

Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life

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*Resiliency is built into every aspect of our biological, psychological, and social being. We are hardwired to work remarkably well, but are far too complicated always to work perfectly and we can lose purchase on normality by mislabeling as mental disorder each and every one of our glitches.*¹

I. Introduction

Judge advocates are frequently involved in decision making processes that can result in the administrative discharge of personnel with mental or physical conditions not amounting to disabilities. In *Saving Normal*, Allen Frances, M.D., convincingly argues that experiencing unpleasant feelings or engaging in activities that have the potential to adversely impact our welfare puts "well" patients at risk for being diagnosed with a myriad of mental disorders as defined in the newly published *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition: DSM-5*² (DSM-5). An outspoken critic of the means and methods used by the DSM-5 task force and the unwholesome silent partnership between the American Psychiatric Association (APA) and pharmaceutical companies, Dr. Frances's concern for the explosive growth of medications being prescribed by physicians and psychiatrists alike is well-grounded and portends rampant diagnostic inflation for many unfounded diagnoses. Dr. Frances expertly and concisely outlines the history and development of psychiatry from Greek times to present day and then critically attacks the alarming trend over the past 60 years of moving away from the use of psychotherapy toward the prolific use of prescription drugs, many of which have the efficacy of a placebo.³ When choosing between administrative separation and retention in the armed forces, commanders generally lean on their judge advocates to aid them in making a determination about the propriety of separation given the complexity and sensitive nature of mental health issues. Judge advocates must, therefore, be familiar with not only the laws and regulations of the service branches, but also the emerging trend of diagnostic inflation that Dr. Frances highlights in his work.

II. Background

Dr. Allen Frances is currently a professor emeritus at Duke University and has been in the practice of psychiatry since he graduated from medical school in 1967.⁴ He served as the chair of the task force that was responsible for the production of the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition: DSM-IV* (DSM-IV) in 1994.⁵ Since its first publication in 1952, the DSM has gained increasing importance in the field of psychiatry and, since the 1980s, has been considered the bible of mental health disorder diagnostics. Since 2009, Dr. Frances has been a vocal harbinger about the detrimental effects that DSM-5 is likely to have on the practice of psychiatry.⁶ Dr. Frances believes that direct marketing campaigns by pharmaceutical companies to the general public and the significant number of primary care physicians who diagnose patients with serious mental disorders and prescribe medications after office visits lasting only a few minutes will exacerbate diagnoses under DSM-5.⁷

III. Role of the Judge Advocate in Administrative Separations

Judge advocates are increasingly involved in the analysis that takes place when a commander decides whether to administratively separate a member due to personality disorders and physical or mental conditions not amounting to a disability. Service branches are largely consistent in their administrative policies surrounding the requirements and procedures for separating a member due to a mental health disorder. Army Regulation (AR) 635-200⁸ and the Naval Military Personnel Manual⁹ (MILPERSMAN) both

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¹ ALLEN FRANCES, *SAVING NORMAL: AN INSIDER'S REVOLT AGAINST OUT-OF-CONTROL PSYCHIATRIC DIAGNOSIS, DSM-5, BIG PHARMA, AND THE MEDICALIZATION OF ORDINARY LIFE* (2013).

² AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed. 2013).

³ FRANCES, *supra* note 1, at 97–101.

⁴ NORTH CAROLINA MED. BOARD, *NCMB Licensee Results*, <http://www.wapps.ncmedboard.org/Clients/NCBOM/Public/LicenseeInformation/Details.aspx?EntityID=31787&PublicFile=1> (last visited Sept. 12, 2013).

⁵ AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS*, at ix (4th ed. 1994).

⁶ FRANCES, *supra* note 1, at 101–03.

⁷ *Id.*

⁸ U.S. DEP'T OF ARMY, REG. 635-200, ACTIVE DUTY ENLISTED ADMINISTRATIVE SEPARATIONS para. 5-17 (RAR 6 Sept. 2011).

⁹ U.S. DEP'T OF NAVY, NAVAL MILITARY PERS. MANUAL, ENLISTED ADMINISTRATIVE SEPARATIONS sec. 1910 (13 Apr. 2005).

provide bases for separation under these circumstances.

