CHAPTER 5

Fads of the Present

"When I use a word," Humpty Dumpty said, in a rather scornful tone, "it means just what I choose it to mean—neither more nor less."
"The question is," said Alice, "whether you can make words mean so many different things."
"The question is," said Humpty Dumpty, "which is to be master—that's all."
LEWIS CARROLL, *Alice's Adventures in Wonderland*

HUMPTY DUMPTY BRAGS unrealistically about his ability to master words and control their definition. His pride qualifies him for the well-deserved great fall he is about to have. One of the things Alice is constantly discovering in Wonderland is that words can fly out of control and have different and confusing meanings, very dependent on context. It is not so much what you "choose to mean" as it is what others take you to mean. And that can be much more or much less than you intended.

We were unaware how much we were in Humpty's precarious position when *DSM-IV* was published in 1994. We shared his complacent

belief in the power of carefully chosen words and were surprised when ours also flew out of control. Our goal was to prevent diagnostic inflation from growing and our conceit was to think we had succeeded in holding the line.[1] We were wrong.[2] It turns out that the impact of the diagnostic system is not in the words as written, it's in the way words come to be used. *DSM-IV* was meant to be a careful and conservative diagnostic manual, but once out of our hands, it was not always used carefully and conservatively. We thought we shot down every new suggestion that might be a giveaway to the drug industry. But we greatly underestimated their power to convince practitioners and patients to apply our words in the loosest possible way. A colorful TV commercial has much more dramatic impact than the fine print of a dry *DSM-IV* criteria set. The constant blitz of misleading marketing easily overwhelmed the barriers to overdiagnosis we thought were built into our definitions. As it turned out, *DSM-IV* unwittingly contributed to three new false epidemics in psychiatry—the overdiagnosis of attention deficit, autism, and adult bipolar disorder. Rule of thumb—if anything in a *DSM* can possibly be misused, it will be misused.

We should have known better. Conflicts between the written and oral tradition are as old as the Bible and as current as the Supreme Court's interpretation of the Constitution. The written words themselves generally don't rule—it is all in their later interpretation. Alternate productions of the same play can each convey very different meanings without ever changing one single word. The lesson of the last fifteen years is that the *DSM* alone does not establish standards. Physicians, other mental health workers, drug companies, advocacy groups, school systems, the courts, the Internet, and cable TV all get to vote on how the written word will actually be used and misused. There are false prophets and false epidemics. You get to exert control over the diagnostic manual only up to the moment you publish it. Once it is out in the public domain, people use it (and often misuse it) as they damn well please.

Below is a rogues' gallery of the current false epidemics in psychiatry—

the mental disorders most likely to be overdiagnosed and overtreated. Describing them will hopefully reduce their spread. But first, one important caveat—a fad diagnosis is a useful diagnosis gone wild. Many, perhaps most of the people who currently have the diagnosis have gotten it for good reason. These are "fads" only because they have become too fashionable and are often loosely and inappropriately applied—particularly in primary care. Each, in its right place and accurately diagnosed, is absolutely essential to understanding and treating psychiatric symptoms. Anyone at the margins who has already received one of these diagnoses should get a second opinion. Always be skeptical, but not too skeptical.

Attention Deficit Disorder Runs Wild

It is 6:00 A.M., dark and rainy, and I am driving to the airport. I can't put up the top to my convertible because it has been broken for months, but I keep forgetting to get it fixed. I arrive, double-park to check my bags, leaving the lights on and the radio blaring golden oldies from the 1960s, 1970s, and 1980s. On returning a week later, I can't find my car in the garage. This is surprising to me, but shouldn't be, because I never parked it there. I forgot it altogether, just checked the bags and blithely boarded the plane. Good-humored security officers call in all their buddies to enjoy a hearty laugh at my expense. I am enormously grateful to them for towing my car to a safe place, charging my battery, and refusing any money because the rare experience of meeting anyone so silly has been more than enough reward.

My secretary, Tammy, has similarly found her life enriched by the delectation of my magical ability to lose papers going the ten feet from her office to mine, my repeated inability to find my office in a hospital maze I have worked in for years, and my capacity to forget meetings and appointments. My wife is much less connoisseur than critic. She unempathically claims that my lack of attention to the needs and errands of everyday life reflects willful avoidance rather than diagnosable mental disorder. My life has been a kind of sheltered workshop. The kindness of friends and strangers has protected me from any serious impairment.

Am I an absentminded professor or psychiatrically sick? Should I start taking stimulants or muddle through after my fashion? In the old days I was a normal, if sometimes ridiculous, person. But things are different now. ADHD is spreading like wildfire. It used to be confined to a small percentage of kids who had clear-cut problems that started at a very early age and caused them unmistakable difficulties in many situations. Then all manner of classroom disruption was medicalized and ADHD was applied so promiscuously that an amazing 10 percent of kids now qualify. Every classroom now has at least one or two kids on medication. And increasingly, ADHD is becoming an explain-all for all sorts of performance problems in adults as well.

How could this possibly happen? There were six contributors: wording changes in *DSM-IV*; heavy drug company marketing to doctors and advertising to the general public; extensive media coverage; pressure from harried parents and teachers to control unruly children; extra time given on tests and extra school services for those with an ADHD diagnosis; and finally, the widespread misuse of prescription stimulants for general performance enhancement and recreation.

The most obvious explanation is by far the least likely—that the real prevalence of attentional and hyperactivity problems has actually increased. There is no reason to think the kids have changed, it is just that the labels have. We now diagnose as mental disorder attentional and behavioral problems that used to be seen as part of life and of normal individual variation. The most convincing evidence of this comes from a large study with a particularly disturbing finding. A child's date of birth was a very powerful predictor of whether or not he would get the diagnosis of ADHD. Boys born in January were at 70 percent higher risk than those born in December simply because January 1 was the cutoff for grade assignment. The youngest, least developmentally mature kids in the class are much more likely to get the

ADHD diagnosis. The birthday effect was almost as influential in girls. We have turned being immature because of being young into a disease to be treated with a pill.[3,4,5]

The *DSM-IV* contribution was inadvertent and probably only a bit player in the selling of ADHD. We changed a few words so that the definition would be more female friendly—taking into account that girls are more likely to be inattentive "space cadets" and less likely than boys to be hyperactive. Extensive field testing predicted only a 15 percent increase in rates, but we were later blindsided by clever drug marketing which caused rates to triple. Until the mid-1990s, ADHD had occupied a tiny, sleepy corner of the vast and active pharmaceutical enterprise, barely worth noting. The stimulant drugs used to treat ADHD had been off patent for decades and could be purchased in generic form for pennies a pill. Total revenues of $50 million a year for ADHD medications amounted to no more than a rounding error in drug company financial reports. There was no advertising to patients or marketing to doctors. ADHD seemed a safe, no-profit diagnosis flying well under Pharma's searching radar.

Conditions changed dramatically a few years after the publication of *DSM-IV*. Several newly patented and expensive ADHD medications came on the market. Coincidentally, the drug companies had just been given the right to advertise to consumers—and did they ever take advantage of this with an all-media-all-the-time advertising fanfare. The blaring propaganda message was the usual—ADHD is extremely common, often missed, and accounts for why Johnny is a behavioral problem and isn't learning in school. "Ask your doctor." Armies of eager sales reps filled the offices of pediatricians, family doctors, and psychiatrists peddling a pill that would magically prevent classroom disruptions and solve home meltdowns. Parents, teachers, and physicians were recruited in an all-out effort to identify and aggressively treat ADHD.[6,7]

There is lingering controversy on how much the tripled prevalence of ADHD should be the cause of celebration or serious concern or perhaps both. Some believe that the higher rates mostly reflect the useful identification of ADHD in people who were previously missed. This is partly true. No doubt increased diagnosis has been helpful for many children who otherwise would not have received a much-needed and appropriate treatment. Medication for these correctly diagnosed kids can (at least in the short run) improve learning, prevent restlessness, reduce impulsive outbursts, help them feel more comfortable in their own skins, and reduce blame and stigma. For children who really need it, stimulant medication is safe and effective—a real godsend to them, their parents, and teachers.

