The DSM-V Project: Bad Science Produces Bad Psychiatry

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The project to develop the successor to fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* has been under way for 10 years, yet it is still several years from completion, and the field trials, the most difficult and expensive part, have not even started. This article explores the reasons why the project is struggling, arguing that the defects the Diagnostic and Statistical Model-V (DSM-V) Committee has found are not chance or random problems that can be overcome by more money but rather represent serious conceptual errors in the very basis of the ideas underlying the project. As a result of these errors, it is predicted that the entire notion of valid categories of mental disorder will collapse in self-contradiction. One of the most recent suggestions for a new disorder, psychotic risk syndrome (now APSS), is used to demonstrate how the principles of science cannot accommodate the unstated ideological demands driving the DSM-V project.

Keywords: DSM-5; scientific psychiatry; biological psychiatry; categorical diagnoses

Looking at the different sciences throughout history, it is probably fair to say that systems of classification have tended to generate intense feelings, and psychiatry is no exception. I have previously argued that the categorical system of diagnosis, as seen in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV*), is so seriously flawed that it cannot be improved without abandoning the basic precepts on which it is constructed (McLaren, 2007). With the projected revisions of the nosology, the psychiatric establishment has a rare opportunity to rectify its errors by enacting a number of major changes to the concept of psychiatric diagnosis.

The project to replace the *DSM-IV* (American Psychiatric Association [APA], 2010) has been under way for more than 10 years, involving 600 researchers as well as unknown numbers of support and other staff. It has cost tens of millions of dollars already, yet the field trials, the largest, most complex, and most expensive part, are still to come. It is undoubtedly the largest single project in the history of psychiatry, dominating the profession's thinking to an extent rarely, if ever, seen in other fields of nosology. Nonetheless, the launch date has been pushed back and back and is currently thought to be some time in 2014. Its progress has been marked by unprecedented controversy, with the chairmen of both the *DSM-III* and the *DSM-IV* Task Forces voicing stringent criticism of their successors (Frances, 2010). There is no reason to believe that the DSM-V Committee has any intention of revolutionary changes to its charge: it will be a case of evolution toward the same goal rather than revolution toward another.

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In this article, I argue that this enormous project is entirely the wrong project for psychiatry at this stage of its development and that the precious resources it consumes should be directed elsewhere. Notwithstanding, even if it were the right project, it would still be wasted effort because its inherent errors mean that it is doomed to failure. DSM-V cannot achieve its basic goal of a further "seminal contribution to patient care and to the scientific study of psychiatric disorders by providing rigorous and reliable diagnostic criteria for (psychiatric) conditions" (Stein et al., 2010). Instead, it will continue the process of damaging psychiatry and reducing its importance in the world of mental health to the point where it becomes a commodity and psychiatrists themselves become irrelevant.

First, I examine some of the thinking behind the central idea in DSM-V that separate categories of mental disorder can validly and reliably be distinguished from normality and from each other. I show that this is wrong in principle, that it cannot be realized in practice, and that it puts the diagnostic cart before the causative horse. Next, using one of the new diagnostic categories, I show that it is impossible in practice.

WHAT IS A MENTAL/PSYCHIATRIC DISORDER? FROM *DSM-IV* TO *DSM-V*

This section's heading is the title of a recent editorial in *Psychological Medicine* that outlines some of the DSM-V Task Force's thinking on defining mental disorder (Stein et al., 2010). The notion that mental disorder and mental normality are not just of a different nature but also incompatible (i.e., a person cannot be mentally normal and mentally disordered at the same time) is fundamental to the DSM project. Thus, if mental disorder cannot be defined sui generis, then the project cannot start. The subcommittee suggested the following criteria:

1. A behavioral or psychological syndrome or pattern that occurs in an individual
2. The consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)
3. Must not be merely an expectable response to common stressors and losses (e.g., the loss of a loved one) or a culturally sanctioned response to a particular event (e.g., trance states in religious rituals)
4. That reflects an underlying psychobiological dysfunction
5. That is not primarily a result of social deviance or conflicts with society

The first point to note is that, on any measure of human behavior, there are no categories of "normality" and "abnormality." Regardless of the parameter under study, if every human in the world were scored on that parameter, there would be a continuous line from the most normal to the most abnormal. Not at any point would there be a clear, reliable, and valid disjunction or discontinuity. Not even death is so clear that we can definitively operationalize its definition. In the field of mental disorder, which is murky and uncertain at best, this is even more true. No mental symptom of any sort can be taken as a certain indicator of mental disorder just because all symptoms grade imperceptibly from absent to florid. Moreover, taking any mental symptom at all, the milder degrees invariably have a wide range of causes that any sensible definition of mental disorder would and does exclude.

