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IS MENTAL DISEASE REAL - OR MERELY A METAPHOR?

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Every 15 years or so, a large group of psychiatrists assemble to update the Diagnostic and Statistical Manual of Mental Disorders (DSM) that defines and categorizes mental illnesses. DSM has become the bible not only for psychiatrists, but everyone. It dictates whether insurers, including Medicare and Medicaid, will pay for treatment, whether schools will expand financing for certain special-education services, and for Courts to determine if a criminal defendant is mentally impaired. Drug companies also rely on it heavily to develop their research and promotional programs.

Also Included In This Issue

Critics contend that DSM does more harm than good because it is constructed by psychiatrists with strong financial ties to pharmaceutical manufacturers intent on finding new indications for existing drugs or those in the pipeline. Some feel that DSM is a fraud, since **there is no proof that mental disorders even exist.**

This ongoing debate has intensified with the preparation of the latest update scheduled to appear in May 2013. The APA (American Psychiatric Association), which publishes the manual, has been criticized in the past for not making its revision process more transparent. In response, starting in 2010, it has periodically posted updated drafts of the new DSM-5 on its web site for public comment. Since then, **they have received 50 million hits from about 500,000 individuals and more than 25,000 comments, the vast majority of which have been critical.**

How And Why Manic Depressive Illness Became Bipolar Disorder

Many are concerned that DSM-V will continue to contain more psychiatric diagnoses than actually exist. For example, the 1952 DSM-I, listed 106 mental disorders, the 1968 DSM-II had 185, and by 1980, DSM-III there were 256 diagnoses grouped by a new system of categories and subcategories. DSM-IV, published in 1994, listed 297 disorders and the manual had increased to 886 pages from only 130 in the first edition. DSM-5 (the Roman numeral system has been dropped) promises to add even more, such as Internet addiction disorder (IAD), Gambling disorder and Pedophilic Disorder. Extreme shyness would also now be classified as a mental disorder. Binge eating disorder is defined as one eating binge per week for three months and Hypersexuality disorder is recurrent and intense sexual fantasies, sexual urges, and sexual behavior for at least 6 months. A new Paraphilic coercive disorder allows rapists to claim they have a legitimate mental disorder if they get special sexual excitement from raping someone. In addition, the bar has been progressively lowered to expand the diagnosis of certain disorders, particularly in children and teenagers. One survey found that the number of office visits resulting in a diagnosis of bipolar disorder in those age 19 or under jumped from 25 out of 100,000 in 1994-1995, to 1003 out of 100,000 in 2002-2003. **This represents a more than 40-fold increase in bipolar disorder among children and teenagers in less than a decade.**

When Emil Kraepelin first described manic–depressive illness in 1902, it referred to patients with recurrent episodes of hyperactivity or depression during which they could not function properly, followed by intervals during which they had few or no symptoms. The disorder usually started in the twenties, was seen much more frequently in women, and was **rare or non-existent in children**. DSM-I referred to this as "manic-depressive **reaction**" largely because of the influence of Adolph Meyer, the first Chairman of the Department of Psychiatry at Johns Hopkins, who viewed this and certain other mental disorders as a reaction to psychosocial stressors, especially in patients with a genetic predisposition. DSM-II termed the condition "manic-depressive **illness**", but this was replaced by **bipolar disorder** in the 1980 DSM-III, which now added a **pediatric form in children with Attention Deficit Disorder**. The definition of bipolar disorder was again changed in DSM-III-R and DSM-IV and there are currently three types of bipolar disorder as follows.

I. People with at least one manic episode and periods of major depression. This was previously called manic-depressive disorder.
II. Individuals who have never exhibited full mania but rather periods of high energy and impulsiveness that are not as extreme (hypomania), and which alternate with episodes of depression.

III. Cyclothymia – a milder form that is manifested by less severe mood swings that alternate between hypomania and depression.

This allows at least three drugs or combinations of drugs to be prescribed for bipolar disorder, including children. The condition is now often called **bipolar disease**, which implies a greater or more urgent need for treatment. Its prior descriptions as a reaction, illness or disorder seem more appropriate and many feel that manic-depressive disorder is a more descriptive term for patients with recurrent mood swings, especially since those with type II and cyclothymia are apt to be misdiagnosed as having depression.

