

Editor's Note: Spiritual Progressive psychiatrist Phil Wolfson, who practices psychiatry in San Francisco and San Rafael, Ca., is a contributing editor for Tikkun magazine with a special focus on consciousness studies and consciousness transformation. Using the hook of a review of a book on psychology by Gary Greenberg, and the occasion of the publication of the latest DSM (Diagnostic and Statistical Manual from which psychologist and psychiatrists derive definitions of "mental illness" that they use to validate the "scientific" nature of their professions, and hence their ability to get medical insurance companies to reimburse their work), Wolfson takes us on a fascinating journey of exploration of therapy and its dubious foundations and prejudices. And as always, we invite you to write letters to the editor (me) with your responses, including full-blown critiques, of Wolfson's perspective.--Rabbi Michael Lerner RabbiLerner.tikkun@gmail.com
From Tikkun on-line email list. To come out on the Tikkun website next week.

Hark! The Psychiatrists Sing, Hoping Glory for that Revised DSM Thing!

By Phil Wolfson MD

The Book of Woes--The DSM and the Unmaking of Psychiatry

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With much anti-climatic squabbling among shrinks at their annual APA convention, held this year in San Francisco, the new edition of the Diagnostic and Statistical Manual, Version V hit the street, all 992 pages in paperback (may be too big for its spine to hold together well for long) for \$140 payable to the American Psychiatric Association. A compendium of 'disorders', its own odyssey towards print was filled with disorder, episodes of secrecy and sequestrations of its authors and committees, and self-serving reputation ambitiousness—get a diagnosis included for your pet 'disorder' and your future is ablaze. After years' of advertisements trumpeting fundamental change, DSM V maintained much the same schemas and orientation. In the end internal controversy was blunted by the entrenched orientation of the people at the helm and the functions the DSM serves, much of that money centered.

In pursuit of this quarry, psychologist Gary Greenberg is at it again. Continuing where his most excellent rant *Manufacturing Depression* left off, he tells the convoluted story of the DSM Vs tortuous path—and more importantly its limited meaningfulness and unlimited impact on all of us. At the heart of the matter is MD psychiatry's prolonged attempt at legitimation and recognition in parallel with disease based medicine. The evolving DSMs have served well to

psychologize its practitioners and the public into believing there are known mental diseases that resemble diabetes or heart disease and a visit to the shrink, the prescription of a pill or two will alleviate that malady, which must be a brain disorder. 'Something is wrong with my brain, I have a chemical imbalance. My serotonin is depleted. I am Bipolar. I have a disease that makes me unhappy, addicted, inattentive, anxious, anti-social, moody with my menstrual cycle, afraid of people.' Shrinks will help you classify yourself--and for them to get paid they have to diagnose you for the insurance to kick in. The diagnosis will also trigger decisions on which medicine to prescribe, and the DSM will constrain and orient research priorities—to whom and for what the money flows, and drug development at big Pharma. So it is biblical in its ponderousness and claims.

But there the analogy ends. The DSM lacks a democratic impulse, social consensuality, and external validation. Its hierarchy is limited to its own self-selected elite--those who employ it, who are of the guild, and by virtue of being in control of the definitions of behavior—aberrant and 'normal'—what are put forth as the 'truths' of mind--control access and purse strings. It's a relatively small coterie who pronounce on who is sane, insane, neurotic--and what is to be done with them. Their views infect us and make us unwitting, too often uncritical users of their format.

What you should know.

What the DSM V is:

- 1) An arbitrary compendium of diagnoses of mental 'disorders' based on selected aspects of human behavior.
- 2) A collection of what is considered abnormal by a medically biased group of MDs who view humans from their own points of view.
- 3) Collated sets of manifestations of behavior and statements of subjective self-reporting of mental contents by those who say and are said to be manifesting these, through routinized questioning, and through reports of related persons.
- 4) A document considered by the American Psychiatric Association to be their intellectual property, from which they may profit.
- 5) A document that by dint of its APA ownership has established a claim on the 'truth' of mental health and disorder—especially the latter—and has become 'official' for institutions at large.