Sadness varies from the faintest ennui to a full-blown depressive psychosis in which the patient can do no more than sit mute in a corner, beyond speech, movement, appetite, and tears. Anxiety varies from the slightest frisson of apprehension to a raging panic attack in which the person is unable to move even to save his or her life. The drive to be tidy and orderly extends from a teenager's bedroom to a person who spends the whole day on his or her morning ablutions. Even apparently clear-cut psychotic symptoms vary widely, depending on the context (going to sleep or waking, drugs, illness, fear states, loneliness, etc.), the culture, and even the subject's wishes (ecstatic religions). Previous editions of the *DSM* have recognized this by including references to "marked" distress or "clinical significance." That is to say, there are no categories in nature, so any attempt to impose them is artificial.

The DSM-V Working Group recognizes this but seems to think that, because general medicine sometimes has difficulties with categorical diagnoses (e.g., malignant vs. premalignant), it does not reflect badly on psychiatry if it has the same problem:

Other considerations:

> H: No definition perfectly specifies precise boundaries for the concept of either "medical disorder" or "mental/psychiatric disorder."

There is, however, a vast difference between occasional, transient problems with minutely defined boundaries in some fields of medicine, compared with the total absence of anything like the most basic concept of a boundary marker in any of the areas in psychiatry since the beginning of its days. It is the concept of a boundary that is lacking in mental life, as the committee implicitly acknowledges with its new category of "mixed anxiety depression."

We can look at each of the criteria in turn:

- *A behavioral or psychological syndrome or pattern that occurs in an individual. . . .*

This is largely meaningless. In this context, behavioral and psychological are largely interchangeable. The "syndrome or pattern" imposes the requirement that the practitioner find an order in the disturbance, mostly by standing back from the patient and seeing him or her not as an individual but as "yet another example of this condition." It invites the practitioner to elide differences, to overlook the person's individuality and homogenize his or her life so that he or she matches the simplified model. Yet this presupposes a utility in this action, specifically a search for common causes in the disorder. That is, from the outset, the psychiatrist must stop seeing his or her patients as the products of vastly complex and utterly unique psychological careers, the only feasible justification being that the patient's life experiences are not relevant. This automatically implies that mental disorder is not and cannot be psychological in nature. It has to be biological since this is the only human commonality of sufficient scope to swamp the individuality. Thus, at the outset, DSM-V begs a critically important question of the nature of mental disorder, irremediably biasing all that follows. On this basis alone, I would say that the DSM project is not scientific, but its proponents would plead a second chance.

- *. . . The consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning).*

Immediately, we run into the pseudo-objective nature of the DSM project. We cannot define "clinically significant" in any reliable or objective sense. The criterion is sufficiently elastic to allow for anxious people declaring themselves significantly distressed or clinicians declaring psychotic people "disabled" even when they disagree. Like beauty, clinical significance is in the eye of the beholder. It is influenced by the patient's wealth and social status, the psychiatrist's interests, the insurer's demands, and other matters, such as war, disaster, and so on.

- *…Must not be merely an expectable response to common stressors and losses (e.g., the loss of a loved one) or a culturally sanctioned response to a particular event (e.g., trance states in religious rituals)….*

This is an implicit admission that the notion of the biological basis of categories of mental disorder is spurious. It says that symptoms will be labeled as mental disorder or normality not by their nature or content but according to their social context. This argument has been elaborated at great and, to my mind, entirely convincing length by Horwitz and Wakefield (2007) in their elegant monograph on the transmogrification of normal sadness into depressive illness.

- *…That reflects an underlying psychobiological dysfunction….*

This is either truism or ideology or, more likely, garbled thinking. It is truism in the sense that, if observable and experienced mental disorder has a cause in the natural realm, then it is going to be somewhere in the psychological and biological spheres, just because there are not any others. However, I think the authors clearly had something else in mind.

