The SUN Personal. Political. Provocative. Ad-free.

THE SUN INTERVIEW MARCH 2012 | ISSUE 435

Side Effects May Include

Christopher Lane On What's Wrong With Modern Psychiatry

by Arnie Cooper

The complete text of this selection is available in our print edition.

Christopher Lane is not a psychiatrist; he's an English professor specializing in Victorian literature and intellectual history. But he knows as much as many psychiatric professionals do about the Diagnostic and Statistical Manual of Mental Disorders*, or* DSM *— often described as "psychiatry's bible." Lane has researched the manual and the process by which new disorders are added to it. What he's discovered has made him a critic of much of modern psychiatric theory and practice.*

Six years ago Lane began to hear from his students at Northwestern University in Evanston, Illinois, that many of them were on psychiatric drugs. They would come to his office to ask for extensions on their assignments, explaining that they were suffering from anxiety or depression but were on medication for it. He had just published Hatred and Civility: The Antisocial Life in Victorian England*, for which he had studied the transition from Victorian psychiatry, out of which psychoanalysis was born, to contemporary psychiatry, with its intense focus on biomedicine and pharmacology. He was already skeptical about the emergence in 1980 of dozens of new mental disorders in the* DSM-III*, the third edition of the manual. Among these new ailments were the curious-sounding "social phobia" and "avoidant personality disorder." Lane wanted to know how and why those new disorders had been approved for inclusion and whether they were really bona fide illnesses.*

He flew to San Francisco to speak with Mitchell Wilson, who'd written about the creation of the DSM-III *years earlier, and Wilson turned over to Lane a cache of documents, including unpublished memos from the archives of the American Psychiatric Association [APA]. Obtaining the papers was itself something of a coup, as researchers had tried unsuccessfully for years to learn how the* DSM *was updated and transformed. Lane was dogged in seeking answers, and the APA eventually relented and gave him access to its archives.*

Lane was troubled by what he found: evidence of drug-company influence, especially in the promotion of "panic disorder" by Pharmacia & Upjohn, maker of the anti-anxiety drug Xanax. He also uncovered extensive evidence of questionable research (sometimes involving just one patient), sloppy thinking, dismissal of nonmedical approaches to psychiatric problems, and a degree of inventiveness with terms and symptoms that struck him as playing fast and loose with the facts.

All of this served as the basis for Lane's 2007 book, Shyness: How Normal Behavior Became a Sickness*, in which he observes that behaviors once understood as reactions to one's environment and upbringing are increasingly seen as innate conditions of brain chemistry, resulting from problematic levels of neurotransmitters, especially serotonin. He suggests that because of the open-ended language in the* DSM *and the wide range of behaviors it pathologizes, anyone who is shy, as he was as a teenager, now risks being diagnosed as mentally ill. The new disorders were "obviously music to the ears of drug companies," he says, "insofar as they massively increased the market for their products, which the media greeted with incredible enthusiasm."*

Born in Wimbledon, England, in 1966 to a music-therapist mother and a father who worked as an antiques appraiser for auction houses, Lane spent his childhood immersed in books. After college he began traveling in Sudan, Turkey, and throughout Asia. He also did a stint teaching high-school literature in Zimbabwe. When an unexpectedly high number of his

students were accepted by the University of Zimbabwe, it "kick-started me into teaching in a big way," he says.

Lane returned to London and received his PhD in English at the age of twenty-five from the University of London. With England's economy faltering, he immigrated to the United States and worked at the University of Wisconsin–Milwaukee, the University of Pennsylvania, and Emory University, where he was appointed director of the interdisciplinary psychoanalytic-studies program (which is housed in the psychiatry department) on the basis of the books and articles he had published on psychoanalysis and nineteenth-century psychology. He was hired at Northwestern University in 2000 and became a full professor at the age of thirty-three.

Lane has written three other books about the Victorian era, the most recent being a study of Victorian agnosticism titled The Age of Doubt: Tracing the Roots of Our Religious Uncertainty. *He is editor of the anthology* The Psychoanalysis of Race *and coeditor of* Homosexuality and Psychoanalysis. *He currently writes for the* Huffington Post *and has a popular blog for* Psychology Today *called "Side Effects."*

Cooper: Why should the average person care about the *DSM*?