But there is an unhappy flip side to this feel-good story. The gains to some have to be offset against the serious costs to others. Much of the increased prevalence of ADHD results from the "false positive" misidentification of kids who would be better off never receiving a diagnosis. Drug company marketing pressure often leads to unnecessary treatment with medications that can cause the harmful side effects of insomnia, loss of appetite, irritability, heart rhythm problems, and a variety of psychiatric symptoms. Add to this the emerging problem of stimulant misuse for performance enhancement and intoxication. Do we really want 30 percent of our college students and 10 percent of our high school students scoring prescription stimulants illegally so they can do better on a test or have more fun at a party? Monitoring the large, illegal secondary street and school market for stimulant drugs has even made it hard to have adequate supplies for legitimate purposes.[8]

How can we cut down on loose diagnosis and excessive use of medication? Just a few doctors in each community are responsible for most of the overprescribing. Quality controls and shaming can dramatically tame their practice habits.[9] Doctors also need education that, contrary to what they have learned from Pharma, the best approach to ADHD is a graduated "stepped diagnosis"—not "shoot first, aim later." Diagnose early and begin medication quickly only when the ADHD symptoms are very severe, pressingly urgent, and classic in presenta-

tion. Whenever symptoms are mild or equivocal (as often is the case), it is best to sit back and have a period of watchful waiting. Often the symptoms will be transient—reactive to family, peer, or school stress. Sometimes the kid is just immature. Sometimes the problem is substance abuse or another psychiatric disorder that needs to be ruled out during the period of observation. If the problems persist but are not severely impairing, the next steps would be educational or psychotherapeutic in orientation. The final step of definitive diagnosis and medication treatment would be reserved only for those who fail to respond adequately to earlier steps. Unfortunately, there is no well-financed public and physician educational campaign to promote this sensible stepped approach. The drug company rush-to-diagnosis and mindlessly prescribe-the-pill message has dominated the conversation—turning many normally immature kids into prematurely medicated mental patients.

Childhood Bipolar Disorder

When I began psychiatric training forty-five years ago, we were not taught anything about childhood bipolar disorder (CBD). There was no point—it was so vanishingly rare that no one had seen any cases. I once evaluated a nine-year-old boy whose symptoms seemed bipolar, but my supervisor told me to stop searching for the exotic. His advice was "when you hear hoofbeats on Broadway, assume it's horses out there, not zebras." In those old days, we were undoubtedly missing some cases of childhood bipolar and sometimes withholding what might have been helpful treatment.

But now the pendulum has swung wildly and dangerously in the other direction. CBD has become the most inflated bubble in all of psychiatric diagnosis, with a remarkable fortyfold inflation in just one decade. CBD satisfied three essential preconditions for excessive popularity: a pressing need, influential prophets, and an engaging story.

The pressing need was created by the disturbed and disturbing kids encountered in clinical, school, and correctional settings. They suffer and cause suffering to those around them—making themselves noticeable to families, doctors, and teachers. Everyone feels enormous pressure to do something. Previous diagnoses (especially conduct or oppositional disorder) provided little hope and no call to action. In contrast, a diagnosis of CBD purports (falsely) to explain the misbehavior and justifies a medication intervention.

The false prophets were influential and charismatic "thought leaders" who had the added prestige of coming from Harvard. They spread an apocryphal gospel evangelized widely to child psychiatrists, pediatricians, family physicians, parents, and teachers. Their energetic crusade was heavily financed by the drug company sponsors who would be the major beneficiaries. The prophets had gone up to the mountaintop and come down with a new dogma—henceforth the old *DSM* rules for diagnosing bipolar need not apply to children. CBD no longer required the presence of classic mood swings between mania and depression. Instead the diagnosis could be made in a free-form, inclusive way to include a variegated hodgepodge of kids who were irritable, temperamental, angry, aggressive, and/or impulsive. The CBD boundaries were thus to be pushed far into unfamiliar territory to label children who previously received other diagnoses (e.g., attention deficit, conduct, oppositional, or anxiety disorder) or no diagnosis at all ("temperamental" but normal kids). A vast new market was opened for grateful Pharma. Mood swings are rare in kids—not a good sales target. But irritability is common enough to bring in blockbuster sales. And bipolar disorder is usually considered a lifelong diagnosis. Turn a child of tender age into a customer and he might be yours for life.

It is not at all surprising that the pharmaceutical industry pushed the expanded definition of CBD and cashed in on its newfound popularity. More surprising was the enthusiastic acquiescence of doctors, therapists, parents, teachers, advocacy groups, the media, and the Internet.

Once the rigors of *DSM-IV* definition were thrown out the window, mood-stabilizing and antipsychotic medications were given out wildly to treat fake CBD. The results have been devastating. Kids can have a rapid and substantial weight gain—an average twelve pounds in twelve weeks—increasing the risk of diabetes and possibly reducing life span.[10,11,12] The most egregious malpractice has been loading up two- and three-year-olds with medication to treat a ridiculously premature diagnosis of bipolar disorder—in some cases killing them with lethal overdoses.[13]

CBD also carries considerable stigma, implying that the child will have a lifelong illness requiring lifetime treatment. The diagnosis can distort a person's life narrative, cutting off hopes of otherwise achievable ambitions, and also may reduce a sense of control over, and responsibility for, undesirable behavior. Other more specific causes of temper outbursts are much shorter lived and amenable to time-limited treatment. Substance abuse should always be the first thought for any irritable teenager. And attention deficit disorder often presents with an irritability that responds best to stimulants, but these may be withheld in the face of an incorrect bipolar diagnosis.

The CBD fad is the most shameful episode in my forty-five years of observing psychiatry. The widespread use of dangerous medicine to treat a fake diagnosis constitutes a vast public health experiment with no informed consent.

It is some small comfort that it did not arise from anything we wrote into *DSM-IV*—we rejected the suggestion for a criteria specific to CBD that would have legitimized the fad and given it more force. But I wish we had put a black box warning in the bipolar disorder section cautioning clinicians not to be fast and loose in giving young kids a diagnosis that most often did not apply to them and could have such dangerous consequences.

Autism Becomes Fashionable

The diagnosis of autism has exploded in the past twenty years. Before *DSM-IV*, this was an extremely rare condition, diagnosed in one child per two thousand. The rate has now jumped to one in eighty in the United States and an even more amazing one in thirty-eight in Korea.[14,15,16] The first reaction was parental panic—worries about autism at the slightest sign that a child was not perfectly conventional. This was reinforced by a paper in *The Lancet* suggesting that autism might be caused by vaccination. In fact, their co-occurrence is no more than a coincidental chronological fluke—the typical age of onset of autism happens to occur at around the same time that vaccinations are scheduled. Conclusive studies have since disproved any causal connection, and *The Lancet* retracted the original paper when it was later exposed as a scientific fraud.[17] But despite all the evidence to the contrary, misplaced parental fear somehow persists. Avoiding vaccination to protect against a false epidemic of autism has put many kids at risk for very real epidemics of measles and other once conquered and sometimes dangerous childhood diseases. All this reflects the general public misunderstanding of how psychiatric diagnosis works—i.e., that the prevalence rates are always extremely sensitive to any change in definition. The twentyfold increase in just twenty years occurred because diagnostic habits had changed radically, not because kids were suddenly becoming more autistic.[18]

The autism "epidemic" has three causes. Some part surely comes from improved surveillance and identification by doctors, teachers, families, and the patients themselves. Spotlighting any problem reduces stigma and improves case finding. Some was triggered by the *DSM-IV* introduction of Asperger's disorder, a new diagnosis that greatly broadened the concept of autism. But about half of the "epidemic" is probably service driven—children get the diagnosis incorrectly because it is the ticket to more attention in the school system and more intense mental health treatment.

