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Robert Spitzer and psychiatric classification: technical challenges and ethical dilemmas

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Dr Robert Leopold Spitzer (May 22, 1932–December 25, 2015), the architect of modern psychiatric diagnostic criteria and classification, died recently at the age of 83 in Seattle. Under his leadership, the American Psychiatric Association's (APA) Diagnostic and Statistical Manuals (DSM) became the international standard.

Dr Spitzer died of complications of heart disease at the assisted living facility, where he lived with his wife, Janet Williams (1).

Dr Spitzer was born in White Plains, New York. He graduated in psychology from Cornell University in 1953 and in medicine from New York State University School of Medicine in 1957. He completed his psychiatric residency from New York State Psychiatric Institute in 1961 and his training in psychoanalysis

at Columbia University in 1966. He spent his career at Columbia University and retired as professor of psychiatry in 2003.

American psychiatry in the 1950s was dominated by psychoanalysis, which had little interest in psychiatric diagnosis. This lack of emphasis resulted in significant and frequent diagnostic disagreements among psychiatrists. Psychiatry was facing a crisis of credibility. There were major scandals with normal people, posing as individuals with mental illness, being diagnosed, admitted to mental hospital and treated with psychotropic medication (2).

The late 1960s also saw many innovations in the field. The US-UK Diagnostic project highlighted significant discrepancies in practice between American and British psychiatrists (3). Edwin Gildea, at Washington University at St Louis, Missouri, advocated a medical model for psychiatry in which diagnosis played a crucial role. Encouraged by John Feighner, a discussion group led by Eli Robins and including Sam Guze, George Winokur, Robert Woodruff, and Rod Muñoz, reviewed key contributions to psychiatric diagnosis. They then set about developing new diagnostic criteria for major depression, antisocial personality disorder, and alcoholism. Their major

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contribution included systematic use of operationalised diagnostic criteria, emphasis on illness course and outcome and the need to employ empirical evidence to support diagnostic categories (4). The Feighner criteria (5), which were developed for 14 psychiatric conditions, were soon widely cited and used in research, and formed the basis for the development of the Research Diagnostic Criteria (6), which in turn were central to the development of DSM-III (7).

The Psychiatric Institute and Columbia University at New York provided the platform for Dr Spitzer's successful career. He became interested in reliable assessment and measurement and was part of its Biometrics division. He became a consultant to the APA's Diagnostic and Statistical Manual II (8), published in 1968, and quickly established his credentials within the profession. He developed a computer programme, *Diagno I*, which was based on a logical decision tree and could arrive at a psychiatric diagnosis using scores on the Psychiatric Status Schedule (9).

Dr Spitzer began reexamining the issues related to homosexuality, which at the time was listed as a mental disorder, in DSM-II. He engaged with gay-rights activists, examined measurable distress among people with homosexual orientation and found many people who were well adjusted with their sexuality. He argued for the label "sexual orientation disturbance" for gays and straights, who experienced distress. He led the movement within the APA to remove homosexuality from the list of psychiatric diagnosis. In 1973, the APA supported the notion that same-sex orientation is a normal variant of sexuality and removed it from its list of psychiatric disorders.

He was made the chair of the APA Task Force for the third revision of the DSM in 1974. DSM-III, produced under his leadership, introduced operational diagnostic criteria for its disorders, examined their reliability, used rigorously tested checklists and included the distress caused by the syndrome as an important precondition to diagnosis.

DSM-III introduced many radical changes including its so-called "atheoretical" approach, which essentially emphasised the medical model of mental disorders (10). It removed many psychoanalytic concepts such as psychoneurosis, hysteria, and depressive neurosis and replaced them with evidence-based ideas. It abandoned the concept of endogenous (melancholic/without stressor) and reactive (exogenous/with stress) depression by its use of a unified category of major depression, which did not consider context. However, its critics argued that collapsing the different types of depression with their differential drug response in a single category sans context was an error. DSM-III also subdivided the traditional category of anxiety into numerous diagnostic heads. Critics opposed the subdivisions as the new categories of anxiety had minor differences between them and they all had similar treatments. The manual also introduced new labels such as "attention deficit disorder" and "post-traumatic stress disorder".

