Lab to Smartphone

Responding to the Psychiatric Diagnosis Deniers

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Another day, another book or blog post that boldly proclaims attention-deficit/hyperactivity disorder (ADHD) or some other psychiatric disorder really doesn't "exist" and is instead a conspiracy of the pharmaceutic industry or an excuse people use to justify underachievement. To child and adolescent psychiatrists, these old accusations are pesky annoyances. But to our patients, these kinds of statements can really *hurt*, as they send the very clear message to them and everyone around them that there is no actual reason for their suffering and they should get themselves back on track immediately without any additional fuss. This is how stigma is generated and maintained, leading people to feel ashamed of their struggles and to avoid seeking help from anyone until the situation becomes dire.

In recognition of how destructive such cycles can be, we psychiatrists need to step up our game by engaging and refuting myths like this, both on the 1:1 level with our patients and families and to the greater public at large. Doing so effectively requires we first examine the "psychiatric disorders do not exist" argument with regards to its origins and logic to see how it stacks up, especially in comparison to non-psychiatric medical conditions.

In trying to do this, I had to admit to myself there might actually be good reasons why the public would have trouble accepting psychiatric disorders as bona fide medical entities. The diagnosis of hypertension, for example, flows rather simply from a simple objective number that doesn't rely on patients trying to describe their inner feelings or doctors having to interpret what the word "often" or "significant" means within a *DSM* criterion. Pneumonia can be seen on an X-ray and comes from some actual *foreign organism* that isn't supposed to be there, in comparison to some of our own psychiatric conditions, like generalized anxiety disorder, which isn't readily observable even on our best neuroimaging technology. Now that sounds suspiciously like feelings *all* of us have at least once in a while.

A little understanding, however, of emerging research coupled with closer inspection of the ways many non-psychiatric medical disorders exist reveal truths that can help us make sense of these apparent discrepancies. Add in a small dose of humility and honest self-reflection, and we are almost there in figuring out why so many people erroneously deny the existence of things we deal with every day.

The first insight is that psychiatric disorders, at least on the phenotypic level, are largely *dimensional* constructs. While the *DSM* system continues to require a yes/no approach to psychiatric disorders, it is becoming overwhelmingly clear from science that very little in our field actually exists this way.[1] Anxiety magnitudes, attention span, activity levels, and autistic *spectrum* symptoms are all complex dimensional entities that lack clear boundaries between normal and abnormal. So how then does one draw the line between a trait and a symptom? In my training, I was taught that the trait/symptom conundrum could be solved with a single word—namely, *impairment*. Unfortunately, it turns out that impairment is pretty dimensional too. That leaves us with having to create some kind of arbitrary "speed limit" between what is and isn't a disorder, with plenty of grey area in between where different people might legitimately disagree. It's similar to the height that a person would need to achieve before being considered "tall." Few people argue over the person who is 6 foot 6 or 4 foot 6, but what about the guy who is 5 foot 10?

Making matters even more complicated is the emerging literature that this dimensionality likely extends beyond the level of the phenotype into neurobiology as well,[2] which may help partially explain why the search has been so elusive to find *the* lab test, *the* cause, or *the* brain abnormality underlying pretty much all of the common conditions that psychiatrists treat. In other words, it's looking like all the complex interacting genetic and environmental factors that contribute to a child being *a little* hyperactive are the same ones that get turned up to make other kids *a little more* hyperactive. This then implies that neuroscience may not help us as much as we'd like to "carve at the joints" with regard to the boundary between typical and atypical.

These aspects of psychiatric disorders need to be appreciated, but they certainly don't undermine the legitimacy of psychiatric disorders as brain-based entities. Neuroimaging and genetic studies consistently find evidence of neurobiological differences between patients and controls—it's just that these differences tend to be quantitative rather than qualitative, and that's okay. Look a little deeper at some of the most common non-psychiatric illnesses such as hypertension, high cholesterol, or type 2 diabetes, and we also see dimensionality. Experts often tinker with their cut-offs as to what should constitute a disease just like we do, just without all the critics. Sure, it would be simpler if we could just point to something on an X-ray or MRI, but those who are ready to declare anything they can't see on an image or lab report as nonexistent will need to write off everything from severe autism to most complaints of physical pain. If you are feeling a headache about now, that will probably have to go into the world of make-believe, too.

Furthermore, it's not just psychiatric conditions that can have multiple causes or, using the more technical term, show *equifinality*.[3] Turning back to hypertension, it is important to remember that the most common version of hypertension is actually "primary" or "essential" hypertension, which means that there isn't some specific cause we can point to as the culprit. Sound familiar?

The second important point to understand about the psychiatric disorder deniers is that this issue is really about medications. If the treatment for serious psychopathology was a warm bath and a good night sleep, nobody would really care about this issue. However, to a big swath of the American public, a formal diagnosis of a psychiatric condition equates to a firm recommendation for a psychiatric medication. In my view, we need to own up to the fact that there is some truth to this stereotype. Furthermore, what is most troubling to many is the frequency with which medications are being given not as *a* treatment for a patient's emotional-behavioral struggles, but as *the* treatment. Combine this trend with the reality that there has been a fairly precipitous drop over the past several decades regarding the official threshold for how severe behaviors need to be before they qualify as pathological, and the ground becomes fertile for skepticism.

Of course, making any kind of defense problematic, is the inconvenient truth that too many physicians continue to be overly cozy with the pharmaceutical industry.[4,5] Having just endured a bruising public policy debate in which I tried, mainly in vain, to explain that marijuana is not a harmless cure-all for every mental and physical malady out there, I can sadly report to you that the continued schmoozing between practicing physicians and the pharmaceutical industry has *seriously* eroded our credibility as honest brokers of scientific information. It turns out that it doesn't matter at all that I receive nothing from drug companies and haven't written an opiate prescription in over 15 years. I was still perceived as another corrupted soldier deployed by the opiate manufacturers to squelch the right of 80-year-old grandmothers to have their pain properly treated. In the starkest of terms, I finally understood that the excessive ties between physicians and pharmaceutical companies hurt the integrity of *all* physicians, not just the ones accepting the gifts and money.

Seen in this light, the current backlash against psychiatrists and the diagnoses that we make may not be excusable, but it is a heck of a lot more understandable. By fully being able to appreciate the complexity and dimensionality of psychiatric disorders, we can more effec-

tively communicate to our patients and to the public at large why we might not actually *expect* our diagnoses to light up easily on a quick lab test or imaging scan. By acknowledging that our field still has work to do to reduce our reliance on medications and the companies that make those medications (and even better by taking steps to accomplish this reduction), we can regain the level of respect and trust so many dedicated and hard-working child and adolescent psychiatrists deserve when we try to deliver our rebuttals to the vast quantity of misinformation about psychiatry and psychiatric disorders that currently permeates the media.

References

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Disclosure: Dr. Rettew has received royalties for his blog for *Psychology Today*.

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