Few people have the incapacitating symptoms of classic autism, and these are extremely easy to identify. In contrast, Asperger's describes people who are strange in some ways (with stereotyped interests, unusual behaviors, and interpersonal problems) but not nearly so gravely impaired as those who have classic autism (which also includes an inability to communicate and lowered IQ). Because many normal people are eccentric and socially awkward, there is no clear line of demarcation separating them from Asperger's. We had estimated that Asperger's would be about three times more common than the classic, severe form of autism. But rates have artificially swelled because many people within the range of normal variability (or with other mental disorders) have been misidentified as autistic—especially when the diagnosis is made in primary care, in school systems, and by parents and patients.

DSM-IV may have started the autism epidemic, but other powerful engines drove it forward beyond all expectation. Probably most important was the positive feedback loop between spirited patient advocacy and the provision of school and therapeutic programs that require an autism diagnosis. As the population of "autistic" patients and their families grew, they gained the power to push for many additional services—sometimes by initiating successful lawsuits. The additional services then provided further incentive to increased diagnosis. With more people diagnosed, there was then an even larger constituency to push for more services.[19,20]

The stigma of autism was also greatly reduced. The Internet provided a convenient and comfortable mode of communication, social support, and camaraderie. Autism received extensive and favorable press and television coverage and was presented sympathetically in movies and documentaries. Many successful people recognized themselves in the Asperger's definition, and some wore it as a proud badge. Asperger's even gained its own kind of offbeat glamour, especially among high-tech types. This publicity had the positive effect of reducing the sting of being diagnosed. But there was the usual

overshoot. Asperger's went from nowhere to being a diagnosis du jour and explain-all for all sorts of individual difference. About half the kids now diagnosed don't really meet the criteria when these are applied carefully, and about half will have outgrown it on repeat evaluations.[21,22,23,24]

The epidemic has had both pluses and minuses. For correctly identified patients, getting a diagnosis has brought the advantages of improved school and therapeutic services, diminished stigma, increased family understanding, reduced sense of isolation, and Internet support. For mislabeled patients, there are the personal costs of stigma and the reduced self and family expectations. And there is the societal cost of misallocation of extremely scarce and precious resources. It would be better if school decisions were not so closely coupled to a psychiatric diagnosis that was developed originally only for clinical, not at all for educational, purposes. Many of the mislabeled kids do have other serious problems that would independently require them to get special attention; they just don't need the extra added stigma that comes with an incorrect diagnosis of autism. School services should be based on school need, not psychiatric diagnosis.

As chair of the *DSM-IV* Task Force, I deserve blame for not having anticipated the rush to overdiagnose Asperger's. It would have been useful in advance to predict the changes in diagnostic rates and to explain their causes. We should have proactively taken steps to educate the public and the media about what the labels mean and what they don't mean—that the kids hadn't changed, just the way they were being diagnosed. It is a lot easier to trigger a fad than to end one.

Bipolar II

Perhaps the most important distinction in all of psychiatry is unfortunately often the most difficult. Does the patient have bipolar mood swings (with cyclical lows alternating with highs) or is this just a straight

unipolar depression (recurrent lows with no highs)? This differential diagnosis has huge implications for future treatment. Antidepressants are good for lows but can worsen the overall course of bipolar disorder by causing irritability, mood swings, and rapid cycling. To reduce this risk, bipolar patients receive either a mood stabilizer or an antipsychotic (or too often, both) in addition to the antidepressant. But striving to prevent harm from antidepressants comes at a potentially heavy cost. The side effects of the mood-stabilizing drugs are dangerous weight gain, diabetes, and heart disease. The tough question is how to draw the diagnostic line between bipolar and unipolar to balance the risks of taking versus the risks of not taking the mood-stabilizing medication.

The question is easy for patients having classic manic episodes who are clearly bipolar. Manic episodes are unmistakable and unforgettable. The person is supercharged in thought and deed; racing around; talking under pressure; spouting grandiose ideas, heightened creativity, a wild succession of totally impossible schemes; joking nonstop; floating on an elevated mood, but irritable if crossed; spending money like a drunken sailor; feeling boundless energy; acting inappropriately and impulsively; being intrusively sexual; and needing little sleep. Your Aunt Tillie could make the diagnosis of classic mania in a minute. And it provides a clear and essential call to action—no antidepressants without the safety net of a covering mood stabilizer.

But what do we do if the person doesn't have a full manic episode but does have periodic elevations in mood that are very different from his normal state? These less-than-full manic episodes are called "hypomanic" and they represent a conundrum. Patients who have alternating periods of depression and hypomania are at the crucial boundary separating bipolar and unipolar disorder. They could have been classified in either camp. If we classify them as bipolar, they will receive mood-stabilizing medication that may prevent rapid cycling, but they might be exposed to unnecessary mood-stabilizing medication that could be quite harmful. If we classify them as unipolar, they

will receive only antidepressant medication, and this may trigger a manic episode. Faced with these ambiguous cards, we chose to add a new category, bipolar II, to describe patients who have depressions and hypomanic episodes. The weight of the evidence on their course, family history, and treatment response suggested they sorted better with bipolar disorder. And, on balance, we decided they could be more harmed receiving antidepressants without coverage than by the added burden of mood stabilizers. A close call, but it seemed safer to include bipolar II.

But there are vulnerabilities in the definition and assessment of bipolar II that gave the drug companies lots of wiggle room. There is no clear boundary between hypomania and simply feeling good—so advertisements began suggesting that even slight shifts upward in mood or passing irritability might be a subtle sign of bipolar disorder. This pitch could work especially well with depressed patients, who would have a lot of trouble distinguishing between being "high" and a return of normal mood. Street drugs or antidepressant medications can also provoke brief periods of elevated mood—should this be bipolar disorder?

We knew that bipolar II would expand the bipolar category somewhat into unipolar territory, but we did not think that it would double. Undoubtedly our decision resulted in more accurate diagnosis and safer treatment for many previously missed truly bipolar patients. But like all fads, it overshot and has led to unnecessary medication for many unipolar patients who have been misdiagnosed as bipolar on very flimsy grounds and are now receiving unnecessary mood stabilizing drugs.[25,26]

Why the big jump? It was the same old story of misleading drug company marketing. The bipolar market is potentially much larger than the schizophrenic market, so the drug companies pounced on bipolar II. The pitch in selling the ill was that any sign of irritability, agitation, temper, or elevated mood indicated a tendency to bipolar disease. Bipolar was everywhere in conferences and journals, on TV, in magazines, in the movies. Psychiatrists, primary care doctors, other

mental health workers, patients, and families were bombarded with warnings on the perils of previously "missed" bipolar disorder.

Which brings up the question—knowing what we know now about the fad it caused, was it a good idea to add bipolar II to *DSM-IV*? I simply don't know. The pluses and minuses balance pretty closely. But one thing is clear—in boundary cases where the call is close, people shouldn't jump on the bipolar bandwagon created by drug company hype. The antipsychotic drugs are too risky to take unless there is a real reason.

Social Phobia Makes Shyness an Illness

Social phobia has turned everyday shyness into the third most common mental disorder, with rates ranging from 7 to a ridiculous 13 percent, depending on how loosely it is diagnosed. At least fifteen million adults would qualify for social phobia in the United States alone, making it a prime target for drug advertising. Shyness is a ubiquitous and perfectly normal human trait with the enormous survival value of keeping people safe rather than sorry. You want your tribe to have some exploratory types eager to venture out when the old water hole runs dry. And it is nice to have some aggressive types when the neighbors get feisty. But for your day-in, day-out survival under stable conditions, avoidance of the new and untried must have been the smart play. Otherwise, the DNA favoring avoidance wouldn't have survived to be so common.