The diagnosis of bipolar disorder increased significantly in the 1990's after Abbott Laboratories introduced Depakote for the treatment of mania. It had been marketed since 1983 for epilepsy but was used off label to treat other disorders, and had been found helpful in manic-depressive patients. Since it was not approved for that diagnosis, Abbot modified the formula slightly, which it claimed formed a more stable solution, and was able to patent the new compound. This Depakote version with more sedative side effects was approved in 1995 for patients with acute manic states based on clinical trials showing benefits. Any sedative agent would have produced the same results but no company had chosen to do this, since manic states were fairly rare and adequately controlled by lithium, which was also very inexpensive. However, **Depakote was advertised as a "mood stabilizer" rather than a treatment for manic-depressive disorder, which would have been illegal since there were no studies to support this. In addition, since mood stabilizer had no precise neuroscientific or clinical meaning,** it was not subject to legal sanction. Other companies that made antipsychotic drugs like Zyprexa, Risperdal and Seroquel quickly began to call them mood stabilizers. Prior to 1995, there were no medical journal articles on mood stabilizers. There are now well over a hundred a year. As noted in a recent paper, "**Pediatric bipolar disorder: An object of study in the creation of an illness**", this combination of 'rebranding' a disorder (from manic-depression to bipolar) and a new class of drugs (mood stabilizers) is unprecedented within psychiatry." It proved to be ingenious.

In 1996, the FDA also approved Depakote for the prevention of migraine headaches. This was another bonanza for Abbott, since well over 30 million Americans have migraine and the company could advertise that they "Take Depakote daily to reduce the frequency of migraine headaches." Depakote also became available in extended release and sprinkle capsules, syrup and injections for ease of administration. Due to aggressive promotional efforts, it became the best selling drug for treating mania even though it was not significantly superior to lithium and much more costly. It was also being increasingly prescribed off label despite the fact that serious side effects were starting to surface that included deaths from pancreatitis and liver

failure. In 2000, the FDA mandated a black box label warning of these, and in 2007, added the risk for congenital malformations in infants exposed to Depakote during pregnancy. Adverse side effects were most likely to occur in patients taking other drugs and children under 10 years of age.

Numerous lawsuits have now been filed for wrongful death and personal injury, and two months ago, **Abbott agreed to pay $1.6 billion to resolve its criminal and civil liability arising from the company's unlawful promotion of Depakote.** While physicians can prescribe a drug for disorders other than those that are FDA approved, pharmaceutical manufacturers are strictly forbidden to endorse or advocate such off label use. Abbott pleaded guilty to misbranding Depakote by promoting the drug to control agitation and aggression in elderly dementia patients and to treat schizophrenia, although neither of these was FDA approved. The company also admitted that from 1998 through 2006, it maintained a specialized sales force trained to market Depakote in nursing homes for the control of agitation and aggression in elderly patients, despite the absence of scientific evidence that it was safe or effective for these complaints. In addition, from 2001 through 2006, Abbott marketed Depakote in combination with atypical antipsychotic drugs to treat schizophrenia, even after its clinical trials failed to demonstrate that adding Depakote was any more effective than an atypical antipsychotic alone. This is the second largest criminal fine for a drug company, with $700 million going to the government and over $800 million to 45 states and the District of Columbia.

Justice Department officials said the agency intended to increase penalties each time it resolves an off-label marketing case with a drug company to deter this practice. Abbott also will be subject to court-supervised probation and reporting obligations for its CEO and Board of Directors. The government's investigations were based partly on federal court lawsuits filed by former Abbott sales representatives. Some claimed the company actively promoted Depakote for treating dementia and other disorders in nursing-home patients, paid kickbacks to doctors and long-term care pharmacists for using Depakote, and deliberately misrepresented its safety and efficacy. These whistleblowers will split $84 million of the federal share of the settlement under a U.S. law designed to encourage people to report possible false-claims fraud, and they will receive additional funds from states.

Why DSM-5 Will Likely Continue To Make The Mistakes Of Its Predecessors

One of the most vocal critics of DSM-5 has been Dr. Allen Frances, Professor Emeritus of the Department of Psychiatry at Duke University School of Medicine. This is somewhat surprising and particularly important since he contributed to DSM-III and its revision, DSM-IIIR, and was Chairman of the DSM-IV Task Force as well as the current 1994 DSM IV. A few days after *The*

New York Times announced the $1.6 billion Depakote settlement last May, it featured an OpEd by Dr. Frances entitled "Diagnosing the DSM". He explained that DSM-IV "tried to contain the diagnostic inflation that followed earlier editions. It succeeded on the adult side, but **failed to anticipate or control the faddish over-diagnosis of autism, attention deficit disorders and bipolar disorder in children that has since occurred."** His concern is that DSM-5 will prove to be a disaster because it will also "medicalize normality and result in a glut of unnecessary and harmful drug prescription." He believes this is because DSM is controlled entirely by psychiatrists, many of whom want to enlarge the purview of their pet projects to the point that common complaints come to be mislabeled as mental disorders. Others have conflicts of interest that influence decisions, especially if their authority or past views are threatened, as noted below.