What the DSM V is not and cannot do:

- 1) Provide a definition of a mental disorder. Provide evidence that mental disorders are reducible to physical illnesses. It is not objective!
- 2) Demonstrate specificity, coherence, and validity to its clustered diagnoses. Instead there is overlap and multiple sets (the permeability of diagnoses), changes in conditions and diagnoses over time, reporting biases and disagreements between practitioners seeing the same person, and a reliance for validation on the retrospective—the outcome of treatment measures such as the often ineffective drugs used to treat.
- 3) A historical document containing class, cultural, gender, and ethnic biases. At times these have reflected political, religious, white straight-male biases—such as the previously long held classification of homosexuality as a disease. There remain strong biases contained in the DSM. Do note them.
- 4) The DSM V is not the only classification of human behavior possible. Far from it. Enjoy the one you have! Explore others. Examine consciousness and social behavior. The DSM is largely a *common sense document* put into medical-ese, a language spoken by only a few.
- 5) The DSM has been modified and will change continually. There is pressure to restructure it based on developing neurocognitive/brain science, but that remains elusive as it still is in its infancy and not practical for application. What will not change is the ongoing attempt to corral a view of our lives by a self-selected few medical practitioners.
- 6) The DSM does not reflect the difficult conditions in which people live, the extensiveness of the multiple sources of trauma as the primary cause of suffering, the looming ecological catastrophe, poverty, lack of opportunity, racism and sexism, social injustice, the pressures of work and the structure of capitalism as it stresses and convolutes our minds and lives.

Psychiatry has truly changed since I completed my MD at NYU-Bellevue in 1968. It has become increasingly medical, drug dependent despite the ineffectiveness of its medicaments, linked to insurance and Pharma by inducements and money-filled contracts that did not exist before for-profit health care became the standard. Back then, the allure of psychiatry was its departure from medievalism with its forced incarceration and treatments, its political use for

the sake of the state and wealthy individuals' selfish goals, its lack of love and lack of a science of mind--these horrors and frank criminality moved into a past historical epoch. The enfranchisement of much of the population—women, people of color and different ethnicities; an aroused sense of social justice; an interest in understanding each other and our different internal processes—all of this led to a new and exciting ethos for those of us engaged in the development of a progressive psychotherapy. This profound change in at least a significant number of psychiatry's practitioners fostered the development of a humanistic, mind penetrating, contextualized, systemic understanding of humans, and their behavior within their social and environmental matrices.

In my freshman year at Brandeis, 1960, I had the benefit of being introduced to the just published *Divided Self*, RD Laing's opening salvo that saw value in being with altered states of mind without tearing them apart or fully suppressing them. It coincided with my own hesitant start--I walked around the counseling center several times without going in, feeling deeply afraid of psychotherapy. It was generously and unusually offered as 30 sessions per year with a faculty member, generally a progressive person, who situated in an academic setting, was drawing on the new notion of 'identity crisis', which so aptly fit my own—and so many of my classmates experience.

After all, we grew up in McCarthy-ite suppression that sucked the life out of the emerging post-war liberated culture and re-imposed state censorship on mind and action. And a new consciousness of opportunity, civil rights, the threat of the bomb, sexuality, and the re-discovery of liberating culture was just poking its Beat head above the FBI's fist. Kennedy's election brought in change, a whiff of the young and new, even as he went head-to-head with Khrushchev and the Soviet Union. So, of course, emerging from an oppressed and oppressive paternalism, to a margin of one's own self-control, there would be pain, suffering, and especially confusion. Who am I?-- was the raging question of identity.

My psychotherapy--I eventually did walk in the door and made my first appointment--was so meaningful to me, that at 18, I decided to become a therapist. Consulting with my PhD professors, they urged me to go to med school so I could become full-fledged--a bit of self-hate and invalidation on their part, I thought. But I followed their guidance and ended up at NYU--Bellevue, where my father's mother, my too delicately balanced grandmother whom I never knew, was first incarcerated for the deep grief she experienced when my namesake, my grandfather Philip, suffered a cardiac arrest and died at 51 on their stoop in the Rockaways where they were housed for the summer, as a benefit for his being the visiting rabbi. It was 1930, the beginning of the Great Depression and, in fact, everything collapsed for my 16 year-old father along with Philip's sudden death. My grandmother never recovered. She left Bellevue for a series of state hospitals, apparently evolving into a catatonic way of life—from utter silence to screeching rages. But what does 9 years of constant incarceration in lock-ups,

leaving your entire world behind for Bedlam, what does that do to a sensitive soul? What it did!

Yes, I carried a bit of rage about all of that. As Laing later wrote, as we who strove to make the sixties in personal authenticity came to sloganize, *politics are personal*. Politics arises from our experience and consciousness. It is never a thing out there, an abstraction that does not reflect our core, personal values. Politics is the expression of our values out in the world. Always!