Lane: The *DSM* is widely regarded as the bible of psychiatric diagnoses. Its authority extends not only to this country's schools, prisons, court system, and health-insurance industry, where it is daily invoked, chapter and verse, but also around the world, where it is highly influential in defining mental illness. It's currently in its fourth edition, and a fifth is due out in 2013. With each edition the number of diagnoses greatly increases, and the thresholds for meeting them are routinely lowered. The number of people who can be defined as mentally ill has grown to the point where Darrel Regier of the American Psychiatric Association says that mental disorders affect some 48 million Americans in their lifetimes. That's one in six people. And he's basing that judgment entirely on *DSM* criteria and language.

Cooper: Since the first *DSM* in 1952, which had 106 disorders, the number has almost tripled. Are we getting sicker, or is something else at play?

Lane: The way psychiatrists define mental illness has itself changed radically. The first two editions of the *DSM* focused on observable traits and behaviors in patients, which were often described as "reactions" to particular incidents or stressors. When the third edition came out in 1980, it defined virtually everything as a "disorder," which connotes an innate, lifelong malfunctioning of the brain rather than a moment of psychological distress that might be due to a brief change in circumstances. This new method of defining mental disease has completely transformed the way mental-health professionals and the general public think about it.

Cooper: But isn't it possible that we are in fact getting sicker?

Lane: I think it's difficult to gauge that accurately. If you follow the APA's line, then most definitely we're seeing epidemic rates of social anxiety disorder and bipolar disorder, with the latter expanding by an eye-popping 4,000 percent. But how did that massive increase come about? It's due almost entirely to the fact that the *DSM-IV* formalized bipolar as a mental disorder among children. Before that, bipolar disorder was understood to be exclusively an adult phenomenon. Psychiatrists like to revise everything backward, to rewrite the past in terms of their current terminology. Doing so makes their new terminology seem natural, even inevitable. There are more than a hundred more mental disorders in the *DSM* today than we had in 1968, including incredible new ones such as "sibling-relational problem" and even "partner-relational problem." But I'm not convinced that the introduction of new illnesses means that more people are actually sicker.

I have extensively researched the APA archives and can attest that their judgments were often flimsy and their rationale for including new disorders questionable, based as they were on anecdotal evidence, ambiguous clinical research, and highly inconclusive trials. One of the consultants for the *DSM-III*, Theodore Millon, admitted to *The New Yorker* in 2005 that there was little systemic research; much of it, he said, was inconsistent and hodgepodge. He was an active participant on the *DSM* committees.

Cooper: How did you become interested in the *DSM*?

Lane: I'm a teacher, and I learned that many of my students were on some kind of psychiatric medication, generally prescribed but sometimes not. I wanted to know why they and their doctors felt that drugs were necessary to treat relatively mild problems that earlier generations had dealt with quite differently. I had just finished writing a book on antisocial behavior in the nineteenth century, when the culture's judgment of such behavior shifted radically. The Romantic Movement, which dominated arts and letters in the first half of that century, often praised antisocial behavior and misanthropy in particular as a valid criticism of social vice, greed, and stupidity. The Romantics lauded the outcast as someone capable of

commenting on what was wrong in society. By the end of the nineteenth century, however, the exact same behavior was held as suspect, pathological, and even criminal, in part because the values it exemplified were not conducive to social cohesion.

During my research I discovered more-recent articles describing misanthropy again as a pathological defect, with little understanding of the intellectual and psychiatric history behind such judgments. No one considers that such behaviors might be useful, even absolutely necessary, to help us recognize social problems. For example, some people taking antidepressants and antipsychotics may not experience strong emotions in reaction to public catastrophes like the BP oil spill or the war in Iraq because the drugs cause "emotional blunting," a phenomenon that's been widely noted and studied.

Cooper: How has the *DSM* changed the psychiatric profession?

Lane: What concerned me about the publication of the *DSM-III* in 1980 was not just the formal creation of more than eighty new mental disorders but the suggestion that behaviors previously understood as reactions to stress and events were now being reclassified as innate conditions of the brain. The speculation at the time was that all mental illness was due to chemical imbalances — problem levels of serotonin, dopamine, or norepinephrine, but principally serotonin.