Despite many controversies, DSM-III became a bestseller for the APA, enriching its coffers. In fact, its critics argued that the subsequent and frequent revisions of the manual (III Revision, IV, IV Text Revision, and 5) had more to do with their profit-making potential, as minor changes made were not based on rigorous evidence. Nevertheless, the changes ushered in by DSM-III found favour with the pharmaceutical industry as billions of dollars in profits were at stake. Its numerous diagnostic subcategories allowed for testing of the molecules in slightly different yet related populations. The inclusion or exclusion of labels had major financial implications for international corporations. The insurance industry also supported the new system as it realised the usefulness of standardised diagnosis for reimbursements.

DSM-III took the psychiatric world by storm. Either you followed the new diagnostic system or were considered unscientific and left behind. DSM-III became the Bible of psychiatric diagnosis and set the blueprint for future classification. One could not communicate with other psychiatrists without using DSM categories or publish articles in scientific journals without employing its criteria. The World Health Organisation's International Classification of Diseases-10 also followed the DSM lead cementing the process of change and the ushering in of a new culture for modern psychiatry.

Dr Spitzer is said to have freely courted attention and craved controversy through debate and disagreement (1). He dominated many revisions of the DSM and influenced successive classifications. However, his personality and authoritarian approach did not go down well with his colleagues. They argued that he delivered standardisation at the cost of humane interviewing and intuition. They suggested that DSM-III, which at the time was considered best available evidence, soon became gospel truth; the art of history taking was now reduced to symptom checklists.

Towards the end of his career, the success and adulation seemed to have affected his judgment. In 2001, he argued in a controversial paper that some gay men and lesbians could indeed change their sexual orientation from homosexual to heterosexual. He had held 45-minute telephonic interviews with 200 people who claimed that they had changed their sexual orientation. His colleagues were outraged and gay-rights activists felt betrayed. The APA issued an official disavowal of his claim arguing that the paper was not peer-reviewed, its methodology weak and its design not robust enough to address the issue or to substantiate the claim. It argued that there is no evidence that reparative therapy is efficacious in changing sexual orientation. In 2012, Dr Spitzer agreed with his critics and wanted to retract the paper.

Towards the end of his career, he also did admit that symptom counts sans contexts for arriving at psychiatric diagnosis medicalised normal human responses to distress in a significant proportion of people. He also felt that the DSM-5 revision process lacked transparency.

Dr Spitzer's legacy is intertwined with that of the DSM system. While it is too early to assess his impact on psychiatry, DSM-5 acknowledges its limitations. It admits that its approach of trying to achieve diagnostic homogeneity by subclassifying major categories no longer seems sensible as the numerous categories created over the past 35 years remain heterogeneous on aetiology, clinical features, treatment response, course and outcome (10). It also admits that inter-rater reliability, the justification for operational criteria and objective symptom checklists, is low (kappa 0.2–0.4) even for its standard diagnosis such as major depression (11).

DSM-5 is already under attack from neuroscience and genetics, which argue that its approach is simplistic, has not, and will not lead to the identification of homogeneous groups and biological aetiology. They argue against using DSM-5 as "gold standard". They propose an alternative format: Research Domain Criteria (RDoC), to map the underlying dimensions (12). However, the new scheme will take many years to bear fruit. The use of DSM in primary care, general and family practice has also been criticised because of differences in setting, perspectives, population, clinical presentations, diagnostic accuracy and usefulness in management (13).

The context of psychiatric diagnosis and classification

Psychiatric diagnosis, therapy and practice do not occur in a vacuum. Psychiatry operates within modern society with its diverse and complex social, economic and political environments, influences and pressures. The issues are briefly highlighted.

Clinical complexity

The lack of pathognomonic symptoms, the use of day-to-day phenomena (such as sadness, worry, anxiety, fatigue, sleep disturbance, etc.) and the absence of laboratory parameters to guide its diagnostic and therapeutic decisions forced psychiatry to focus on clinical syndromes (ie cluster of symptoms) making clinical decision-making complex.

DSM-III and its successors adopted a two-pronged approach to characterise psychiatric categories, identify unique aetiology and recognise specific treatments: (i) employing operational criteria for diagnosis to achieve good inter-rater reliability, and (ii) subcategorisation of broad diagnostic heads to attain diagnostic homogeneity. The DSM system with its operational criteria and symptom counts is essentially a technical advance for psychiatry.

