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COMMENTARY

Will Denial Make *DSM's* Validity Problem Go Away? A Reply to Pies and Ruffalo

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This article is a response to the article "Psychiatric Diagnoses Point to Real Conditions That Cause Debilitating Symptoms" by Ronald W. Pies, MD, and Mark L. Ruffalo, MSW, DPsa.

We thank Ronald W. Pies, MD, and Mark L. Ruffalo, MSW, DPsa, for continuing this dialogue on the nature of psychiatric diagnoses. We would like to respond to some of their claims that we think are mistaken.

Pies and Ruffalo accuse us of having "grossly oversimplified—indeed, trivialized—the diagnostic process" because we used *DSM-5*'s criteria for major depression in an example. Unlike Pies and Ruffalo seem to assume, our aim was not to exhaustively describe how a careful clinician might go about assessing a patient in practice, but to clarify the difference between a descriptive diagnosis and a causal explanation. Whatever else a clinician may or may not do in addition to evaluating diagnostic criteria does not change the fundamental point that psychiatric diagnoses are descriptive

in nature. This is because according to the *DSM-5,* “a complete description of the underlying pathological processes is not possible for most mental disorders.”[1]

Pies and Ruffalo further claim that we are confusing diagnostic criteria with “the clinical condition to which the criteria point.” According to Pies and Ruffalo, it is “this clinical condition” that causes the patient’s symptoms, not the symptoms or the label. However, this hypothesized distinction between diagnostic criteria and “the actual clinical conditions to which the criteria point” is deeply problematic. It is highly unlikely that current *DSM* categories pick out natural kinds that exist in the world independently of our categorizations and cause the listed symptoms.[2] The diagnostic categories in the *DSM-III* were not constructed on the basis of scientific discovery but by using what Harold Pincus, a cochair of a later *DSM* panel, described as the BOGSAT method, “A Bunch of Guys Sitting Around a Table.”[3] Originally, the *DMS-III* Task Force did want to base their decisions on empirical evidence. Unfortunately, the evidence simply was not available, and the members disagreed about the evidence that was.[4]

Crucially, while many details in the *DSM* have changed after the *DSM-III*, the scientific validity of the BOGSAT-informed categories has not. This is how David Kupfer, Michael First, and Darrel Regier evaluated the validity of *DSM* categories 30 years after their construction[5]:

“In the more than 30 years since the introduction of the Feighner criteria by Robins and Guze, which eventually led to *DSM-III,* the goal of validating these syndromes and discovering common etiologies has remained elusive. Despite many proposed candidates, not one laboratory marker has been found to be specific in identifying any of the *DSM*-defined syndromes. Epidemiologic and clinical studies have shown extremely high rates of comorbidities among the disorders, undermining the hypothesis that the syndromes represent distinct etiologies. Furthermore,

epidemiologic studies have shown a high degree of short-term diagnostic instability for many disorders. With regard to treatment, lack of treatment specificity is the rule rather than the exception."

An editorial in *Nature* put it even more bluntly 10 years later[6]:

"Psychiatrists have long known that the illnesses of patients they see in the clinic cannot be broken down into discrete groups in the way that is taught at medical school. Symptoms overlap and flow across diagnostic boundaries. Patients can show the signs of two or three disorders at the same time. Treatments are inconsistent. Outcomes are unpredictable. … Psychiatrists joke that their patients have not read the textbooks. The reality is serious and more troubling—the textbook is wrong."

Pies and Ruffalo's assumption of "actual clinical conditions" that cause psychiatric symptoms is just that: an assumption. Psychologically, we all have a common human tendency often to assume that members of a category—such as a mental disorder—share an underlying, causal essence.[7] In terms of scientific evidence, by contrast, it is the consensus view that *DSM* categories are a poor basis for identifying the causes of mental disorders,[6,8-10] but their continued use often makes both clinicians and laypeople believe otherwise.[10] Not surprisingly, there are now numerous research projects around the world actively trying to formulate diagnostic systems and alternative approaches whose validity would be better than the *DSM*s.[11-12] Yet others are seeking to challenge the assumptions of these standard approaches more fundamentally.[13]

Ignoring the profound problems in how the diagnostic system is set up, Pies and Ruffalo simply *assert* that diagnoses nevertheless point to "real, underlying" conditions. This confident assertion, in

essence, is a sleight of hand: Pies and Ruffalo evoke unseen entities that are not identical to diagnostic criteria but happen to magically correspond to them—although no such entities have been found and the validity of the categories themselves is under heated debate.

To use an analogy, we could decide that the epidemic of loneliness in Western countries is a biomedical problem. We could invite a Bunch Of Guys to Sit Around A Table again to come up with "official" BOGSAT criteria for a new psychiatric construct, give it a *DSM* code, and name it "major loneliness syndrome." Doing that would not magically make an "underlying disorder" entity appear and start causing loneliness. Claiming that this newly-invented entity is a causal explanation for loneliness would both be logically circular and also trivialize the complexity of the phenomenon, mask the psychological, cultural, and societal factors actually contributing to it and make it harder for us as a society to respond to it.

To be fair, the sleight of hand of simply assuming that an underlying disorder exists is not unique to Pies and Ruffalo. It is a common move, encouraged in fact by the *DSM*. Resorting to interesting doublethink, the *DSM-5* both claims to be able to pick out "disorders underlying the symptoms" *and* acknowledges that it cannot reliably do so: On the one hand, it recognizes that "the current diagnostic criteria for any single disorder will *not necessarily identify a homogeneous group of patients who can be characterized reliably with all of these validators*" (emphasis added).[1] On the other, it nevertheless claims that diagnostic criteria are "intended to summarize characteristic syndromes of signs and symptoms that *point to an underlying disorder* with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course" (emphasis added).

In other words, the *DSM-5* aims to summarize conditions that share characteristic risk factors, biological correlates, and clinical outcomes while simultaneously admitting, albeit briefly and without fanfare, that it cannot reliably do so. One can only wonder why. Is it in the hope that if the true limitations of the manual's validity are (poorly) hidden, the diagnoses will seem better or more useful? We do not think they will, whatever the rationale behind the self-contradictory description.

Faced with the *DSM's* elephantine validity problem, we believe that it would be best to openly acknowledge that no causal essences have been discovered, and that psychiatric diagnoses remain purely descriptive. To us, this seems preferable to Pies and Ruffalo's awkward position that psychiatric diagnoses are "indeed descriptive" but not "merely descriptive." This confusing distinction seems like a prime example of an attempt to sell 2 contradictory statements both as true.

One can of course make the assumption that human distress, thoughts, emotions, and behavior are caused by an external, mysterious, pathological entity yet to be discovered. We should not pretend, however, that the assumption is supported by scientific evidence, let alone imagine that it is the only legitimate view. Moreover, this assumption can be reductionistic and disempowering in practice because it renders the human being and their social and societal context irrelevant. This is likely why framing psychological distress as an illness engenders pessimism and lack of agency, but framing it as an adaptive signal with meaning leads to better outcomes.[14]

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