When Prozac came on the market in the late eighties, it was viewed as a kind of miracle drug. A 1994 cover piece in *Newsweek* was subtitled "How Science Will Let You Change Your Personality with a Pill." On the heels of the new *DSM-IV* that same year came a rash of articles saying we could use antidepressants to enable "personality sculpting." It was a trendy way of thinking about self-improvement, along the lines of the sitcom *Home Improvement*. [Laughter.] If these foibles or quirks were holding you back, the thinking went, why wouldn't you take an antidepressant that could shape your personality into a more optimal one?

Cooper: Peter Kramer, author of *Listening to Prozac*, called it "cosmetic psychopharmacology."

Lane: Kramer was one of the people responsible for the giddy reception to the drug. There was virtually no discussion in his book of the side effects and other downsides to taking an antidepressant without a clinical diagnosis, let alone with one. I'm sure he'd dispute this, but I would consider the widespread embrace of cosmetic psychopharmacology to be largely responsible for the amount of off-label prescribing we're seeing today — for example, when people (and it's illegal to do this, by the way) take psychostimulants such as Adderall and Ritalin, which are forms of amphetamine, in order to promote what they consider "neuroenhancement." We're seeing widespread misuse of these drugs ostensibly on the grounds that they are enhancing neuroactivity, but, like all amphetamines, they create many problems too.

Cooper: Let's say that these drugs had no notable side effects. What's wrong with being, as Kramer says, "better than well"?

Lane: With meds, unfortunately, there is almost always a downside, even if it's not immediately obvious. In the history of pharmacology many new drugs have been presented as the wonder cure, the remedy for everything. It takes about a decade for the long-term studies to catch up with that initial enthusiasm. The studies invariably point to not just a downside but, quite frequently, serious physiological and psychiatric risks. Selective serotonin reuptake inhibitors [SSRIS] such as Prozac are now associated with a litany of medical problems, including sexual dysfunction and increased risk of suicide. These are serious side effects for drugs that are represented as enabling people to be "better than well." There's enough risk of suicidal ideation that in 2004 the Food and Drug Administration [FDA] asked the drug companies to put a black-box warning on the label.

Cooper: The pharmaceutical industry funds much of the testing done for the FDA. Is there a conflict of interest there?

Lane: Yes. As key sponsors of much of the research, the drug companies help determine which drug trials will take place and how they will be conducted. Historically they haven't funded studies that examine the downsides of their products. They are interested in positive results, even if the evidence of benefit is negligible. In 2008 *The New England Journal of Medicine* published a major study on the overall reporting of clinical trials for antidepressants. The study found that trials that had determined the drugs were not beneficial or had extensive side effects were often filed away and never published. Moreover, in trials that *were* published, the authors had sometimes manipulated ambiguous or negative data to make the drug look potentially useful when the data had shown otherwise.

Cooper: And by influencing the *DSM* task force, the drug companies help determine what constitutes sickness.

Lane: Indeed. In an ideal world they would have no influence on such decisions. The FDA has to be the watchdog that polices those boundaries, but in reality the FDA finds itself reliant on psychiatric experts, all of whom have multiple ties to drug companies. The only semblance of "neutrality" is that those FDA consultants are presumed to have ties to *all* the companies instead of just one or two. It's an alarming situation. I believe the FDA could be doing more to reduce the drug companies' involvement. Instead it's tolerating greater and greater amounts of indirect influence.

Cooper: The leaders of the task force for the *DSM-5* deny having any conflicts of interest. Even psychiatrist Allen Frances, who headed up the *DSM-IV* and has been very critical of the *DSM-5*, says that despite all its problems, there really isn't a conflict of interest with pharmaceutical companies.

Lane: I respect Allen Frances, but I think he's simply wrong there. *The Washington Post* provided figures showing that every single person working on schizophrenia and depression on the *DSM-IV* task force had ties to pharmaceutical companies. Requiring no ties whatsoever is an unrealistic proposition today, because it would exclude almost every expert. So the *DSM-5* task force agreed that each member could receive a maximum ten-thousand-dollar annual honorarium from the drug companies. That strikes me as a high amount — certainly enough to impair judgment. Even the appearance of impropriety is enough to put the whole endeavor at risk.