Nevertheless, three decades later, while there has been modest improvement in reliability (11), the current categories remain heterogeneous (10). Despite major advances in human genetics and neuroscience, mental distress, illness and disease remain complex mysteries. While psychiatry argues that diagnosis and classification are based on available evidence, critics contend that the current socioeconomic and political climate influence the process.

The antipsychiatry position

While psychiatry argues that DSM and psychiatric classifications are based on empirical evidence, others suggest that they are a result of value judgments. The "antipsychiatry" movement has contended that mental illnesses are social constructs as there are no demonstrable abnormalities in the brain (14). They buy into the Cartesian dichotomy, with its strict dichotomous alternatives, and argue that mental illnesses are myths and should not be the concern of medicine and psychiatry, which should focus on the body and disease (15).

They posit that deviations from societal norms are used by society, in conjunction with the medical profession, for social control. The misuse of psychiatric labels to stifle all social and political dissent in the Soviet Union is an example of the role of psychiatry and medicine in social control. The argument is supported by the role of value in defining abnormal sexuality. Homosexuality initially diagnosed as a psychiatric disorder was changed to a normal variant of human sexuality through a vote among members of the APA in 1973.

Science and society

Despite its scientific base, medicine is a system sanctioned by the society in which it practices. Scientific knowledge consists of beliefs shared by experts (16). The social nature of science argues that scientific authority belongs to communities, both within and outside medicine. Michel Foucault recognised knowledge structures, which enhance and maintain the exercise of power (17). He argued that the religious practice of confession, secularised in the 18th and 19th centuries, allowed people to confess to their innermost thoughts. These became data for the social sciences, which used the knowledge to construct mechanisms of social control. However, Medicine in the early 20th centuries, switched emphasis from sin and social deviance to individual pathology.

Social determinants of mental health

Nevertheless, there is hard evidence to suggest that mental distress and illness are linked to social determinants of health (18). The failure to meet basic needs (eg clean water, sanitation, nutrition, housing, immunisation) due to poverty impacts physical and mental health (19). Patriarchy results in gross gender injustice and significantly affects the health of girls and women. Low education and unemployment are common causes of mental distress. Structural violence, discrimination, social exclusion, political oppression, ethnic cleansing, forced migration are common in poorer countries. Armed conflicts and war take their toll. These risk factors for poor mental health work through insecurity, hopelessness, rapid social change, risk of violence and poor physical health (20). However, the presence of interpersonal problems and marital discord, social and occupational stress, domestic violence and sexual abuse, poverty and structural violence, ethnic cleansing and forced migration, armed conflict and war, etc., although often causal, are not considered in the diagnosis (21).

Impact of political and economic systems

While illness represents individual suffering, the term disease is used to document structural and functional abnormalities. The blurred disease–illness divide, the inter-changeable use of these concepts and the illusion of specific brain pathology are supported by academia, health, insurance and pharmaceutical industries. Despite evidence that social determinants produce significant mental morbidity, most intervention strategies favour post-hoc individual treatments to population-based public health approaches that are useful in reducing structural violence and in empowering large sections of society.

Psychiatric labels for distress have shifted the focus from the responsibility of the state for poverty and structural violence and transferred pathology and burden to the individual. The disparate environments under which anxiety, depression and common mental disorders now exist are brought together as many strands, de-contextualised and unified into disease labels.

The progressive medicalisation of distress is compounded by increasing individualism in society, reduction in social and community supports, lowered thresholds for tolerance of suffering and for seeking medical attention (22). Consequently, in such situations, psychiatric labels are used to justify medical input and treatment. The use of symptom counts sans context to diagnose mental disorders results in people with normal reactions to stress and those who cannot cope with the complex demands of life receiving psychiatric labels. Clinical presentations of individual suffering are interpreted by the new psychiatric diagnostic system as abnormalities of structure or function and labelled as mental disorder. A diagnosis of depression, when viewed through the biomedical lens, tends to suggest disease, supposes a central nervous system aetiology and pathogenesis, documents signs and symptoms, offers differential diagnoses, recommends pharmacological therapies and prognosticates about the course and outcome (21). In addition, recent psychiatric classifications have increased, manifold, the number of diagnostic labels. Such diversity also means that those seeking help for any form of distress are often given a label and treated for that condition.

The political economy of health, deeply rooted in capitalistic economic and social systems, undergirds these formulations. It reiterates the historical relationship between medicine and governments; with governmental administration serviced by experts responsible for managing social security, stability and economic growth (17). It is an example of the broader role of medicine, of social control.