> The fight over the DSM-5 pits some of the biggest egos in the world of psychiatry, but it's more than a battle among 301.81s (narcissistic personality disorder). For people seeking help for life's problems who don't want to be labeled mentally ill or have their treatment limited to medication, and for clinicians who want to help people without reducing them to a category, the stakes are high. [1]

New diagnoses are more dangerous than new medications and it is necessary break up this psychiatric monopoly. Most psychotropic drugs are prescribed by primary care physicians who are more apt to be aware of their efficacy and side effects, as are nurses, psychologists, social workers and counselors. All of these, as well as epidemiologists, health economists and public policy experts should be represented in the DSM process.

Dr. Frances dismisses "shilling for drug companies" as a major problem, but others vehemently disagree. A peer-reviewed analysis documenting such financial conflicts of interest revealed:

> Our inquiry into the relationships between DSM-IV panel members and the pharmaceutical industry demonstrates that there are strong financial ties between the industry and those who are responsible for developing and modifying the diagnostic criteria for mental illness. Of the 170 DSM panel members 95 (56%) had financial ties to pharmaceutical companies. The connections are especially strong in those diagnostic areas where drugs are the first line of treatment for mental disorders. **One hundred percent of the members of the panels on 'Mood Disorders' and 'Schizophrenia and Other Psychotic Disorders' had financial ties to drug companies**. The leading categories of financial interest held by panel members were research funding (42%), consultancies (22%) and speakers bureau (16%). [2] (emphasis added)

1. Rob Waters Therapists Revolt Against Psychiatry's Bible, *Salon Magazine* 12/27/11
2. Cosgrove, L., Krimsky, S., Vijayraghavan, M. & Schneider, L. (2006). Financial ties between DSM-IV panel members and the pharmaceutical industry. Psychotherapy and Psychosomatics, 75, 154-160.

This problem was alleged to have been corrected in assembling the DSM-5 panels by instituting a new financial conflict of interest disclosure policy and providing greater transparency similar to that used by leading medical journals. However, a recent review revealed that financial ties to industry actually increased from 56% in DSM-IV to 70% in DSM-5. It is very likely much higher since APA's disclosure requirements exclude fees for promoting products and "unrestricted research grants" as noted below:

> The current APA disclosure policy does not require panel members to specifically identify speakers bureau membership but rather cloaks it under "honoraria." Therefore, despite increased transparency, it remains unclear how many individuals participate on speakers' bureaus, because panel members may simply list "honoraria." None of the *DSM* panel members identified participation on a speaker's bureau. When we did an Internet search of the 141 panel members, we found that 15% had disclosed elsewhere that they were members of drug companies' speakers bureaus or advisory boards. Exclusions to the APA *DSM*-5 disclosure policy include unrestricted research grants . . . panel members are not required to disclose unrestricted research grants from industry. However, we would argue that this exclusion allows for commercial interests to be reflected in the revision process: there is no evidence to suggest that simply because money comes in the form of a large "unrestricted" research grant it does not create an obligation to reciprocate or invoke an implicit bias. The current policy places high and arbitrary threshold limits on monies allowed from industry: DSM-5 panel members are allowed to receive $10,000 per year from industry (e.g., for consultancies), and panel members are allowed to have up to $50,000 in stock holdings in pharmaceutical companies. **In contrast to other disclosure policies APA's policy does not require disclosure of the amount of money received from industry.** [3] (emphasis added)

Another recent report entitled "New Guidelines May Sharply Increase Addiction Diagnoses" describes DSM-5 as "a hideous distortion of medical science", whose members often have little insight or honesty when questioned about their financial conflicts of interest. As it explains:

> Dr. Charles O'Brien [University of Pennsylvania and The Charles O'Brien Center for Addiction Treatment] who led the addiction working group, has been a consultant for several pharmaceutical companies, including Pfizer, GlaxoSmithKline and Sanofi-Aventis, all of which make drugs marketed to combat addiction. He has also worked extensively as a paid consultant for Alkermes, a pharmaceutical company, studying Vivitrol, a drug that combats alcohol and heroin addiction by preventing craving. He was the driving force behind adding "craving" to the new manual's list of recognized symptoms of addiction. "I'm quite proud to have played a role, because I know that craving plays such an important role in addiction," Dr. O'Brien said, adding that he had never made any money from the sale of drugs that treat craving. Surely such an indication of dissociation must qualify for a DSM diagnosis and a psychotropic drug.[4]

3. Cosgrove, L., Krimsky, S. (March 13, 2012) A Comparison of DSM-IV and DSM-5 Panel Members' Financial Associations with Industry : A Pernicious Problem Persists, PLoS Medicine 9(4): e1001210.

4. Ian Urbina, *The New York Times*, May 12, 2012.

In another article entitled **"Psychiatry's Bible, the DSM, is Doing More Harm Than Good**, Dr. Paula Caplan, who served on two DSM-IV committees until she resigned in protest about pathologizing pre-menstrual cramps, also criticized DSM's lack of a scientific foundation and stranglehold.

> I used to believe that the manual was scientific and that it helped patients and therapists. But after seeing its editors using poor-quality studies to support categories they wanted to include and ignoring or distorting high-quality research, I now believe that the DSM should be thrown out. An undeserved aura of scientific precision surrounds the manual: It has "statistical" in its title and includes a precise-seeming three- to five-digit code for every diagnostic category and subcategory, as well as lists of symptoms a patient must have to receive a diagnosis. But what it does is simply connect certain dots, or symptoms — such as sadness, fear or insomnia — to construct diagnostic categories that lack scientific grounding. Many therapists see patients through the DSM prism, trying to shoehorn a human being into a category. **Psychiatry estimates that within their lifetime, 50% of the American population will be "diagnosed" with a mental disorder. A psychiatric label causes serious harm: it can cost anyone their health insurance, job, custody of their children, or right to make their own medical and legal decisions.** And if patients take psychiatric drugs, they risk developing physical disorders such as diabetes, heart problems, weight gain and other serious conditions. [5] (emphasis added)

As Dr. Frances noted in a recent blog, "APA has already spent an astounding $25 million on DSM-5 compared to $5 million for DSM-IV" and nobody seems to know what caused this colossal waste. The new additions are very difficult to distinguish from what is generally considered to be normal, and would "radically and recklessly" expand the boundaries of psychiatry. **"And these days, most diagnostic decisions are not made by psychiatrists trained to distinguish between the two. Most are made by primary care doctors who see a patient for about seven minutes and write a prescription."** Under the new criteria, **grief after the loss of a loved one, mild memory loss in the elderly and frequent temper tantrums in kids could all be psychiatric diagnoses that require drug treatment**, without any scientific evidence that it would be safe or effective. From the very start, APA has treated DSM-5 more as private publishing asset than as public trust, and while all DSM-5 participants were forced to sign confidentiality agreements, they are of little value. According to a study previously cited [3], some of most conflicted panels are those for which drugs represent the first line of treatment, with two-thirds of the mood disorders panel, 83 percent of the psychotic disorders panel and 100 percent of the sleep disorders panel disclosing "ties to the pharmaceutical companies that manufacture the medications used to treat these disorders or to companies that service the pharmaceutical industry."

5. Paula Caplan, *Washington Post*, April 27, 2012

Can Anyone Prove That Mental Illness Really Exists — Or Is It A Myth?

In February 1969, David L. Rosenhan, a psychology professor at Swarthmore College in Pennsylvania, went to a state psychiatric hospital complaining that he periodically heard unfamiliar voices inside his head repeating the words "empty," "thud" and "hollow." Although he had nothing else that was unusual to report, he was immediately admitted with a diagnosis of schizophrenia. Over the next 3 years, 7 of his friends and students were also admitted to 12 different hospitals in five states after claiming that they similarly heard strange voices in their head. They included a psychology graduate student in his twenties, three psychologists, a pediatrician, a painter, a psychiatrist and a housewife. None had a history of mental illness, they used pseudonyms, and those who worked in the mental health field had been given false jobs in a different sector to avoid invoking any special treatment or scrutiny. Apart from the fake names and employment details, all other biographical details were truthfully reported. The psychiatric facilities included underfunded public hospitals in rural areas, urban university-run hospitals with excellent reputations, and an expensive private hospital. Although hearing voices was their only complaint, they were all diagnosed as having schizophrenia or bipolar disorder and admitted to psychiatric wards for between 8 and 52 days. After admission, all acted normally and told the staff and doctors that they felt fine and had not experienced any more hallucinations. Nevertheless, they were forced to take more than 2,000 pills, most of which they pocketed or kept in their cheek pocket until they could be flushed down the toilet.