By the beginning of the 1980s, the new wave of progressive anti-institutional psychiatry had begun to wane. That near-constant California Governor Jerry Brown had begun the defunding of public community mental health programs. The alternatives such as Diabasis, I Ward, and others were disappearing from the landscape. Therapy became more and more of a professionalized, 50 (or 45) minute office based practice and big Pharma began to exert its control as its profits soared with new tranquilizers and drugs like Prozac. Psychiatry increasingly was losing its connection to psychotherapy and the quest for more standardized and statistically potent methods like cognitive behavioral therapy that could be coordinated with the DSMs as they rigidified diagnosis. Add to that the disastrous effect of the lost 'war on drugs', which criminalized MDMA/Ecstasy use in 1985 (illegal use soared thereafter)—a very promising new method (It requires the therapist to be with the patient for three hours or more per session) for treating many states of mind, individuals and couples. Add to that, the criminalization of virtually every other psychedelic substance—a few only recently being allowed for very limited scientific research.

The result has been the empty triumph of Pharma in coordination with the medicalization of psychiatry that shovels 'patients' into pervasive, inadequate drug treatment—there has been no truly new anti-depressant in over 20 years and the success rate of the extant ones is reluctantly acknowledged to be less than 50 percent, just a shade above the high placebo effect. The hospitals and especially the privatized locked units are full of the failure to treat. The community mental health agenda that was to put the institutionalized and potentially institutionalized into the community is a failure to fund and to conceive. Instead we have the homeless phenomena, the poor attention of the board and care system, the extraordinary increase in the use of prisons to confine the mentally ill and addicted, and the substitution of the for-profit locked facility for the state hospital. Psychiatrists have very little to crow about, and the numbers choosing to enter a psychiatric residency have drastically fallen in the last decades. With the loss of the therapist concept as the essential element in the training of psychiatrists, there is not that much of interest to the field. Tack on to that the television marketing of pharmaceuticals, which creates a popular false sense of success, and you have a uniformity of interest between doctors and patients in the same marketing delusion of a smash-hit that isn't.

It's amazing! Just listen to the dire warnings that potential malpractice suits force us to listen to for each and every pastoral effect of the drug advertised and you wonder why anyone would go to their MD and say, 'I want that drug I saw on TV'. And the doctor is then in a pressured position to conform to that request. In fact, he/she may have been influenced in the same way by the same marketing. And this is abetted by the drug companies who send in reps to seduce him/her, the 'research' psychiatrists paid for by Pharma who doctors listen to at their professional conferences, and the journals that tend to focus on the research path defined by the market and who pays. It's a pretty monolithic entity with many formal and informal connections. The result is a crass uniformity, a failure to explore, and a dreadful confusion as to what is true and real. Indeed, nobody has seen a chemical imbalance, nor has the serotonin hypothesis stood up to time—disproven decades ago. Yet, these are but two of a host of inculcated mis-conceptions that patients bring into the office as if they know what is happening in brain and mind. In fact, nobody does.

This is the history and trajectory for Gary Greenberg's relentless and brilliant exegesis. Within his often tormented pages, there is exceptional analysis and 'truths' about the formalization and grab of the mind by the psychiatry/Pharma/officialdom axis that dominates and suppresses in its own interests. And these are clearly interests that are very different than the self-interest of the bulk of humans to truly understand themselves, to situate their suffering and misery within the realities of economic, gender, race, traumatic, developmental, and natural relations. Like in his earlier book, Greenberg's history recounts the axis's formation and the solidification of its grasp on the field. His tale is of the successful propagation of the DSM view that sells its drugs, its programs, funds its self-serving research, and rewards those who practice, in other words prescribe/sell, its products. This is supported by lobbied political representatives who officialize and further feed this 'system'. Greenberg's history of this recent remaking of the DSM is absorbing. It is illuminating of just how arbitrary and personality ridden the exercise has been. No hint of objectivity there.

For example, is there really such a thing as a hoarding 'disorder'? There are certainly humans who hoard, shut themselves into narrow confines in their homes between piles and extraordinary collections of useless things that they consider their sacred, un-eliminable possessions. Their lives are often tortured, depressed, fearful, and isolated. Their relatives feel helpless and confused. They don't seek treatment and if it is imposed, do very badly in terms of cleaning up their act. Certainly a difficult and annoying thing. Not to be minimized as suffering, or suffering for others. But an illness? Hardly. Deep and complex roots to be sure. But one of an infinite variety of strange behaviors of which most of us are capable of some one or other at some time.

To be honest, I am a bibliophile. I hate throwing out my books. They

are important to me. Like friends that give me a sense of security, of times past, and ideas and fantasies that I used to have, a bad holding onto a notion of self that I as a Buddhist practitioner must abhor. I don't. It creates in me a bit of distress when I have to find more room for them. And for my mate, she may feel their presence and their Andromeda spread and have feelings. Its not enough to reach criteria to give me a hoarding disorder diagnosis, but a symptom for sure. Better watch myself!