Psychiatric disease labels and individual treatments offer distinctive niches to diverse stakeholders: disease, reimbursement, profit, and deflection of responsibility. Depression, anxiety, common mental disorder labels and the culture of medicine fit in well with the neo-liberal agenda, allowing the free market to expand its business interests. It demonstrates the nested position of the discipline of medicine, within the agendas of governing, which determine

perspectives, formation of knowledge, institutional control and policy (17). The technical approaches of evidence-based medicine are not necessarily value-neutral nor above specific interests (23). Medicine is politics writ large and the health sector is a powerful player in national economies.

Classification in context

Classifications are not absolutes; they are merely indicators of current understanding of concepts and theories. They are meant to help mental health professionals communicate and are useful tools for statisticians and public health administrators. They aid in reimbursement for insurance companies. They provide pharmaceutical companies “homogeneous populations” on whom to carry out drug trials. They also help individuals find terms to communicate distress and seek support and treatment. However, the complexity and multiple dimensions of mental health, distress and illness complicate issues. The current classifications provide labels by arbitrarily dividing the many complex dimensions of mental health, distress and disease into dichotomous normal/abnormal categories. While the introduction of objective operational criteria for diagnosis has reduced subjectivity, arbitrariness and idiosyncrasy, the discounting of context in diagnosis has also medicalised normal human distress.

Nevertheless, legitimate diagnoses seem to combine fact and value (24). Dysfunction can be viewed both in terms of biology, science and fact as well as in the sociocultural context. While the DSM system clearly emphasises that societal norms should not be the sole criterion to assess mental disorders, it employs the definite requirement for the presence of “clinically significant” dysfunction, distress or disability in the individual to diagnose mental disorders (10). While it suggests that a negative value judgment is *per se* insufficient to diagnose mental disorders, it does not clearly acknowledge that psychiatric diagnosis seems to involve complex value judgments.

Values in psychiatric diagnosis and classification

While psychiatry contends that mental disorder diagnosis is value-free, philosophers and ethicists argue otherwise. They emphasise the role of values in psychiatric diagnosis, classification, research and treatment (24,25). They suggest that while diagnoses in psychiatry are based on science and evidence, they are also based on values. Their arguments include: (i) initial observations suggest that mental disorder is value laden compared to physical or bodily disorder; (ii) the value laden nature of mental disorders requires complex value judgments; (iii) psychiatric diagnosis is supported by complex facts and multifaceted values.

The shifting of the moral/medical boundary in forensic psychiatry, insanity defence and determinants of responsibility from moral-humanistic to medical scientific concepts was based on the changed emphasis from freedom of action and choice to determinism and the causal law in science (25). The shift of boundary is not just restricted to insanity defence in

psychosis but also to other psychiatric diagnosis. For example, alcohol dependence, and sexual deviations and disorders are medical categories, while sickness certification for work-related absence for mental ill health also excuses responsibility. Similarly, the evaluation of dysfunction, disability and distress, a requirement for all mental disorders, requires difficult clinical assessment, which in essence suggests challenging value judgments.

The psychiatry–antipsychiatry debates of the 1960–1970s held opposing positions related to psychiatric diagnosis as factual on the one hand and mental disorder labels as based on deviance from societal values on the other. There is a growing realisation that psychiatric diagnosis is based on scientific facts and on evidence and also involves complex value judgements (25). Openly acknowledging the factual and value-based nature of psychiatric diagnosis and making them explicit is crucial to understanding mental health, distress, illness and disease.

Values

Value can be defined as “guides to human action that are subject to praise or blame and that are present, implicitly or explicitly, in all human activities” (26). Values useful in psychiatric research include (i) *aesthetic*: related to notions of form and beauty; (ii) *epistemic*: related to claims of knowledge; (iii) *ethical*: related to goods, morality and virtue; (iv) *ontological*: related to human nature and existence; and (v) *pragmatic*: related to practical fulfilment of human actions.

Values can also be divided into value commitments, consequences and entailments (26): (i) value investment and commitments include relieving suffering and aiding the ill, considered an ethical imperative; knowledge acquisition and scientific development are epistemic and pragmatic objectives; (ii) value consequences, weighted according to effects of actions, include stigmatisation of people through diagnostic labels, an ethical problem; inappropriate prescription of psychotropic medication has negative ethical consequences; (iii) value entailments are implied or assumed in individual and global worldviews. These, including neurobiological reductionism and reification in operational criteria, diagnosis and classification and the commercialisation of mental healthcare with its political and economic pressures, are ontological issues.