The authors do not define "psychobiology" but imply that a form or kind of mental-biological reductionism is the correct explanation of mind: "There is a growing awareness of the extent to which all behavior and psychology are dependent upon brain processes" (Horwitz & Wakefield, 2007, p. 5). I am not aware of any serious thinker in the field of human affairs who believes that human psychology is not somehow crucially dependent on the intact, functional brain, the only interesting question being the precise nature of that mind–brain relationship. They continue with "and the extent to which brain changes have complex behavioral and psychological effects" (Horwitz & Wakefield, 2007, p. 5). This preempts the vital question by ignoring the option that psychological changes also have complex effects on the brain: I decide to lift my arm, and, behold, it elevates. These days, does any educated person hold that the desire was not somehow causative of the action? Using what Dennett (1993) scornfully calls the "intuition pump," the authors artfully lead the reader away from mind–body causation down the path of mind–brain reductionism. When one looks at the qualifications of these authors, it is incomprehensible that they should have elected to imply that they know the answer to the nature of mind–body interaction. They do not mention that biological reductionism has been shown to be unworkable in principle (McLaren, 2010), and advocating it in this deceptive manner is ideology, not science.

However, the authors further cloud the matter by bringing the psychological back into the equation: "The term 'psychobiological' emphasizes the extent to which these different types and levels (behavioral, psychological or biological) of dysfunction are intertwined in reality" (Horwitz & Wakefield, 2007, p. 5). With the mental set they have previously established, that is, mind–body reductionism, this is meaningless. It is not possible to state

that "all behavior and psychology are dependent upon brain processes" (Horwitz & Wakefield, 2007, p. 5) in the implied context of reductionism and then say that psychological matters can also be causative of mental disorder. I suggest that this is just garbled thinking *caused by* an implicit ideological commitment to biological reductionism.

- *. . . That is not primarily a result of social deviance or conflicts with society.*

In combination with criteria C (not your usual upsets) and D (psychobiological dysfunction), this authorizes the DSM Committee to name anything they like as a mental disorder and exclude anything else. If a woman becomes distressed to the point of being nonfunctional because she does not want a road bulldozed through her house, she is not thereby mentally ill because she is showing an expectable response to conflict with society. A boy who hates school and wants only to leave and get a job in the bush can be deemed either mentally ill (white middle class) or socially deviant (poor black). Some behavior was first mental illness, then social deviance, then a harmless eccentricity, and, finally, a perfectly legitimate lifestyle choice (homosexual conduct).

DSM-V IS A BAD ANSWER FOR THE WRONG QUESTION

I conclude that the criteria for mental illness as developed by the DSM-V Committee are incapable of generating a science of mental disorder. They are, in fact, pseudoscience. The reason they failed is just because there is no articulated scientific model of mental disorder that, ab initio, dictates the borders and contents of mental disorder. Trying to derive a classification of mental disorder when we do not even have a model of how it arises is totally back to front.

Some people might object to this gloomy conclusion by pointing to the success of the Linnaean system of classification in biology. Prior to the work of Carl Linnaeus (1707–1778), biology was largely an incoherent mess. There were many systems of classification in use, but they were often idiosyncratic or based on misperceptions (e.g., dolphins and whales were normally grouped with the fish). It is not, however, the case that Linnaeus boldly imposed the civilizing vision of humans on nature's unruly array, bringing order to a "blooming, buzzing confusion." Rather, he chanced on the supremely elegant innate system of speciation that had evolved throughout a billion years of life. Linnaeus's binomial system firmly established the principle of classification according to relationships. The reason it succeeded was not because it drew lines in the sand and issued fiats but because it faithfully followed the biological fact of evolution of species. That was Linnaeus's good fortune because, at that stage, he knew nothing of the mechanism of speciation. There had been many equally intelligent and diligent thinkers before him who did not quite stumble on the correct model, so biology students today are taught the Linnaean system, not the Baconian or the Stensenian (after Niels Stensen, or Nicolaus Stenonis). His example is similar to Mendeleev's monumental work on the periodic table of the elements. He did not draw boxes on a piece of paper and shove elements in them because they looked artistic; rather, by careful attention to the phenomena of the elements, he found the natural order that the (then unknown) atomic model imposed on them.

In psychiatry, we are still in a pre-Linnaean phase of trying to impose a preconception on the bewildering complexity of human mental disorder, the preconception being that

mental disorder must be categorically distributed. In turn, this procrustean exercise is impelled by the belief that each and every separate mental disorder must have a unique and discoverable, nonmental cause, which is another name for the biological model. That is, the DSM nosology of mental disorder is driven by the need to find a series of specific, internally uniform clinical pictures as the surface manifestation of specific unseen biochemical lesions. I have no argument with the idea that this obsessive drive for etiological neatness results from psychiatry's near-death experience with the Byzantine folly of psychoanalysis, but it is actually the wrong way to approach science. The proper way to conduct science is to find the model and then see what nosology it dictates. Biochemistry is a good example, as is the germ theory of illness. Somewhat further afield, aberrations of planetary motion told astronomers using the Copernican model of the solar system where to look for new planets. That could never have happened with the geocentric model.

