pp. 120-131)**

Field studies' objective was to 'debug' the new classification system, not assess its validity.

The majority of participants diagnosed without meeting all DSM-III criteria.

## **VI) Reliability and the Remarkable Achievement (pp. 132-160)**

DSM-III trials evaluated 13K patients by 550 clinicians over 200 different facilities.

Diagnostic reliability ( $\kappa$ ) is the Achilles' Heel of psychiatry. Values of 0.7 are "standard".

## **VII) The Art of Claim-Making (pp. 161-198)**

The “impression management” hypothesis holds that politicians talk of issues in simplistic ways during campaigns, but in more complex ways after winning power.

Publications are appeals for scientific legitimacy, the “currency of intellectual exchange”.

An article is designed to answer the question: “Against the background of accumulated knowledge ... how can I present an original claim about a phenomenon to the appropriate audience convincingly so that thinking and behaviour will be modified accordingly?” [p164]

Major articles average 50 days for acceptance.

Doctor-patient information asymmetry is a major cause of low reliability.

Spitzer was sure he couldn't convert any Szaszians.

Psychiatrists are always careful to diagnose *disorders*, not patients.

Linking DSM-III to the ICD systems creates more “authority” and political power.

### **VIII) Securing Diagnostic Turf (pp. 199-218)**

Psychiatry's diagnostic “Critical Cs”: Correct; Clinical; Clarity; Compassion.

New DSM versions, “encourage everyone to purchase the new publication with its paraphernalia”. [p214]

### **IX) The Social Context of Diagnostic Error (pp. 219-248)**

Rationale for overdiagnosis (money) contradicts the justification for underdiagnosis (stigma of psychiatric labelling).