Of course, there are some people whose social anxiety is totally incapacitating and enough to meet anyone's definition of mental disorder. But these are rare individuals, far too small a market ever to interest the drug company. Pharma's brilliance was to see past these few—to envision a world where even slightly excessive shyness could be magically transformed into a mental illness that would require a drug fix.

The statistical normality of shyness was exactly what gave the drug company a big fat marketing target. There is no clear boundary separating normal shyness from the mental disorder social anxiety. So the company began an all-out campaign to convince all shy people that they are sick and will miss out if they don't take the cure. It turns out conveniently that a number of public figures are really painfully shy and ready to shill ringing testimonials to the liberation that comes from owning up to the diagnosis and finally receiving proper treatment. Doctors were also blitzed and softened so as to be ready to prescribe Paxil when prospective "patients" followed the advertising command to "Ask your doctor." Before long, social anxiety disorder emerged from its lowly status as a rare psychiatric footnote and became a blossoming diagnostic star, one of the most common and commonly treated of the mental disorders.[27]

Social anxiety had a second feature that made it a marketing dream. Because most of the people who get the diagnosis are not really sick, it is easy to get them well. This is a population with an appallingly high placebo response rate. For the drug companies, this was actually appealingly high. Once someone (who wasn't really sick) got better due to the placebo effects of a drug (he never really needed), he was likely to stay on it as a good luck charm so as not to risk rocking the boat. He became a longtime loyal customer getting no benefit but set up for unnecessary complications.[28]

In preparing *DSM-IV*, we did not give social anxiety much attention. It didn't seem to be a diagnosis of great import to psychiatry. And until several years later, when it was blown up and abused by misleading advertising, it wasn't really of much interest. But we clearly had our collective heads in the sand and badly miscalculated. Our definition of social anxiety should have set an extremely high threshold to filter in only the really incapacitated and to filter out the merely uncomfortable. It is possible the smart advertising types could have overcome any definitional resistance on our part, but with greater foresight we could have put up a better fight.[29]

Major Depression Is Not Always So Major

Major depressive disorder (MDD) sometimes lives up to its ominous-sounding name; sometimes it doesn't. At its worst, MDD is one of mankind's cruelest afflictions. The emotional pain is worse than anything imaginable, worse than losing your closest love. But a lot of what passes for major depressive disorder is not really "major," is not really "depressive," and is not really "disorder." Loose diagnosis has created a false epidemic of MDD, with fifteen million Americans now qualifying at any given time. The transformation of expectable sadness into clinical depression has turned us into an overmedicated, pill-popping population.

The *DSM* definition of MDD is one of the most stable in the book, remaining essentially unchanged since its initial development in *DSM-III* in 1980—an endurance that reflects its usefulness. But there is a fatal flaw. Because the same criteria set defines both the most and the least severe depressions, it was written to meet the needs of both. The MDD definition works well at the severe end, but at the mild end it has led to the creeping repackaging of everyday normal unhappiness into mental disorder.

Mild major depression is a peculiar contradiction in terms; the descriptors "mild" and "major" are awkwardly juxtaposed and internally inconsistent. This semantic clumsiness reflects a clinical conundrum. There is no way to demarcate a clean boundary between the milder forms of clinical depression and severer forms of ordinary, normal sadness. If we try to diagnose everyone who really has major depression, inevitably we will misdiagnose many people who are simply having a rough patch in their lives that needs no medical label and requires no treatment.

There has been much controversy whether antidepressants work better than placebos precisely because many patients treated in studies are not very depressed or not depressed at all and really don't need an active medication.

Sadness should not be synonymous with sickness. There is no diagnosis for every disappointment or a pill for every problem. Life's difficulties—divorce, illness, job loss, financial troubles, interpersonal conflicts—can't be legislated away. And our natural reactions to them—sadness, dissatisfaction, and discouragement—shouldn't all be medicalized as mental disorder or treated with a pill. We are usually resilient, lick our wounds, mobilize our resources and our friends, and get on with it. Our capacity to feel emotional pain has great adaptive value equivalent in its purpose to physical pain—a signal that something has gone wrong. We can't convert all emotional pain into mental disorder without radically changing who we are, dulling the palette of our experience. If we can't tolerate sadness, we can't experience joy. Huxley's dystopian *Brave New World* shows how quickly pain-free translates into brain-dead.

The *DSM*s have made it too easy to get a diagnosis of MDD. The biggest weakness is not recognizing the role of severe life stress in causing reactive sadness. Suppose something terrible happens and you respond with two weeks of sadness, loss of interest and energy, and trouble sleeping and eating. Sounds perfectly understandable and completely normal, but *DSM* tags it major depressive disorder. The "epidemic" of MDD initiated by the loose *DSM* definitions was then driven by a combination of biological reductionism among physicians and fancy drug company marketing. Doctors bought the story line that all depression results from a chemical imbalance in the brain and therefore requires a chemical fix—the prescription of an antidepressant medication. This is absolutely true for severe depressions, absolutely false for most milder ones. The proof of this pudding is that psychotherapy is just as effective as medication for milder depressions, and neither has a big edge over placebo. Millions of people take medicine they don't need for a diagnosis of MDD that they don't really have, on the false assumption of chemical imbalance.[30,31,32]

I have saved the most sobering question for last. Suppose we had appropriately raised the thresholds for major depressive disorder so

that it lived up to its name and no longer overinclusively captured the aches, pains, and sufferings of everyday life. Would this return to a saner and tighter diagnosis of MDD have resulted in saner prescription habits cutting into the excessive sales of Prozac, Zoloft, Paxil, Celexa, and the others? Or would 11 percent of the population still be taking antidepressants whether or not there is a clear diagnostic indication for them? How relevant was the excessive diagnosis of depression in supporting the vast overtreatment with antidepressants?

There is no way of knowing for sure. Certainly *DSM-IV* legitimizes the easy availability of antidepressants by fostering depressive diagnosis. But there is a recent historical precedent illustrating that promiscuous prescribing can occur even if there is no specific diagnosis to prescribe for. The antianxiety drugs Valium and Librium ruled the 1970s and 1980s with a dominance almost as impressive as that enjoyed now by antidepressants—and without a clear target diagnosis. It may be that the American public, under the auspices of profit-driven drug companies and careless doctors, will pop one pill or another whatever the *DSM* chooses to say or not say.

There is another historical precedent—a much older one going back all the way to shaman times. The wisdom of the ages is that whenever they feel bad, people want to take something to feel better. The five-thousand-year-old mummified man, wonderfully preserved in the ice of the Alps, was carrying his little bag of plant medicine—the Prozac of his day. As we have seen, most medicine taken for most illnesses, most of the time, since the dawn of time, has at best been of very little specific help, usually has been completely inert, and very often has been directly harmful, even poisonous. But shamans, priests, and doctors prescribed them and patients dutifully took them and seemed to benefit. The magic of medication manages to survive its ineffectuality and potential harm. The popularity of placebo seems to be built into our DNA.

My medical purism rebels against the idea that millions of people are taking expensive, potentially harmful, largely placebo medication

for a psychiatrically endorsed, drug company promoted "illness" that is really no more than an expectable discomfort or existential problem, inevitable in life as we know it. For a significant percentage of people with mild or transient symptoms, SSRIs are nothing more than very expensive, potentially harmful placebos. There are better ways to deal with sadness. People should have more faith in the remarkable healing powers of time, natural resilience, exercise, family and social support, and psychotherapy—and much less automatic faith in chemical imbalance and pills. There is some good news from *DSM-5* on this issue. Under much external pressure, *DSM-5* makes it easier to withhold the diagnosis of MDD when the person's sadness is an understandable reaction to loss or stress.

Of course, none of this applies when the depression is persistent or more severe. It is a shame and a tragedy that one third of the people with severe and incapacitating MDD get no treatment whatever for it. Medications would be enormously valuable in these situations when they are so sorely needed, but instead they have been oversold for situations when they are not. I would prefer a psychiatry doing what it can do well, taking care of the really sick who need and can benefit from our help—not wasting time, money, and effort turning normal into mental disorder.