Therefore, at this stage of its intellectual development, the correct project for psychiatry is to decide the question of the nature of mental disorder: is it biological or psychological? By answering the question of whether mental disorder is psychological or biological, we will ipso facto answer the question of whether the final nosology of mental disorder will be categorical or dimensional in form. Even though the DSM-V Committee has not overtly embraced the reductionist, biological model of mental disorder, they have shifted the focus of thinking by implication. Early in the article, they debate the correct terminology for the subject matter of psychiatry: "'Mental' implies a Cartesian view of the mind–body problem, that mind and brain are separable and entirely distinct realms, an approach that is inconsistent with modern philosophical and neuroscientific views" (p. 2). Without specifying their stance, they clearly imply that mind–body dualism is not scientific. This stance is completely unsupported by the literature, by philosophers, and by psychiatrists. The philosopher David Chalmers (1996) has outlined in great detail a convincing case for a rational dualism. My own work has shown that reductionism cannot be a model for psychiatry (McLaren, 2009) and that the monist philosophers Daniel Dennett and John Searle have failed to establish their case (McLaren, 2010). The claim that a scientific model of mind must meld or unite mind and body is absolutely without warrant. Given the process that Stein and his group have undertaken, of setting the intellectual tone, as it were, of the scientific status of psychiatric theorizing, this is intellectually dishonest. Their duty was to explore the options, not announce ex vacuo that the competition between psychological and biological models was over.

If it emerges that the correct model of mental disorder is psychological in nature, and I have argued at length that it is (McLaren, 2007, 2009), then the categorical system of DSM diagnosis will disappear as quickly as the psychoanalytic model did. Until this question is determined, openly and honestly, we are simply engaged in a vastly expensive exercise of drawing boxes in the sand and then watching impotently as the social winds blow them away. But who would want a categorical system of diagnosis in psychiatry? Only those psychiatrists who have decided that mental disorder is biological in nature, that is, ideologues who are not prepared to debate the nature of mental disorder just in case they lose. When we consider the industries, both academic and commercial, involved in this debate as well as the stupefying sums of money, questions over the true nature of mental disorder should not be brushed aside by a committee representing those vested interests who stand to lose most from an unfavorable outcome.

DSM-V WILL LEAD TO WORSE PSYCHIATRY, NOT BETTER

Anybody who goes to a psychiatric convention will be familiar with the "keynote" speeches where eminent psychiatrists trumpet the rapid advances psychiatry has made since the dawn of the modern era, more or less since the publication of *DSM-III* in 1980. Thirty years of rapid scientific progress, they boldly declaim, have brought us to the brink of a complete understanding of mental disorder. However, growing numbers of perfectly sensible psychiatrists are starting to wonder where the progress is and why we have been hearing the same bravura speeches for three decades. In particular, young psychiatrists and trainees are beginning to question what, to them, sounds suspiciously like propaganda. DSM-V, however, promises to propel psychiatry into a field that is normal for all other fields of medicine but that, for us, has been nothing more than a vague dream: prevention. Specifically, it offers the hope of preventing the most devastating illness of all: schizophrenia. If so, it would be a dramatic transformation of the practice of psychiatry and of its status in medicine, and a vindication of those who first dreamed of a rational biology of mental disorder.

One of the most important innovations in DSM-V is the concept of the person who is "at risk" of developing a psychotic disorder. Initially, the DSM-V Development Site defined the concept of psychosis risk syndrome, but on May 17, 2010, this name changed to attenuated psychotic symptoms syndrome (APSS). The diagnostic criteria did not change. The purpose of the new category of mental disorder is to identify people with a significantly increased risk of a psychotic breakdown, offering early psychiatric intervention to prevent the appearance of the full syndrome. This represents a substantial shift in emphasis from the traditional role of psychiatrists, which was to wait within their hospitals until floridly disturbed people were brought in by their relatives, their friends, or the police. There are several reasons for paying attention to the prodromal symptoms of psychosis. The first would be to prevent the huge dislocation of life that accompanies a psychotic episode. The second would be the recognition that drugs are not magic; they are expensive and unpleasant, have many side effects, and offer no more than partial remission under long-term supervision with no prospect of cure. Finally, there have been several theoretical developments that indicate the possibility of greater precision in identifying people at risk of psychotic states.