Important interests are at stake when the government decides whether to exercise these bases for administrative separation. Members are provided costly training from the time they enter military service, and the government must be vigilant about safeguarding that investment. For members, there is grave risk of losing at least one significant benefit—the GI Bill—if his or her service is characterized as General (Under Honorable Conditions).¹⁰ Upon a complete review of a member's service record, commanders have the power, under both the AR and MILPERSMAN, to characterize a member's discharge as General which may act as a bar in many cases should the member wish to use his education benefits. Even more concerning is when the member has already availed himself of those educational benefits and is discharged for a mental health condition: he may be responsible for repayment of a portion or all of those benefits, depending on numerous factors.¹¹ The DSM-5 plays an increasingly critical role as military mental health professionals assess members and make diagnoses of mental health disorders. The size of the mental health disorder aperture as listed in DSM-5 criteria has a direct correlation to whether members stay on active duty or face administrative separation and possibly lose their educational benefits.

IV. Widening the Net on Characterization of Mental Disorders

The DSM is a diagnostic tool that facilitates the identification and diagnosis of mental health disorders by licensed practitioners. That practice, however, encompasses not only psychiatrists, but also clinical psychologists, primary care physicians, nurse practitioners, and other professionals who are authorized to both diagnose and treat mental health disorders through psychopharmacology. Dr. Frances highlights three disorders that are redefined in DSM-5 in a way that widens the aperture and risks over inclusion of well patients in diagnoses of Attention Deficit Disorder (ADD), autism, and bipolar disorder.¹²

A. Attention Deficit Disorder

One in ten American school-aged children takes medication for ADD and diagnosis is rising for adults.¹³

¹⁰ UNITED STATES DEP'T OF VETERANS AFF., *What Type of Discharge Is Required to Qualify for the Post-9/11 GI Bill?*, https://gibill.custhelp.com/app/answers/detail/a_id/942/kw/characterization%20of%20service (last visited Sept. 12, 2013).

¹¹ *Id.*

¹² FRANCES, *supra* note 1, at 139.

¹³ L. PRATT ET AL., NAT'L CTR. FOR HEALTH STATISTICS, *ANTIDEPRESSANT USE IN PERSONS AGED 12 AND OVER: UNITED STATES, 2005–2008* (2011).

Relying on decades of professional experience, Dr. Frances asserts that the reasons for the high rates of diagnosis for ADD among children and adults includes definition and criteria changes within the DSM-5, aggressive marketing by pharmaceutical companies to patients and physicians, media coverage, desires of parents and educators to control unruly behavior in classrooms, assignment of additional benefits in schools, and prescription drug abuse.¹⁴ Illustrative of the reduced threshold for diagnosis of ADD is the fact that DSM-5 lowered the requisite number of criteria for diagnosis in adults as compared to DSM-IV. It also removed the requirement that actual impairment before the age of seven resulted from the behavior to merely requiring the presence of symptoms prior to the age of 12.¹⁵ Additionally, the DSM-5 allows a co-diagnosis of ADD with autism spectrum disorder.¹⁶

Common sense dictates that we consider whether the rapid increase in the diagnosis of ADD is due, among many reasons, to groundbreaking and overwhelming scientific evidence that did not exist at the time that DSM-IV was published or, alternatively, our physiological constitution has degraded to the point where we are suddenly so susceptible to this disorder. There is a dearth of scientific evidence in general within the practice of psychiatry.¹⁷ So little is known about the human brain and no significant discoveries have been made in the last twenty years that would aid in the diagnosis of ADD.¹⁸ Direct marketing to patients, coupled with the ease of obtaining a diagnosis under increasingly inclusive criteria, is a logical explanation for the increase in the prevalence of ADD. Dr. Frances rightly argues that we haven't become sicker since 1994; we've simply allowed direct marketing tactics by pharmaceutical companies to influence us.¹⁹

B. Childhood Bipolar Disorder

In order to satisfy the DSM-IV diagnostic requirements of Childhood Bipolar Disorder (CBD), simultaneous classic mood swings between mania and depression were required.²⁰ DSM-5 has changed those requirements so that the mere presence of some symptoms of mania and depression will

¹⁴ FRANCES, *supra* note 1, at 141.

¹⁵ AM. PSYCHIATRIC ASS'N, *HIGHLIGHTS OF CHANGES FROM DSM-IV-TR TO DSM-5* (2013) [hereinafter *APA HIGHLIGHTS*].

¹⁶ *Id.* at 2.

¹⁷ Drake, Robert, et al., *Implementing Evidence-Based Practices in Routine Medical Health Service Settings*, *PSYCHIATRIC SERVS.*, February 2001, vol. 52, no. 2, <http://ps.psychiatryonline.org/data/Journals/PSS/3561/179.pdf?resultClick=1/>.