Post-Traumatic Stress Disorder: Hard to Get Right

Of all the many conditions in *DSM-IV*, post-traumatic stress disorder (PTSD) is paradoxically one of the most underdiagnosed and also one of the most overdiagnosed. Errors in both directions are common and easy to make; I know this well because I have made them both ways. PTSD is missed when people suffer its symptoms stoically and in silence. PTSD is overdiagnosed when it is a trigger for financial gain.

PTSD has probably been with us since the birth of humanity. Our ancestors were slow, weak creatures exposed and dreadfully vulnerable

at the water hole. Life was always at risk, likely to be "nasty, brutish, and short." Death lurked everywhere—unpredictable, sudden, and often violent. The human reaction to trauma is a great equalizer—regardless of all the differences in our personalities or previous life experiences, we all have the same set of remarkably uniform and stereotypical symptoms in response to a life-threatening stress. We relive the moment over and over and over again in a profoundly emotional way. Images, memories, or flashbacks bring it alive again, intruding incessantly during the day, and at night there are terrifying dreams. Anything resembling the event cues avoidance and terror. Every strange male face is a reminder of the rapist. A car backfiring is a reminder of being under rifle fire. Driving seems impossibly difficult after a bad car accident because the driver keeps visualizing the accident about to happen again. This set of reactions must have had enormous survival value—providing an absolutely indelible object lesson in the importance of avoiding similar dangers in the future. It was the ultimate in powerful one-trial learning—our ancestors had to learn fast and learn well because predators don't often give second chances.

Almost everyone has at least some intrusive imagery and emotional reactivity to cues after a shocking event—this is part of the human condition and until recently was not defined as illness. For most people the intrusive images gradually become less intrusive and the triggers become less terrifying. The mental disorder PTSD should be diagnosed only when the symptoms persist and cause significant disability. At the severe extreme, PTSD can become chronic and incapacitating. Life is filled with haunting memories and scary triggers. It feels empty, stale, flat, and without meaning. The suicide rate is high.

What determines whether the reaction is transient enough to be considered normal versus devastating enough to be a mental disorder? A lot has to do with the nature and duration of the trauma. PTSD is more likely the more terrible the stress, the longer it lasts, the more intense and intimate the exposure, the more helpless the person feels. Someone who is shot is more at risk than someone who sees the

shooting, and seeing is more risky that just hearing the shot at a distance. Horrors intentionally inflicted by humans—torture, rape, and assault—tend to cause worse symptoms than accidents or natural catastrophes. The course also depends on the person and his context. People who have had more emotional troubles before the trauma are more likely to have worse and more prolonged reactions to it. And traumas accumulate—the more one experiences, the greater the risk of PTSD. Family, job, support systems, and treatment are healing; drinking or using substances makes things much worse.

Although PTSD is straightforward and absolutely characteristic on paper, its accurate evaluation in real life is often difficult or impossible. The first part of the definition—describing the nature of the traumatic stress—is easy. It has to be absolutely terrifying, far beyond the expectable problems that plague our everyday life. Rape, assault, totaling a car, natural disaster, torture, war, violent death or injury of a loved one—these all qualify. Nonviolent disasters—divorce, job loss, financial catastrophe, romantic disappointment—these don't cause PTSD.

But then things get difficult. The diagnosis of PTSD is imprecise because it is based exclusively on the person's own self-report—there is no laboratory test or objective measure. It is inherently difficult for people to accurately report their reactions to an overwhelmingly terrible event. Many and complex psychological and contextual factors may lead them, consciously or unconsciously, to downplay or to exaggerate symptoms. It is no surprise that rates of PTSD in returning veterans can vary so dramatically—just a few percent to as high as 20 percent—depending on how the diagnosis is made and which country is surveyed, even if the troops have had similar wartime experiences.[33]

Underreporting helps people reduce fear and pain in the short run, but at great cost in the long. It is in the very nature of PTSD that people suffering from it will attempt to avoid reminders. Who wants to keep describing and reliving the worst moment in his life? Some will fear that talking about symptoms will make them worse or cause a break-

down. Some are too depressed to speak of the pain. And some underreporting is macho, particularly among military types who prefer to brave out debilitating symptoms rather than admit to what they regard as weakness in having them.

Overdiagnosis is also easy. Everyone has some PTSD symptoms after going through something horrible, but these usually wear off without causing long-term or clinically significant hardship. Symptoms are more likely to persist and be interpreted in their worst light if significant financial gain is attached to having them. All other emotional problems, both preexisting and subsequent, may be incorporated into the PTSD experience. Patienthood can become a way of life and rationale for people who are struggling for other reasons. On the military side, PTSD is incentivized because the diagnosis qualifies someone for otherwise unavailable disability and health benefits. In civilian life, the most frequent context for overdiagnosis is the assignment of workmen's compensation or of damage awards in legal suits. The overdiagnosis is not necessarily a question of conscious manipulation (although faking certainly does happen); symptoms just tend to take on more consequence when money is at stake.[34]

PTSD is one fad that has not been much instigated by drug companies. They shy away from advertising for it because medicines are not very effective and they fear the risk of bad publicity when things don't go well in patients with such high visibility.

The Sexual Revolution

Sex has always been sexy to the world at large but something of a bore to psychiatry. The field boasts only a small handful of experts, attracts almost no research funding, has a thin professional literature, and is a very small part of most clinical practice. I had more than the usual exposure as part of my job as head of the outpatient clinic at the Cornell University/New York Hospital during the 1980s and 1990s. One of the stars of our faculty was Helen Singer Kaplan, a glamorous pioneer in the field. Why pioneer? It was she who popularized the notion that the sexual disorders should reflect problems occurring in each of the stages of the sexual act: desire, arousal, and orgasm. Helen was the person most responsible for shaping the *DSM-III* sexual disorders, and her influence is enduring because this section has remained stable through subsequent *DSMs*.[35]

Why glamorous? Helen had personal style, but beyond that she had a practical hands-on attitude to sex therapy that seemed shockingly direct but was probably very effective. In her private practice, she made use of a stable of "sexual surrogates"—breathtakingly beautiful, sexually wise assistant therapists who taught the ropes to Helen's male patients and were perfectly capable of rekindling anyone's flagging desire. Helen claimed her surrogates got incredible results—and I certainly believe they could work wonders. Another of Helen's sidekicks—Dr. Ruth Westheimer—had a completely different claim to fame and an improbable TV and radio stardom. "Dr. Ruth" got great ratings by being the tiny old grandmother who could cheerfully rattle off the graphic details of the most intimate sexual acts, in a delightful Old World accent.

For *DSM-IV*, the sexual disorders represented the stillest backwater of psychiatry, our least important task. We had a sexual disorders work group that sifted through the limited literature, offered very few suggestions, did no field trials. It was a relief to have at least one section of the manual that required so little work.

This was the quiet before an unanticipated storm. Several years after *DSM-IV* was published, the sexual disorders exploded off its dull pages to become the marketing hit of a lifetime. Viagra changed the world, becoming one of the best-selling drugs in history and turning an obscure sexual disorder into a ubiquitous lifestyle issue. Viagra could not have risen to its heights of fame and fortune without first

convincing the world that "erectile dysfunction" (affectionately nicknamed ED for the TV and print ads) was a ubiquitous problem that could occur even in the seemingly hardy.

The first step was to persuade old folks to come out of the closet and own up to their ED. A brilliantly designed ad campaign managed to purchase the services of the world's most perfect shill. Bob Dole, on the rebound from losing to the much younger (and obviously more virile) Bill Clinton in the 1996 presidential election, started a second and more lucrative career as the poster boy of Viagra and the champion of rejuvenated geriatric sex. The implication was that Viagra provided a fountain of youth that could expand virility and vitality even for guys too old to be president. And if someone as famous as good old Bob could man up on TV and admit to having ED, why not bring up your problem in the privacy of your doctor's consulting room? The message—you owe it to yourself and to the little lady to be all you can possibly be. With Viagra on board, seventy was to become the new forty.