What about Hypoactive Sexual Desire Disorder—HSDD? So many people suffer from it. Perhaps 30%. However, for it to reach DSM criteria for a disorder, it must cause marked distress or interpersonal difficulties. So for many people, there is acceptance of their lack of desire, often for reasons of trauma, relationship failure, potent childhood messages, distrust of others, etc. They may have hypoactive sexual desire, but not a 'disorder', for to have that you must be troubled by your lack of libido. You must really want to get turned on—and can't, or some other(s) want you to get turned on and you can't. To call this a 'disorder' makes it medical and medical treatment must be necessary. Certainly what is being described is a form of suffering. 'I want to get turned on and am unable. I am blocked. Perhaps it is hormonal. But perhaps it is not.' There are so many potential causes and so many non-medical possibilities for amelioration. Does it qualify as a disorder, or is it one of the myriad forms of suffering that deserve our attention. And not just from those who wear white coats. We may turn to them for certain specific kinds of evaluations and treatments, but it is not a suffering for medical exclusivity.

These examples are just the tip of the difficulty that pokes above the DSM Vs pages, actually like a mountain made of problems. Greenberg climbs it with ease and alacrity, constantly questioning and debunking. His passion is warm, alive, angry, progressive and persuasive. I see myself in his soliloquies, frustrated, knowing the lies, wishing that humans would rebel, get it right, throw off the bull makers, turn to love and sharing as the values that will make life less depressed for the vast majority.

In fact, some folks will get upset, symptomatic, and depressed no matter that there may seem to be great quality and wealth to their circumstances. Attachment to false desires and judgment are everywhere, as are delusional attitudes, blame, anger and hate. We all have to struggle. And some stricken folks do seem to have wounded biologies. After all, given the extraordinary complexity of brain interacting in the extraordinary complexity of world, how can wounds and aberrations be avoided? The brain is an organ, however complex and interconnected, and all organs when viewed as distinct entities have their potential malfunctions and mal-developments. These can be gross alterations of anatomy and function, or more difficult to discern aberrant 'sensitivities', and 'connectivities' that give rise to malfunctions.

With all the research on brain and ‘mental illness’ the complexity of brain-mind remains like a mountain in the path of true and deep explication of malfunction; and the same for the arising of great treatment that could alter these malfunctions. The genetics of complex behavior and what is behind it eludes us, despite the constant flow of claims to have discovered the alcohol gene, the mania gene, the depression gene, the schizophrenia gene, etc. Prospective assessment of those who may be at high risk for significant mental maladies is based on the manifestations of behavior that appear ‘off’, or problematic to parents and friends and are dubbed early symptoms, like an expressed paranoid delusion for example. There is no hard, science driven prognostic markers. There are only observations made by unavoidably biased observers—we all carry our perspectives. All explanations of complex mental phenomena have been irreducible thus far to the reductionism of biochemistry, scanning, neuroanatomy, and our various attempts at instrumentalism. I expect this to continue to be the case. And above all, we need to avoid reducing mind to brain!

Add to this spectrum for biologically related difficulties the subtler repetitive traumas of bonding and nurture and the great traumas that so many people experience as a result of poverty, illness, bad parenting, lack of love, destructive acts, war, cultural confusion and contradiction, and injustice and it becomes clear that few of us escape some significant wounding of the soul. In all my decades of experience as a psychiatrist, the truth for me remains that ‘causes’—the impactful circumstances that orient mind unconsciously, or just out of awareness, as well as in awareness--outweigh the inexplicable—what shrinks call ‘endogenous’, or self generated for no ‘reason’ that can be found-- although there is plenty of the latter—we are very complex, contextualized creatures. And how causes work is not always clear, or linear, and is generally multifactorial. Yet, it appears to me to be a democratic right and a positive demand for personal and social justice that ‘causes’ be sought for suffering and aberration; and the pathological labeling of humans by symptom clusters as checklists for shrinks, insurance and drug companies be avoided. This is one of those far off ‘rights’ that are not on the political agenda—no comfort that neither is global climate change.

Complexity belies the DSM-V. Greenberg is great at showing us the tautological nature of diagnosis—for example, defining depression as a cluster of the symptoms that in turn define depression--and how it limits therapy and the investigation of our relationships and situations. Instead, the manual serves the diagnostician and the industry, creating a false consciousness of mental life as diseased and awaiting some drug, much like diabetes, and therefore stifling our interest in the nature of the individual and our social units, like the family and community in their nearly infinite contexts.