For my book I interviewed Robert Spitzer, who's considered the father of the modern classification of mental disorders. He made an interesting admission: He observed that none of his colleagues ever says the disorder that he or she is studying is rare. All of them, out of professional self-interest, play up its prevalence to the point where they are endlessly overstating — my word — its pathological significance and pervasiveness. There's a great deal of hype and distortion built into the process.

Cooper: Is there any reward for being a whistle-blower and saying some people aren't really sick?

Lane: Colleagues of mine in the medical school at Northwestern, who checked and agreed with my research, insisted that their names not appear anywhere in my book, because it could jeopardize their connections to drug companies that were funding their studies. That's just one indication that there's a strong disincentive to be critical of drug companies. Those who come forward with criticisms are likely doing so because they have nothing to lose professionally.

Cooper: Who is running the show: the pharmaceutical industry, the APA, or the *DSM* task force?

Lane: The APA is ostensibly running the show, advised by the *DSM* task force, but there is an inescapable, mutually beneficial relationship between psychiatrists and the drug companies. The latter's contributions also make up a sizable percentage of the APA's annual budget. That relationship is leading to a massive escalation in the number of disorders and an overreporting of disorders that didn't even exist two or three decades ago. Before 1980 social phobia wasn't listed in the *DSM*, and the experts I interviewed in Britain, on whose work the APA drew heavily to justify the new disorder's inclusion, said it should never have been split off as a separate disorder. It was a form of anxiety that, at low levels, was actually seen as necessary, even beneficial. Darwin argues that a certain amount of anxiety is advantageous to survival. Under mildly stressful conditions we perform better. We react to danger more quickly and become more aware of our surroundings. I don't want to be glib about this, because some people do suffer chronic levels of anxiety. But it's important to recognize that not all anxiety is bad for us, and that the number of people afflicted with chronic levels is much smaller than we tend to hear — in the region of 1 percent of the general population, as distinct from studies putting that level at close to one in five Americans. The highest results came from a telephone survey of urban Canadians that asked whether they were ever afraid of figures of authority, ever felt discomfort at parties, and so on.

There have been some provocative pieces on this, including one in *The Daily Beast* that asks whether the subprime meltdown might have been tied to overuse of antidepressants. I originally found that argument ridiculous. The main cause was obviously the deregulation of banking policies that had been in place since the 1930s. But I think it's possible that the widespread use of anti-anxiety medication — including on Wall Street, where huge bets were being made — may have worsened the crisis by making people too tolerant of risk. Anxiety is intimately related to how we perceive risk and react to it. If someone is medicated, he or she may not respond quickly enough to dangers.

Cooper: In your book on shyness you write, "Before you sell a drug, you have to sell the disease."

Lane: One of the givens of pharmaceutical marketing is that you have to "create need" to expand the market. The criteria for social phobia in the *DSM-III* included fear of eating alone in a restaurant, avoidance of public restrooms, and fear of one's hand trembling when writing a check. In other words, the requirements were set so low that people who experience garden-variety shyness could be swept up in the diagnosis. Fifty percent of people in any population around the world will define themselves as shy. So what the drug companies set out to do was convince people that shyness might be a symptom of something more serious called "social anxiety disorder."

Independent agencies have since determined that in 2000 GlaxoSmithKline spent more than $92 million on direct-to-consumer advertising on a single drug, Paxil, which is more than Pfizer spent the same year on Viagra, and those Viagra ads were all over TV and magazines, and even appeared on race cars. The Paxil marketing campaign took a product that had produced spotty results in early trials — including one so riddled with side effects that the company had seriously considered shelving the drug — and turned it into a blockbuster, so called because its annual revenue surpasses $1 billion.

When they realized that they could sell Paxil not simply for depression, where it was competing with Zoloft and Prozac, but also as the first FDA-approved drug for social anxiety disorder, they went all out. They organized and funded a public-awareness campaign — "Imagine being allergic to people" — that didn't even mention the drug but helped sell the condition. Large numbers of people went to their physicians asking for free samples, which GlaxoSmithKline, of course, made sure were abundant.

Cooper: Is there no difference between social anxiety disorder and shyness?