Despite constantly and openly taking extensive notes on the behavior of the staff and other patients, none of these pseudopatients were identified as impostors by the hospital staff, although some of the other psychiatric patients seemed to suspect this and several thought they might be journalists or researchers. Hospital notes indicated that the staff interpreted their actions in terms of mental illness, with one nurse labeling the note-taking as pathological "writing behavior". Their biographies were also written up to emphasize anything consistent with schizophrenia and all had to admit they had a mental illness and agree to continue taking antipsychotic drugs as a condition of their release. Their discharge diagnosis was schizophrenia "in remission," since mental disease was perceived as an irreversible condition (with a permanent stigma) rather than a curable illness. Their hospitalizations were characterized by an overwhelming sense of dehumanization due to severe invasion of privacy and the way they were treated. Possessions were randomly searched, they were often observed when going to the bathroom, and while the staff was generally friendly, they would openly discuss patients as if they were not present. There was little

personal interaction save for administering medications, and contact with doctors averaged less than 7 minutes a day. Attendants were often verbally and physically abusive when other staff members were not present.

These experiences were reported in "On Being Sane in Insane Places", a 1973 paper in *Science*, which correctly concluded that psychiatrists did not have a valid way to diagnose mental illness. [6] This was further confirmed when a famous research and teaching institution claimed that this could never have happened at their facility. Rosenhan accepted the challenge. He arranged that over a 3-month period, one or more fake patients would try to be admitted if the staff would rate every incoming patient with respect to the likelihood of being an imposter. Out of 193 patients, 41 were rated as impostors and 42 were considered suspect. In reality, Rosenhan had sent no pseudopatients, and all the possible impostors were ordinary patients. Dr. Maurice K. Temerlin split 25 psychiatrists into two groups who listened to an actor portraying someone with no mental problems. One group was told that the actor was "a very interesting man because he looked neurotic but was really quite psychotic". A control group was told nothing. Sixty percent of the first group diagnosed a psychosis, usually schizophrenia but none of the control group did so. [7] In another report, when 300 psychiatrists who read the same patient interview were split into two groups and told that the patient was either black or white, it was clear that blacks were considered to be much more violent, dangerous and suspicious. [8]

These and other studies showing the effect of suggestion and bias on psychiatric diagnosis accelerated the movement to reform mental institutions and discharge as many mental patients as possible. In 1887, Nellie Bly, an investigative reporter for the *New York World*, had portrayed herself as a Cuban immigrant, and also feigned insanity in order to be admitted to the Women's Lunatic Asylum on Blackwell's Island. Her undercover assignment was to evaluate reports of brutality, abuse and neglect and she confirmed the unbelievably horrid conditions in *Ten Days in a Mad-House* [9]. This brought her international fame and instigated a Grand Jury investigation in which she participated. Embarrassed doctors and nurses were unable to explain how so many health professionals could have been fooled and the jury's report recommended all the changes Bly had proposed. The mental health budget was increased by $850,000, all patients were released or transferred to a facility in nearby Ward's Island, and the Blackwell Island Woman's Lunatic Asylum was abandoned a few years later.

6. Rosenhan, L. I. On Being Sane in Insane Places *Science*, 1973; 179:250-258.
7. Temerlin, M.K. Suggestion Effects in Psychiatric Diagnosis Journal of Nervous & Mental Disease. 1968; 147: 349-353.
8. Loring M, Powell B. Gender, race, and DSM-III: a study of the objectivity of psychiatric diagnostic behavior. Journal of health and social behavior 1988; 29:1–22
9. Nellie Bly, *Ten Days in a Mad-House* 1887 Ian L. Munro, New York City

"My aim in this essay is to raise the question 'Is there such a thing as mental illness?' and to argue that there is not." That was the opening sentence of *The Myth of Mental Illness* that appeared in the February 1960 issue of *The American Psychologist*. In this, and a book with the same title published the following year, Dr. Thomas Szasz, Professor of Psychiatry Emeritus at the State University of New York Health Science Center in Syracuse, argued that mental illness is merely a term to describe problems in living that are perceived as abnormal by a psychiatrist. That is quite different than similar peculiarities of behavior and thinking due to neurosyphilis, a disease of the brain that was also thought to be a psychiatric disorder when it was first described. This gave rise to the notion that all mental illnesses are caused by "physicochemical processes which in due time will be discovered by medical research". While this has never been demonstrated, people still cling to this belief due to aggressive advertising. Sales of SSRI antidepressants are soaring despite lack of proof that depression is due to a serotonin deficiency; clinical trials demonstrating they are not significantly superior to placebos; and growing evidence that they are associated with severe side effects.