But why stop with the geriatric set, and its necessarily narrow market, when there is so much product to sell, so little time. Soon no one of any age could possibly hide from the long reach of ED; no bedroom was safe from its chilling grip. ED was everywhere, featured on all media all the time.

The marketing of ED required that its threshold be pushed ever lower. ED started as a medical condition applying only to a small population of sufferers with well-established flaccidity. Soon Viagra became a general potency tonic. If it could raise the dead, just imagine what a grand slam home run it could hit for the living. Sex pills went from being a medical treatment to a performance enhancer and an insurance policy protecting against that occasional off day. After all, a wise man is always armed and loaded to the hilt. ED had outgrown the narrow confines of psychiatry and medicine. It was more than just another "epidemic"; it was a lifestyle choice worthy of consideration by every couple. Viagra to the rescue to make the man of the house truly a man in full. The selling of ED was a total success.

Well, almost total. So far the sexual dysfunction story had pretty much left out half the human race, not something that sits well with the drug company financial types or their marketing geniuses. Women had surely made their lovely appearance in some of the Viagra ads, exuding the unbelievable satisfaction that comes from consorting with a Viagra man. But she was decidedly the sidekick and trophy, not the primary target of the campaign. This was unacceptable to the dignity (and greed) of the Pharma machine. Certainly women have sexual dysfunctions too. They are described right there in black-and-white in *DSM-IV*. If they have the ill, let's set about the job of selling them the pill.

There was one small problem—no real evidence that Viagra works for women. The other products being hawked (e.g., testosterone patches) were also not all that effective and had problematic side effects. But no matter, let's create the disorder and the customers will come. This marketing tale is well spelled out by Ray Moynihan in his well-researched book with the wonderful title *Sex, Lies, and Pharmaceuticals*. The ploy was to redefine expectable glitches in normal female sexuality into an almost ubiquitous "female sexual dysfunction" (FSD).[36]

The best hook for selling FSD was the use (really, misuse) of surveys asking women about their sexual experience. It became widely reported, and accepted as established fact, that 43 percent of women had FSD. These results were remarkable—a marketing godsend and triumph. Previously obscure *DSM* sexual disorders were being inflated into something that actually transcended mere epidemic. The expectable sexual experience of almost one half of women had been repackaged as FSD.

One symptom does not a diagnosis make. Asking a woman seven questions about her sex life and concluding she has an illness if she responds positively to any one of them is either naive or intellectually dishonest. It leaves out altogether the determination of whether there is a necessary cluster of symptoms and whether these cause enough

distress to warrant clinical attention. Women who checked a box were often not troubled by having a less than completely perfect sex life; nor did they usually see themselves as having a medical problem. Not every woman wanted or expected to live a *Sex and the City* lifestyle.

The sexual revolution in drug marketing is the most blatant widening of a narrow medical indication into a performance-enhancing, cosmetic, lifestyle "treatment." It is also the most evident exhibition of the raw power and profitability of advertising to sell attitudes, illness, and product. *DSM-IV* was no match for all this muscle, easily misused or sidestepped. Also lost in the pill-pushing shuffle were sexual and relational psychotherapies that might bring lasting benefit, not just real or imagined symptomatic improvement.

Rape Is a Crime, Not a Mental Disorder

This a cautionary tale of legal loopholes, Supreme Court dithering, and *DSM-IV* foul-ups—all combining to create constitutional violations and a terrible misuse of psychiatry.

The story begins with a laudable legal reform that had unanticipated dreadful consequences. Thirty years ago, the civil rights movement became rightly concerned that blacks were getting longer prison terms than whites for committing equivalent crimes. The answer was to substitute fixed sentencing for each type of crime instead of allowing the previously indeterminate (and possibly biased) judicial discretion. This was meant to guarantee uniformity, predictability, and fairness. To keep the total number of prison beds constant (and thus not raise costs), the fixed sentence for each crime was set at the average of what had before been a wide range. For rape, this was seven years. A brutal serial rapist (who previously might have pulled twenty-five years from a disapproving judge) now was limited to a term of only seven. The result was predictable, but not predicted. Brutal recidivists used their

premature freedom to rape again, often soon after release from prison and in the most despicable ways possible.

The ensuing public outrage inspired a legal loophole to keep rapists locked up. Twenty states and the federal government passed "sexually violent predator" (SVP) laws that allowed the continued psychiatric incarceration of offenders if it could be shown that they had a mental disorder. At the end of their prison terms, the prisoner would become a mental patient, transferred involuntarily to a psychiatric "hospital" that actually quite closely resembled a prison. Few of the railroaded SVPs ever accepted a "treatment" format that allowed whatever they said to be used against them in later hearings. Even among those who complete the "treatment," few ever achieve release.

From the public safety standpoint, this lifetime-within-walls approach was a brilliant solution, a convenient way to keep possibly dangerous rapists from prowling the streets. But there is a downside that presents a different set of dangers—the statutes strike straight to the heart of hard-won constitutional protections against preventive detention and double jeopardy. The wise legal saying is that "bad cases make for bad law." Thousands of undesirable rapists have been confined for the best of motives, but using the worst of methods and creating a slippery slope erosion of precious constitutional protections.

Which brings us to Supreme Court dithering. In three close and remarkably ambiguous rulings, the Court supported the constitutionality of this convenient parking of SVPs—but emphasized that it is legal only when the rapist has a mental disorder that made him do it. The U.S. Constitution doesn't allow preventive detention for criminals no matter how dangerous they are feared to be, but it does allow long-term involuntary treatment for mental patients. The Supreme Court approval of SVP commitment depends completely on the presumed ability to distinguish individuals whose sexual dangerousness arises from sickness rather than common criminality. Lacking the presence of mental disorder, enforced incarceration in a psychiatric hospital-

cum-prison would clearly represent a deprivation of due process and a violation of civil rights. Our Constitution does not allow us to turn all about-to-be-released prisoners into unwilling patients, just because we fear they may possibly still be dangerous.

The constitutionality of the SVP statutes rests on having a meaningful way of distinguishing the mentally ill sex offender from the simple criminal. Given three chances, the Supreme Court refused to provide guidelines on the critical question of what constitutes a qualifying diagnosis. Unfortunately, the state statutes are also far too vague to be of any help. The American Psychiatric Association does have an unequivocal position. Rape as a mental disorder was considered in the last four *DSM* revisions (*DSM-III*, *DSM-III*R, *DSM-IV*, and *DSM-5*) and definitively rejected by all of them and also by a special task force report. Rape is a crime, not a mental disorder.[37]

But what was the legal system to do with potentially dangerous rapists awaiting their release dates? This is where a *DSM-IV* foul-up played its part. The very worst writing in all of *DSM-IV* is concentrated in the sexual disorders section. Not anticipating the later misuse of *DSM-IV* in SVP hearings, our wording was imprecise and did not provide adequate protection against the stretching of the definition of mental disorder to include rape. Zealous, misinformed, and highly paid evaluators, employed by the government, badly misinterpreted the intent of *DSM-IV* and began the strange practice of diagnosing the act of rape as itself an indication of the presence of a qualifying mental disorder that would justify psychiatric incarceration. The evaluators ignored the many forms of criminal intent that motivate rape—callously grabbing opportunity, drug disinhibition, poor impulse control, exerting power, revenge, profiting from the sex trade, gangbanger peer pressure, wartime mayhem, and so on. Instead, rape was magically medicalized, in the service of legal and public safety expediency, to allow preventive detention and deprive rapists of their civil rights.