Focusing in on depression, it is a complex and varied thing--as varied as the humans who get there in their various forms, for however long. The bulk

of significant depressive episodes remit within three months time, without treatment. Most depressed people never see a psychiatrist. Some folks get depressed from seeing a psychiatrist. Many self-medicate. Marijuana is probably the most widespread and successful drug treatment for depression, anxiety and insomnia—it is estimated that about 50 million folks use marijuana at least monthly in the US alone. Alcohol has a very poor impact and far too often personal and social toxicity. It mixes badly with depression, but of course is often consumed despite this awareness. A very partial list of ‘anti-depressants’ includes multiple types of chemical anti-depressants like the SSRIs (Prozac as the model) with very different neurotransmitter actions; and--anti-convulsants, stimulants, exercise, meditation, hedonism, temporary satisfaction of cravings, elimination of cravings, oxytocin, sexuality, spiritual practice, money, love, children, activism, justice, a good job, respect, friendship, education, a good book, a bad book, etc, etc.

There are so many aspects of being and being in the world and they all reflect and infect our mood. All evaluations are oversimplifications, whether they are made by MDs and therapists, or on our own. An at best partial evaluation of our parameters and aspects must include: energy—enthusiasm—motivation—sexuality—engagement—learning and intellect—spirit—love and hate—trauma—grief and loss—failure/success—pleasure/displeasure—hopefulness/hopelessness—health and illness—age—intelligence—blocks and phobias—our social and environmental context—the cultural effect—religion—gender—education—our origins and history of oppression—parenting—grief and loss—responsibilities—family—addictions—again, etc, etc. There is just no getting around complexity. It is a product of the eons old evolution of our animal consciousness being in this extraordinary, awesome and very difficult environment.

From this perspective, which I am honored to share with Gary Greenberg, facing the truths of this life explodes the notion that one can be happy by the route of immunity to the sources of distress, as if one can disconnect, deconstruct, and hermitize free from influence and dependency. Impossible! Psychiatric reductionism serves to isolate us from our own true nature and our inescapable connections, serving the cultural delusion that our sadness, discouragement, traumatization and lack of trust can be overcome by pills and therapy, by bowing out and seeing just to our own needs—as if even these are separable.

Fortunately, that is not the whole story. For there are wonderful people workers, great therapists, true friends and lovers, fabulous spiritual guides and practices, the awe of being alive even in adversity, and the pounding of our hearts that keep us moving through this unique and precious existence. Some of our remedies do help. I try to use medicines carefully and with informed consent, knowing the limitations and the individuality of each person’s

responses. I practice an engaged therapy and many of my people do make great and good changes in their lives and their approaches to their lives. While there is no guiding empirical science, there is the great guideline of interest, impartiality, listening, empathizing, contextualizing, reframing, sympathizing, organizing, diversifying, learning, humoring, confronting, sharing, loving, struggling, dancing, separating, investing in the other, knowing the limitations, staying independent, and keeping the balance—the middle way. With all that, no methodology is perfect. Humans are independent and self-seeking and depression and mental/emotional struggles do not always end. We have unfortunate examples of great and skilled folks who couldn't leave the serpent's strangling coil, like William Styron, who taught us this lesson of modesty and humility.

What then is a rational view of psychopharmacology, of the limited resource that is available to us at this time? Medications are often useful tools, especially when employed within a holistic, humanistic, therapeutic practice. Mania, depression, anxiety, insomnia, erectile dysfunction, difficulties with focus, concentration and energy, fatigue, confusional states, paranoia, delusions, some substance abuses, and other behavioral manifestations are truly amenable to improvement in mindfulness and functionality. When we do not refer to states of mind as disorders, or diseases, but rather as conditions of mind, potentially useful medications are aimed at those states and not falsely presented as treating and eradicating diseases. Applied respectfully, thoughtfully and consentfully with full disclosure of expectations, limitations, side effects, long-term problems, and what really is known of how the specific medication works, psychopharmacology has a potentially important role in our lives. Such rationality may result in a diminution of the magic of the placebo effect--an important aspect of all prescription. But that potential loss is offset by the educated view of the consumer. Recognition of the limits of the ability of medication to 'cure', impact difficult states of mind, and succeed in helping us assists with over-expectations, feelings of failure, and assumptions that just taking pills will transform us. This leads to better prescribing and better research.

Gary Greenberg's book is a source and a very thoughtful contribution. Do read it. As for the Book of Woes, the DSM V, avoid it. If you are seeing a shrink, work carefully to avoid diagnoses that will haunt you for the rest of your life. Ask to know what he/she intends to put in your records and send in to your insurance. At least be aware and wary of the labels new and old.