In "Fifty Years After The Myth of Mental Illness", a stunning 2010 essay, Szasz answered subsequent criticisms and supported his views as follows:

> Fifty years ago, the question "What is mental illness?" was of interest to the general public as well as to philosophers, sociologists, and medical professionals. This is no longer the case. The question has been answered – "dismissed" would be more accurate – by the holders of political power: representing the State, they decree that "mental illness is a disease like any other." **Political power and professional self-interest unite in turning a false belief into a "lying fact."** In 1999, President William J. Clinton declared: "Mental illness can be accurately diagnosed, successfully treated, just as physical illness." Tipper Gore, President Clinton's Mental Health Advisor, stated: "One of the most widely believed and most damaging myths is that mental illness is not a physical disease. Nothing could be further from the truth." Surgeon General David Satcher agreed: "Just as things go wrong with the heart and kidneys and liver, so things go wrong with the brain." A White House Fact Sheet on Myths and Facts about Mental Illness asserted: "Research in the last decade proves that mental illnesses are diagnosable disorders of the brain." In 2007, Joseph Biden – then Senator, now Vice President –declared: "Addiction is a neurobiological disease – not a lifestyle choice – and it's about time we start treating it as such.... We must lead by example and change the names of our federal research institutes to accurately reflect this reality. By changing the way we talk about addiction, we change the way people think about addiction, both of which are critical steps in getting past the social stigma too often associated with the disease." At the same time, Biden introduced a bill in the Senate titled "The Recognizing Addiction as a Disease Act." The legislation called for renaming the National Institute on Drug Abuse as the "National Institute on Diseases of Addiction," and the National Institute on Alcohol Abuse and Alcoholism as the "National Institute on Alcohol Disorders and Health." In 2008, Congress required insurance companies to provide people with mental illnesses "the same access to affordable coverage as those with physical illnesses.
>
> **The claim that "mental illnesses are diagnosable disorders of the brain" is not based on scientific research; it is a lie, an error, or a naive revival of the somatic premise of the**

> **long-discredited humoral theory of disease.** My claim that mental illnesses are fictitious illnesses is also not based on scientific research; it rests on the materialist-scientific definition of illness as a pathological alteration of cells, tissues, and organs. If we accept this scientific definition of disease, then it follows that mental illness is a metaphor, and that asserting that view is stating an analytic truth, not subject to empirical falsification. (emphases added)

This paper is replete with illustrations that support this thesis, explains why our health care system is a failure, and provides suggestions as to what should be done. Since I cannot do justice to it here and it should be required reading, it is attached as a bonus. Szasz also predicted the rise in addiction as a psychiatric diagnosis. This promises to reach new heights in DSM-5, which will expand the list of recognized symptoms for drug and alcohol addiction while also reducing the number of symptoms required for a diagnosis. It would include gambling as an addiction and might introduce a catchall category, "behavioral addiction not otherwise specified", such as a dependency or obsession with shopping, sex, using the Internet, texting, playing video games, etc. This could readily be used by doctors to prescribe drugs, despite a lack of research as to their efficacy, and result in millions of additional people being diagnosed as addicts and defamed for life. It would also have huge financial consequences for health insurers and taxpayers.

As noted in previous Newsletters, pharmacracy is a term Szasz coined in 1974, because "while we have words to describe medicine as a healing art, we have none to describe it as a method of social control or political rule". It is derived from the Greek *pharmakon* (medicine or drug) and *kratein* (to rule or to control), just as theocracy is rule by religious sects and democracy is rule by the majority of people. In that sense, he also accurately anticipated that our health care system and regulatory bodies would be dominated by the pharmaceutical industry's desire to increase profits rather than improve health. DSM-5 will be a stellar example of their success if his warnings and suggestions continue to be ignored — so stay tuned to see what happens!!

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