Lane: In my research I found that the percentage of people who experience acute shyness overlaps almost identically with the group the APA wants to say suffers from social anxiety disorder. So precise was that overlap that the *DSM-IV* added a rider saying that social anxiety disorder should not be confused with shyness — which to me is an indication that they did, in fact, pathologize shyness and were worried about the overlap. But because of the sheer number of people asking for Paxil as a result of the advertising campaign, doctors were encouraged to consider whether shyness was a symptom of something more serious.

Cooper: How can we convince pharmaceutical companies to focus on serious existing illnesses rather than helping invent questionable new ones?

Lane: One way to do that would be for Congress to prohibit direct-to-consumer advertising. If the ads were once more restricted to professional journals, drug companies would stop trying to push their products on concerned but essentially healthy people or to license drugs for new, off-label uses. Once you've got a drug cleared by the FDA, it's much cheaper and easier to press for additional licenses than to develop new products.

Cooper: Only the U.S. and New Zealand allow direct-to-consumer advertising. How did that happen?

Lane: In August 1997 the FDA, with the backing of the Clinton administration, relaxed what had previously been strict rules. For the first time drug companies were allowed to market directly to consumers, in effect bypassing providers and doctors and leading to a pattern of self-diagnosis, including through the use of online quizzes and such. The change was supposed to address unmet need — segments of the population that apparently didn't know they were suffering from a treatable problem. The ad campaigns were expensive and slick, with the drugs' side effects mentioned hurriedly at the end, and usually just nausea and headaches, unlike some of the more dramatic lists today, which will even mention risk of death. Even so, the ad campaigns were very successful, and they continue to be. In 2011 almost $11 million a day was spent on direct-to-consumer advertising.

Cooper: I've seen ads for Seroquel in which the devastating side effects constitute the majority of the narration. Why are so many people willing to take this drug?

Lane: The Seroquel phenomenon is interesting in itself. Right around the time that the patents on SSRI antidepressants expired, we saw a massive shift in advertising resources to antipsychotics such as Seroquel, whose patents made them major revenue earners. Bipolar became the diagnosis of the day. So drug companies tried to bundle bipolar disorder with depression to reach both markets — even though bipolar by nature would include depression as a symptom. Of course, when the patent ends and competing versions of a drug surface on the market, the rate at which the brand-name drug is prescribed falls dramatically. President Clinton allowed a six-month extension of the patent on Prozac through the brand name Sarafem. The formerly yellow-and-green pills were recolored lilac and prescribed for premenstrual dysphoric disorder [a severe form of premenstrual syndrome], a heavily contested diagnosis. The extension yielded another $1 billion in revenue for Eli Lilly.

The moment the patents on antipsychotics end, we'll almost certainly see a desperate effort by drug companies to find new markets for them — which means we'll see antipsychotics prescribed for much milder disorders. For example, I unearthed a clinical trial that was testing Seroquel on people with public-speaking anxiety. Think about that: an antipsychotic for fear of public speaking, one of the most common and widespread fears in our society. The idea they could market an antipsychotic for a common fear is shameless, but I can easily imagine them trying.

Cooper: But how likely is it that Seroquel is actually going to be used in that way?

Lane: There are precedents for it in licenses already granted for generalized anxiety disorder on equally flimsy evidence. Of course, one-time medications such as beta blockers already exist for performance anxiety, and the list of side effects from them is relatively small. But prescribing a powerful antipsychotic for that kind of routine condition, when the drug in question comes with a litany of dangerous side effects, is flat-out wrong and unacceptable.

Cooper: So if you could take a drug for performance anxiety that had zero side effects, you wouldn't have any problem with that?

Lane: Even if we could get to zero side effects — which is something of a medical fantasy in itself — ethical concerns would clearly surround drugs that give only an illusion of competence or excellence. In fall 2010 I wrote an article for *Phi Beta Kappa* magazine on the risks of using Adderall and other "neuroenhancers" for undergraduate work. Among students there seems to be a widespread myth that these drugs enhance creativity and mental performance. In fact, those outcomes are greatly overstated, and pronounced side effects are frequently associated with abuse of these drugs. Yet studies show that undergraduates are taking them in large numbers, apparently not recognizing the difference between caffeine and what is essentially a refined amphetamine.

The complete text of this selection is available in our print edition.