¹⁸ FRANCES, *supra* note 1, at 104.

¹⁹ *Id.*

²⁰ *APA HIGHLIGHTS, supra* note 15, at 1–2.

permit diagnosis.²¹ Furthermore, there is no minimum age requirement. Dr. Frances's concern for the application of diagnoses to young patients is well-founded. In one case, a psychiatrist in Boston prescribed Clonidine, Seroquel, and Depakote to a twenty-eight month old girl until she died two years later from overdosing on the pharmaceutical cocktail of blood pressure, antipsychotic, and anti-seizure medications.²² Neither Clonidine nor Depakote is approved by the Food and Drug Administration for use by children.²³ Although this is an extreme case that is likely due to medical malpractice vice typical courses of treatment for toddlers, the fact that DSM-5 did not take this as a lesson-learned and provide guidance for diagnosticians when examining children highlights its failure to employ best practices for diagnosing disorders to patients who can even qualify for a diagnosis.

C. Autism Spectrum Disorder

The DSM-5 rolled four separate disorders related to autism into a single disorder—Autism Spectrum Disorder (ASD)—with a sliding scale of severity.²⁴ As described by the APA, ASD is characterized now by “deficits in social communication and social interaction.”²⁵ Once again, children become the most susceptible to diagnosis because they may be diagnosed with ASD for exhibiting no more than social awkwardness. As is true in the case of ADD diagnoses, children diagnosed with autism and its milder sister diagnosis, Asperger's Syndrome, are eligible to receive more specialized educational and mental health services.²⁶ Dr. Frances concedes that the expansive definition in DSM-IV that sparked widespread diagnosis of autism and Asperger's was partly due to the DSM-IV task force's inability to predict the rate of increase in diagnosis.²⁷ However, the proliferation of services being offered within school systems is directly tied to the requirement that the child be formally diagnosed with autism.²⁸ Dr. Frances points to positive media influences that destigmatize both disorders as being another reason for the increased frequency of diagnosis.²⁹ He relies on studies to support his

position that only half of the children diagnosed with autism truly satisfy the criteria, while half of those who are diagnosed will not qualify for the diagnosis as they age and mature.³⁰

V. Pharmaceutical Companies' Revenues Surge While Their Sphere of Influence Grows

Shortly after DSM-IV was published, pharmaceutical companies were allowed to advertise prescription psychiatric medication to patients via direct marketing.³¹ Prior to that, pharmaceutical companies were generating some \$50 million in revenue annually from ADD medications.³² Once these companies were permitted to market to unwitting patients through television, clever advertising campaigns were highly effective at helping individuals to self-diagnose their own mental health disorders and ask a doctor for a prescription to the miracle cure. Evidence of just how effective these advertising campaigns have become is found in the volume of psychiatric medication prescriptions that are written by primary care physicians – up to 90%, depending on the type of medication.³³ In 2010, physicians wrote more than 51 million prescriptions for ADD medications, and pharmaceutical companies made a staggering \$7.42 billion in revenue—an 83% increase over 2006 revenue levels.³⁴

Other drugs are also extremely lucrative. Recent studies from 2012 show that Abilify, an anti-psychotic used to treat depression and bipolar disorder, was the second highest revenue generator for pharmaceutical companies—raking in \$5.6 billion.³⁵ Cymbalta, used to treat depression, was ranked the fifth highest revenue generator and brought in \$4.7 billion.³⁶ These rankings and revenue levels reflect our belief as a society that we are not only mentally ill, but that we can get our mental health care from primary care physicians instead of psychiatrists. The APA is complicit in this epidemic by failing to change the criteria required for diagnoses of mental health disorders within DSM-5. They shoulder significant responsibility for the proliferation of

²¹ *Id.* at 4.

²² Shelley Murphy, *Doctor Is Sued in Death of Girl*, 4, BOSTON GLOBE, Apr. 4, 2008, http://www.boston.com/news/local/articles/2008/04/04/doctor_is_sued_in_death_of_girl_4/.

²³ *Id.*

²⁴ APA HIGHLIGHTS, *supra* note 15, at 1–2.

²⁵ *Id.*

²⁶ FRANCES, *supra* note 1, at 147–49.

²⁷ *Id.* at 148.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ Rosenthal et al., *Promotion of Prescription Drugs to Consumers*, N. ENG. J. MED., Feb. 14, 2002, vol. 346, no. 7.

³² *Id.* at 142.

³³ *Id.* at 101.