The first of these points is beyond question. A psychotic disorder shatters the lives of not just the patient but even of family and friends. The second point, that the available drugs are nasty, toxic, relatively ineffective, and outrageously expensive, might be disputed in public but not in private. The third is open to debate, but one recent development is seen as offering much greater precision in identifying people at risk. The notion of the endophenotype was introduced to psychiatry from insect biology (Gottesman & Gould, 2003). Researchers screen psychotic people for any sort of abnormality that might be taken as a biological marker of the genetic tendency to the psychotic state to apply to people who have not developed a mental illness. Thus, if square thumbs were more common in psychotic people and clustered in their families, then screening the population for square thumbs may yield people with a high genetic risk of psychosis. As yet, there are no such reliable indicators, but researchers remain hopeful, and considerable sums of money are available for this, the most recent development in genetic research of psychosis.

While the concept of the "at-risk" individual is still being debated and is far from approved, there are powerful constituencies arrayed behind it. The suggested criteria are as follows:

1. Characteristic symptoms: At least one of the following in attenuated form with intact reality testing but of sufficient severity and/or frequency so as to be beyond normal variation: (a) delusions, (b) hallucinations, (c) disorganized speech.
2. Frequency/currency: Symptoms meeting criterion 1 must be present in the past month and occur at an average frequency of at least once per week in past month.
3. Progression: Symptoms meeting criterion 1 must have begun in or significantly worsened in the past year.
4. Distress/disability/treatment seeking: Symptoms are sufficiently distressing and/or disabling to the patient and/or others to lead to help seeking.
5. Characteristic attenuated psychotic symptoms are not better explained by another DSM-V diagnosis.
6. Clinical criteria for any DSM-V psychotic disorder have never been met (APA, 2010).

I believe that this is a singularly dangerous idea and should be resisted strenuously by anybody who adopts a humanist stance. It is a case of psychiatry unleashed, and the benefits its planners hope to achieve can never outweigh the potential damage it will do. My case against this rubbery notion is that it is not and never can be scientific:

1. *APSS is not science but is a case of value judgments masquerading as science.*

The idea of "characteristic psychotic symptoms" that are not manifestly psychotic is self-contradictory. The delusion is defined as "A fixed, false belief out of context with the subject's cultural and intellectual background." There is no room in this definition for "normal variation," for "attenuation" or for "intact reality testing." Further, the notion that "disorganized speech" can reliably and validly distinguish between prepsychosis and all other types of garbled talk is nonsensical. There is no possible way the term can be operationalized objectively. It will simply license repression and dismissal of people who stutter or stumble over their speech. Agitated foreigners, frightened or guilt-ridden teenagers, minorities, hostile or defiant prisoners, the confused elderly, inarticulate country people, the intellectually handicapped, exotic religions, fringe political groups, people locked in mental hospitals against their will—the list is endless.

Similarly, the types of symptoms listed here occur commonly in other diagnoses as well as in the normal population. Criterion 3, that symptoms must get worse in a year, is meaningless in practice: it does not distinguish between the symptoms actually getting worse and the observer becoming less tolerant. It licenses the powerful to menace the weak. Criterion 4 is a straight value judgment, while criteria 5 and 6 are simply there to force psychiatrists to choose one category just because DSM does not like "comorbidity."

2. *The idea of an "at-risk" person will spread to all other psychiatric diagnoses.*

As soon as the "attenuated psychotic symptoms syndrome" is promulgated, we will be flooded with the "attenuated bipolar symptoms syndrome," the "attenuated attention deficit disorder (ADD)/attention deficit/hyperactivity disorder (ADHD) symptoms syndrome," the "attenuated substance abuse symptoms syndrome," and, worst of all, the

"attenuated personality disorder syndrome." This cancerous process will be irresistible just because researchers in one field will find their subjects being rediagnosed to fit another, as happens with ADD/ADHD and pediatric bipolar affective disorder. The symptoms are the same, only the diagnosis is changed (and the drugs of course). As the lists of "at-risk" syndromes widen, the numbers of people in the population deemed mentally disturbed will rise to ludicrous levels. In its pursuit of perfection, psychiatry will declare itself nonsensical, just as the Freudians did.