Regarding rape as a mental disorder violates common sense and time-honored legal precedent. Rape has always been treated as a crime,

never as a sickness. The Bible says so; the much older Code of Hammurabi says so, and, in fact, so does every legal code ever written. Punishments have varied. In tribal law, the female victim is treated as private property that has lost some of its value after the rape. The rapist therefore has to pay off her father, husband, or other owner. Later systems, with more respect for women, treat rape not just as a matter of lost financial value, but rather as a crime against the women and the state. Never before has rape ever received legal recognition as a sickness and never before has the incarceration of rapists been psychiatric, rather than penal.

Rapists are always bad people, very rarely mad people. They should not be able to use mental disorder as a legal excuse, but neither should rape be a legal excuse for mental hospitalization. Rapists should be kept off the streets with very long prison sentences, not loopholed into involuntary psychiatric commitment. Once they have served their time, they should be released, as would any other common criminal.

My concern does not arise from any sympathy for rapists. Instead my fear is that treating them unfairly greases that slippery slope to a more general degradation of the Constitution, lessening respect for the sacred values of due process and the protection of civil liberties. The frightening experience of other countries should counsel caution in ours. Psychiatry has elsewhere been dangerously abused by the penal system to stifle political dissent, economic complaints, or individual difference. A legal system willing to compromise its constitutional principles to deal with inconvenient rapists may in the future stretch further to use psychiatry against those with inconvenient political goals, religious beliefs, or sexual preferences.[38]

As Robert Musil pointed out seventy years ago, "The angel of medicine, if he has listened too long to lawyer's arguments, too often forgets his own mission. He then folds his wings with a clatter and conducts himself in court like a reserve angel of the court."[39]

The Lesson

Even if you do most things pretty much right in preparing a diagnostic manual (and we didn't do a bad job with *DSM-IV*), you don't get to control how it will be used and misused once it is published and the genie is out of the bottle. We must take partial responsibility for the epidemics of autism, attention deficit, and adult bipolar disorder. But epidemics are driven by many other powerful and converging forces: the drug company's aggressive selling of diagnoses; reckless thought leaders; gullible patients and doctors; advocacy groups; the media; the Internet; and social networking. Some inflating influences are diagnosis specific: school systems encouraging the diagnosis of autism or ADD as a qualification for extra services or the VA requiring a PTSD diagnosis for health and disability benefits. Others are general trends—the unrealistic expectation of so many people in our society that they, and their children, not only be perfect but also feel perfect.

DSM-IV was a bit player in the continuing march of diagnostic inflation. The major engine was drug company marketing. Three years after *DSM-IV* was published, Pharma lobbyists finagled an unprecedented reversal in federal regulations to allow advertising directly to consumers. This was the key to the kingdom. In the next decade, the companies tripled spending on marketing—selling depression, ADHD, bipolar, social phobia, and sexual disorders with the same enthusiasm that Coca-Cola sells pop. The ads were usually misleading but devastatingly effective. Patients self-misdiagnosed and asked their doctor for the magic pill that would correct their chemical imbalance. The doctors listened. Patients who requested a drug they had seen advertised were seventeen times more likely to walk out of the office with a prescription. The massive advertising had put the companies in charge of diagnosis. In the excitement, I doubt that many people were checking the fine print of *DSM-IV* criteria sets to ensure that there was a good fit. *DSM-IV* had lost control of the system—assuming we ever had it. There are no defenders of normality, nothing to prevent the

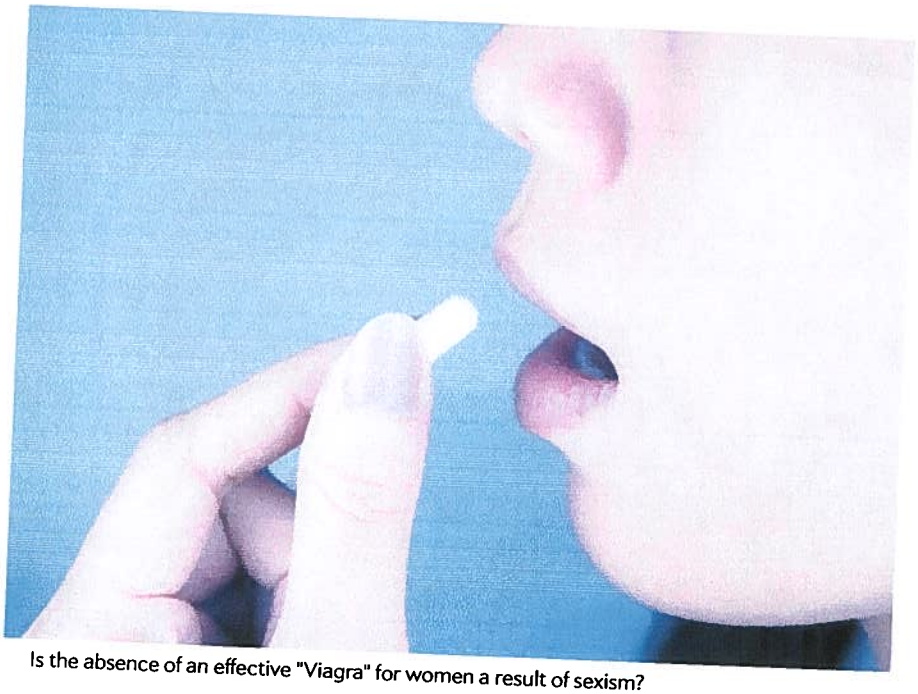
constant creep of diagnosis. It is an unfair fight. Humpty Dumpty was certainly not calling the shots.

DSM-IV didn't by itself do much harm, but we certainly didn't do much good (unless you give us dubious credit for not making a bad situation worse). On paper, we won most of the battles to contain diagnostic spread—but we badly lost the war to the outside forces that determined how *DSM-IV* would be used. I really don't know whether a more aggressively revised and deflating *DSM-IV*, with markedly raised thresholds, would have been feasible or effective. However, in retrospect, knowing what I know now, I regret that we didn't do the experiment. We probably could not have stopped diagnostic inflation, but I would feel better if we had gone down fighting, rather than just standing pat with what turned out to be a losing hand.

How to Handle FDA Rejection

Women's groups are calling the FDA sexist for not approving female Viagra. They are so wrong.

By Paul D. Thacker



Is the absence of an effective "Viagra" for women a result of sexism?

Photo by Khuntapol/Thinkstock

When the FDA denied Sprout Pharmaceutical's bid last October to begin marketing flibanserin, a drug aimed at treating low sexual desire in women, women's groups responded in anger. In January, representatives from eight different women's groups, including the National Organization of Women, met with Janet Woodcock, the FDA's head of pharmaceuticals, to protest the decision. Congress also got in on the act, with Reps. Debbie Wasserman Schultz, Chellie Pingree, Nita Lowey, and Louise Slaughter sending a letter to FDA Commissioner Margaret Hamburg to implore that, when evaluating drugs for female dysfunction (in medical terms Hypoactive Sexual Desire Disorder, or HSDD), Dr. Hamburg apply "the same standards of consideration given to the approved drugs for men in your risk/benefit evaluation."

"We've now got 24 drugs for men for either testosterone replacement or erectile dysfunction," Cindy Whitehead, Sprout's chief operating officer told the Associated Press. "Yet there are zero drugs for the most common form of sexual dysfunction in women." Anita H. Clayton, the interim chair of the department of psychiatry and neurobehavioral sciences at the University of Virginia School of Medicine, was more explicit, writing in a blistering column for the *Huffington Post*: "For the millions of women with HSDD, the FDA must overcome the problem of institutionalized sexism—unconscious and perhaps unintended, but damaging nonetheless."