³⁴ Gardiner Harris, *F.D.A. Finds Short Supply of Attention Deficit Drugs*, N.Y. TIMES, Dec. 31, 2011, available at http://www.nytimes.com/2012/01/01/health/policy/fda-is-finding-attention-drugs-in-short-supply.html?supply.html?pagewanted=all&_r=1&.

³⁵ *Top 10 Money-Making Drugs of 2012*, DRUGS.COM, <http://www.drugs.com/slideshow/top-10-money-making-drugs-of-2012-1034#slide-2> (last visited Sept. 12, 2013).

³⁶ *Id.* slide 5.

psychopharmacology because they refuse to take back their profession. By allowing unqualified and inexperienced primary care physicians to prescribe these medications, they have abdicated their prerogative to be the primary care providers in the specialty field.

VI. Self-esteem and Personal Accountability

Dr. Frances does an admirable job covering the breadth of issues surrounding the rampant increase in use of prescription drugs. He also adeptly addresses one of the most important intangible issues—that of self-esteem. Recounting several stories of specific individuals who were harmed by the failure of mental health professionals, Dr. Frances exposes the significance of self-esteem and the potential that fake diagnoses will discourage patients from seeking healthy self-help treatments because of the stigma that can be associated with labels. His credibility is bolstered by his recollection of a patient named Mindy who was treated on an inpatient basis for more than two years for schizophrenia at the age of 15 after she exhibited rebellious and eccentric behaviors.³⁷ She was forced to treat her disorder with medications until another psychiatrist realized that Mindy was merely a teenager who had a hard time dealing with her mother. She went on to lead a productive life and eventually forgave the care provider who forced treatment on her for two years of her life—Dr. Allen Frances.³⁸ The story strengthens Dr. Frances' plea to his profession to start controlling the treatment of mental health disorders.

Unfortunately, Dr. Frances did not go the extra step of discussing the concept of how personal accountability is degraded through the excessive use of prescription medications to ensure that we don't feel unpleasant things and think unpleasant thoughts. If a patient fractures his arm, he lowers his expectation of being able to use that arm until the injury is healed. He knows that it takes time to heal, and he feels no compulsion to take external corrective action since the cast will do the work. Similarly, when a patient is diagnosed with a mental health disorder and begins taking medications without engaging in psychotherapy, that patient divorces himself from his personal conduct as it relates to symptoms of his disorder. The patient has a natural tendency to ignore his own character flaws or shortcomings as symptomatic of a mental health disorder. Long-term use of medication only reinforces the diagnosis in his mind and gives him the freedom to let the drugs do the work when he would be better served by seeking psychotherapy from a licensed professional. We are resilient enough as a species to weather significant psychological trauma without sustaining permanent injury.³⁹ When we self-medicate, we

do ourselves a serious disservice and risk teaching future generations that feeling anything other than happiness is not natural.

VII. Impact of the Proliferation of Diagnosis and Prescription Medications on Administrative Separations

Based on increasing trends of diagnoses for mental health conditions that are rooted in the comparatively liberal DSM-5 criteria, judge advocates can be assured that they will encounter greater numbers of personnel with documented mental health conditions in the future. Given the complexity of mental health disorders and the ease with which many health care providers diagnose and prescribe medication, judge advocates are called upon to assist their commanders with distinguishing between those personnel who can safely and effectively continue their duties from those who cannot carry on without endangering those around them.

Far from being a bright-line determination, mental health issues require a sound understanding not only of the law and service regulations, but also of the nuances of mental health diagnoses given the proliferation of diagnosis and medication. Because administrative separation of personnel can cause significant financial harm to the servicemember, it is crucial for judge advocates to ensure that commanders and servicemembers alike understand what is at stake in terms of benefits and entitlements.

VIII. Conclusion

Saving Normal is a warning to patients and the psychiatric community that urges well-reasoned mental health disorder diagnoses, prudent use of prescription medications with reasonable efficacy rates for articulable disorders, and prohibition of marketing to patients by pharmaceutical companies. Dr. Frances acknowledges his own role in contributing to the current conditions as the former DSM-IV task force chair, increasing his credibility. We are in dire need of reform in the area of psychopharmacology. Dangerous drugs are prescribed by the wrong professionals to the wrong people who are told by manufacturers to take a pill to cure their blues. Somebody had to raise a red flag. Thankfully, Dr. Frances had the moral courage to do so.

³⁷ FRANCES, *supra* note 1, at 244–47.

³⁸ *Id.*

³⁹ *Id.* at 30.