3. *There are not enough psychiatrists to administer the newly widened diagnoses.*

At a time when fewer medical students are entering psychiatry, there will be a huge increase in the demand to assess people who have shown no mental symptoms in their lives. And if they refuse, it will not be long before applications are made to enforce psychiatric assessments and thence psychiatric treatment in the absence of formal symptoms. Very quickly, there will be intense pressure for nonpsychiatrists to be given the right to assess and diagnose people as "at risk." From there, it is but a very short step to nonmedical people being granted the right to prescribe psychotropic drugs, just because the purpose of the "at-risk" syndrome is to provide early treatment, and there will not be enough psychiatrists for the job. The process of "dumbing down psychiatry," initiated by *DSM-III*, will accelerate exponentially.

4. *A psychiatrist who does not diagnose psychosis risk syndrome will be culpable.*

If a psychiatrist or any medical practitioner declines to confirm the diagnosis of APSS and, 20 years later, something goes wrong, he will certainly be sued, just as obstetricians are now routinely sued for deliveries a quarter of a century before. This is inevitable. However, if a patient is diagnosed with the prepsychotic syndrome and given treatment either with or without his agreement and he later wishes to sue for wrongful diagnosis, he will lose his case on the basis that, since he did not develop a psychotic state, the treatment was effective and he cannot show an injury. If he does develop a psychosis despite the treatment, that will be because he had a severe disorder. The idea that being labeled psychotic and treated against his will could have precipitated a psychosis will not be entertained.

5. *The diagnosis of APSS will carry huge and unpredictable social consequences.*

Already, people who have been prescribed psychotropic drugs are subject to restrictions, and the law of unintended consequences means there will be more if the numbers of patients rises. Anyway, can we actually afford this program? As a psychiatrist with very lengthy experience in remote areas and with socially disadvantaged populations, I am certain that the so-called screening will occur in pleasant, middle-class areas in large cities and that the poor, the rural, and the socially disadvantaged will remain poor, rural, and disadvantaged. Even in a welfare state, that is almost guaranteed. In the United States, it is inevitable.

The notion of a valid, reliable prepsychotic syndrome (attenuated psychotic symptoms syndrome, psychosis risk syndrome, and so on) is manifestly a case of psychiatry running riot. It has no scientific validity whatsoever. It cannot be operationalized, meaning that it can never be reliable; it cannot be put into practice, and it will have huge unforeseen

consequences. If this is the best that 600 experts working over 10 years can manage, then I believe we psychiatrists have handed our critics their case. Through DSM, we are destroying our scientific credibility.

As I have said so often, the reason this is happening is because modern orthodox psychiatry does not have an articulated, scientific model of mental disorder to guide its daily practice, its teaching, and its research. The whole concept of the psychotic risk syndrome or the attenuated psychotic symptoms syndrome (or whatever it is called) is testimony to the failure of the DSM project. There are no boundaries. Mental disorder is dimensional, not categorical. In the absence of science, pseudoscience will flourish.

CONCLUSION: MORE WILL MEAN WORSE

In 1962, the British author Kingsley Amis objected to plans to open universities to half the adult population on the basis that it would necessitate an irremediable and pointless lowering of academic standards: "More will mean worse," he shouted, and he was absolutely correct: more has indeed meant worse. The DSM-V project is a case of "more of the same," but more of the same old failed DSM ideas will inevitably mean worse psychiatry. It does not matter if the language is updated. It is of no account if categories are reshuffled, broadened, blurred, or loosened; the faults are conceptual, not operational, a case of old wine in new bottles. The DSM-V Task Force has spent some 3 million hours so far (600 people at 10 hours per week for 10 years), and the biggest jobs are still to come (Frances, 2010). It has been 3 million wasted hours, just as all those psychoanalytic textbooks and conferences, plus the therapeutic hours on the analyst's couch, were wasted. It is the wrong model.

The faults of the DSM project stem from the fact that it is not a scientific project just because the profession of psychiatry does not have a declared, articulated scientific model of mental disorder to guide its daily practice, its teaching, and its research. It has nothing on which to hang its observations. We have libraries full of observations, of male and female, young and old, from hundreds of cultures, and yet we have no catalog to tell us where everything should go. This is why the DSM project will eventually be declared bankrupt. We should be working on the model of mental disorder; once we have that, the system of classification will fall in our laps, just as, in 1846, the planet Neptune gave the clues of its presence to Alexis Bouvard, who had the model to understand them. Without a formal model of mental disorder, psychiatry cannot "read" the symptoms and understand what is happening beneath the surface manifestations. Absent understanding, there can be no cure.

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