> "It is hard to see what is sexist about the national drug regulatory agency refusing

The chorus was loud and clear: The FDA is sexist. The federal agency charged with approving drugs to protect and improve our health is now standing in the way of a woman's right to have a satisfying sex life. This framing played out in numerous stories, with similar charges appearing in the *American Prospect* ("the FDA's kinda sexist"), and the *Washington Post* ("Some critics say the agency—consciously or not—may be succumbing to society's squeamishness about women's sexual desires compared with those of men"). Not to be outdone with mere institutional sexism, a writer for the *Wire* mused whether "blatant, medieval sexism is also at play."

So where did the idea that sexism it to blame for the FDA's rejection of flibanserin come from? It appears from Sprout itself.

> to approve a drug that was ineffective."
>
> *Barbara Mintzes, University of British Columbia*

Pharmaceutical companies have long been trying, and failing, to develop a pill to treat female sexual dysfunction. According to a study cited on Sprout's website, "43% of women experienced some type of sexual dysfunction compared to 31% of men." And the most common complaint from these women is low sexual desire. But, according to several medical experts I contacted for this story, the very idea that women can be cured from low sexual desire with a pill was created years ago by the drug industry. Flibanserin, they argue, is far from a cure-all.

"It is hard to see what is sexist about the national drug regulatory agency refusing to approve a drug that was ineffective and like all active pharmaceutical products, has the potential for harm," says Barbara Mintzes an assistant professor at the University of British Columbia and co-author of the 2010 book *Sex, Lies, and Pharmaceuticals: How Drug Companies Plan to Profit from Female Sexual Dysfunction.*

Many of the doctors accusing the FDA of sexism have received some sort of monetary compensation from Sprout. Dr. Sheryl Kingsberg, chief of behavioral medicine at University Hospitals Case Medical Center and a vocal critic of the FDA's rejection of flibanserin, told the *American Prospect*, "There's some underlying institutional sexism at play." She added: "The FDA is saying we need more driving trials because flibanserin makes women sleepy. But it's a drug you take at bedtime." In another story about the FDA's rejection of flibanserin, Kingsberg blamed a double standard in society's "willingness to allow women to take any risk for improving their sexual health." Neither story disclosed that Kingsberg receives consulting fees from Sprout. Anita Clayton, who wrote that passionate *HuffPo* plea, is also a consultant for Sprout, which was not disclosed in her piece. And the International Society for the Study of Women's Sexual Health (ISSWSH), which conducted a poll that found "[n]early two-thirds of women polled believe it's inappropriate that the score is 24-0 when it comes to federal approval of treatments for desire, arousal or orgasm dysfunction in men vs. women," is also financially connected to Sprout. Not disclosed in the press release for that poll is that the group's leader, Irwin Goldstein, director of sexual medicine at Alvarado Hospital, has also received funding from Sprout. (When I reached out to Sprout, the company confirmed that Goldstein, Kingsberg, and Clayton have been compensated by Sprout for their research and consulting services, and added that they believe in "the need for healthcare professionals to be open about their financial relationships with the healthcare industry.")

Sprout says that while many groups have been vocal about the FDA's rejection of flibanserin, Sprout executives have not made accusations of sexism at the FDA. The company has definitely been pushing the talking point, which organizations like NOW are repeating, that there are zero drugs available for women but almost two dozen for men. However, that's a misleading claim: Viagra has several generics approved for use, but when you count actual active ingredients, there are really only a handful of available therapies for male dysfunction.

The lack of a magic pill to cure female sexual dysfunction has long been blamed on sexism, of some sort. "Any time a drug comes around as the female Viagra, that framing of sexism comes up," says Amy Allini, deputy director of the National Women's Health Network. "I think that Sprout has picked up on that and is trying to do something strategic. But it didn't start with them."

Allini's organization sent a letter to the FDA urging the agency to *not* approve flibanserin because it failed to work and had serious side effects. "[W]hile the Network agrees with Sprout's assertion that women deserve to have our problems with sex taken seriously, we do not believe that a minimally effective drug that must be taken daily, causes significant side effects and has not been evaluated for long-term safety offers women a serious solution," the letter reads.

Former FDA official Susan Wood agrees. In 2005, Wood resigned from the FDA when the agency failed to approve Plan B—the morning after pill. She is now an associate professor at the George Washington School of Public Health and says the agency is doing the right thing with flibanserin. To counter the claim of sexism, Wood points out that there are many different pharmaceutical contraceptives available for women, but zero for men because of side effects. "One might argue that this is sexist. But the science is that it's just more complicated for men and harder to develop a drug that's safe and effective for long term use."

It may go without saying, but perhaps needs repeating: Men are not women; women are not men. One might get confused on this issue when reading articles about "pink Viagra" or other comparisons of female sexual dysfunction to male sexual dysfunction.

But male sexual dysfunction is not the same as female. Drugs help men get an erection—a clinical endpoint that is quite easy to grasp. For women, the issue is low sexual desire, a complicated matter that involves a complex interplay of neurochemicals that affect behavior. "Women are more complicated, it's not just increasing blood flow," says Adriane Fugh-Berman, a physician at Georgetown University who directs PharmedOut, a nonprofit

that educates experts about pharmaceutical marketing practices. "If you give women Viagra they will have increased blood flow and lubrication but they will not feel more turned on."

Fugh-Berman says she has been tracking flibanserin since it first came up for approval. The drug was created by the pharma company Boehringer-Ingelheim as an antidepressant, but failed to get approval. Then Boehringer attempted to repurpose flibanserin as a drug for female sexual dysfunction, and was denied approval again. Sprout's attempt to gain the FDA's OK is the third time up for the drug.

Fugh-Berman is concerned that flibanserin may be another attempt to medicalize the female body, and Leonore Tiefer, associate professor of psychiatry at New York University, agrees, arguing that the very condition that flibanserin is trying to treat was created by the drug industry. In 2006, Tiefer published a piece in *PLOS Medicine* documenting the history of female sexual dysfunction as "a textbook case of disease mongering by the pharmaceutical industry and by other agents of medicalization." In fact, Hypoactive Sexual Desire Disorder, which Sprout claims flibanserin treats, no longer even exists as a diagnosis. (Sprout responds that HSDD has been combined with another condition to create Female Sexual Interest/Arousal Disorder (FSI/AD). Women treated in clinical trials with flibanserin would meet this new diagnosis, they say.)

"A fascinating side to this story is the shift in the way that female sexual dysfunction has been framed depending on which drug is being promoted," Mintzes says. "When Viagra was being tested for women, you saw press coverage that defined women's sexuality in terms of blood flow to the genitals; when testosterone was being tested, women's sexuality was defined in terms of hormonal problems; when flibanserin, a failed antidepressant, was being tested, it was a brain chemistry problem."

And yet, with all this uncertainty, many women's groups are sure that they know what the real problem is here: a sexist FDA that doesn't care about women's rights. In a coy manner to bolster these claims, Sprout pointed me to a recent statement released by NOW after the FDA rejected flibanserin. "The National Organization for Women has a long history of looking at the standards by which FDA approves drugs for women and there is clearly a bias here. When it comes to approving drugs for male sexual dysfunction, the FDA says yes with more limited research and serious side effects, but when it comes to women, their go-slow tactics are preventing us from having access to a treatment option where we make the decision in consultation with our healthcare provider," said Terry O'Neill, president of the National Organization for Women.

"It does speak to the shallowness of feminist understanding, that it's all about rights," Tiefer told me, commenting on flibanserin as a feminist cause. "What happened to the women's health movement? We've been fighting so that women can be given good quality science, just like men."

Some women's groups are pushing back against the sexism claims. On Wednesday, nine women's organizations representing health care providers, physicians, and scientists sent a letter to the FDA asking that they maintain an "evidence-based evaluation" and not bend to recent attempts to frame the issue along gender lines. "The problem with flibanserin is not gender bias at the FDA but the drug itself," the letter reads. "Nevertheless, the inflammatory claim of gender bias produced press and political attention."

For its part, Sprout says it is now working to respond to the FDA's latest rejection and plans to submit two more trials later this year.