Addition of ethical values to facts

While DSM-5 reviewed available evidence, used extensive field trials and rigorous reliability assessments and did allow for comments on its draft operational criteria prior to publication, many critics argued that the process lacked transparency. They argued that there was no public record of the rationale for changes, nor were the comments or response to the feedback available publicly (27). DSM-5 also does not directly discuss the role of ethics and values in diagnosis and classification (10).

While the reduction of human suffering is an ethical imperative for medicine and psychiatry, explicit commitment to relieving

distress is not directly stated in DSM-5 (10). However, the manual and its value commitments are mainly geared to aiding clinicians in their practice. The fact that DSM-5 is a useful guide to clinical practice implies that it does also share the goal of relieving distress, dysfunction and disability, albeit indirectly (27).

The DSM commitment to the expansion of knowledge and understanding of mental illness are also related to commitment to values. However, these are epistemic and political in nature. An increase in our scientific understanding will allow for preventive interventions, which would align psychiatry with medicine and would increase its status within medicine (27).

While stigma of psychiatric labels is widely acknowledged and the low threshold for prescribing psychotropic medication is a reality in psychiatric practice, they are not debated in DSM-5. Opponents to psychiatric diagnosis and classification frequently highlight over-diagnosis and inappropriate treatment, with their consequent stigma and discrimination, while psychiatry tends to sidestep these issues by focusing on benefits of early intervention (27).

The influence of social, economic and political forces is not usually discussed in the official DSM-related literature. Nevertheless, those who oppose the newer diagnostic categories emphasise “diagnostic creep” where people with milder symptoms are given psychiatric labels to satisfy requirements for insurance to meet diagnostic standards of treatment guidelines. In addition, pharmaceutical companies, with their physician education programmes, have significant influence on prescribing practice including off-label prescribing (27).

The other consequences of diagnosis include neurobiological reductionism, which seems to encourage psychotropic medication as the treatment of choice. It also leads to the reification of criteria, which imply a misplaced concreteness to abstract formulations (27).

These diverse values also result in conflicts and conflicts of interests. These values and conflicts are also dependent on people holding them. Diverse stakeholders in the care and treatment of people with mental illness including people receiving psychiatric labels, their career, mental health activists, researchers and those from the pharmaceutical and insurance industries hold conflicting positions. For example, the pharmaceutical industry favours lowered diagnostic thresholds and early intervention with psychotropic drugs and consequently supports values that argue for relieving distress, expanding knowledge, neurobiological reductionism and reification to push for increased use of medication. On the other hand, those who oppose psychiatric diagnosis will support the relief of suffering and psychological treatments. Researchers, in addition to supporting new understanding, prefer a niche for themselves within academia. The complex

issues related to the prioritisation of conflicting values and positions demand an open discussion of values, and their ranking by diverse stakeholders.

Value-based clinical psychiatric practice will demand an open debate. The proponents of value-based framework for clinical practice have argued in favour of fact-plus-value perspectives in healthcare. They suggest the need for a new skill-based approach to working more effectively with complex and conflicting values in health and social care (28).

DSM-5 did not debate ethics and values. In fact, it seems to take a position that objective operational criteria are value-free (29). DSM-5.1 will necessarily have to discuss the complexity of psychiatric diagnosis and classification including the diverse pressures and influences and its impact on ethics and values (28). There should be openness about disagreements and conflicts of interests, while acknowledging a plurality of values, where more than one set is justifiable but they may also be incompatible. Respect for different values held by diverse stakeholders should not prevent debate and interrogation of the issues.

Conclusion

Although Robert Spitzer's efforts resulted in DSM becoming the international standard, psychiatry, despite its current attempts at testable conjectures, is still within a paradigm, which seems inadequate for the complexity of the task. It is awaiting a paradigm shift (30), which will provide new understanding. Nevertheless, modern psychiatry, based on operational diagnostic criteria and phenomenological categorisation will need to acknowledge the influence of values on diagnosis and classification. It needs to openly debate values and devise classifications where values add to evidence. It awaits its paradigm shift and revolution.

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