2014

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Note:
This is the author's manuscript as accepted by Springer. The final published version of record is available at http://www.springer.com/us/book/9781461455820#

Citation:
Lacasse, J.R., & Leo, J., & (2014). Overdiagnosis. In T. Teo (Ed.)., *Encyclopedia of Critical Psychology* (pp. 1308-1310). New York: Springer.

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Introduction

The overdiagnosis of mental disorder has been the subject of much scholarly examination and public debate over the past several decades. Since the introduction of fluoxetine in 1987, the "Decade of the Brain" (1990-1999), and the introduction of blockbuster atypical antipsychotics and "mood stabilizers" by the pharmaceutical industry (1990s-present), the estimated prevalence of many mental disorders has skyrocketed. This led psychiatrist Allen Frances, chair of the DSM-IV Task Force, to summarize the issue of overdiagnosis by writing, "The NIMH estimates that, in any given year, twenty-five percent of the population (that's almost sixty million people) has a diagnosable mental disorder. A prospective study found that, by age thirty two, fifty percent of the general population had qualified for an anxiety disorder, forty percent for a depression, and thirty percent for alcohol abuse or dependence....In this brave new world of psychiatric overdiagnosis, will anyone get through life without a mental disorder?" (Frances, 2010).

Definition

Overdiagnosis has been identified as a problem in general medicine. The narrow definition of overdiagnosis within medicine is the diagnosis (and usually, treatment) of an asymptomatic disease which will not cause early mortality (Moyniha, Doust, and Henry, 2012). Concerns have been raised that the reflexive diagnosis and treatment of such patients may actually cause reduced quality-of-life (Healy, 2012). In broader terms, which is more relevant to psychiatric diagnosis (see below), overdiagnosis is defined as "...the related problems of overmedicalisation and subsequent overtreatment, diagnosis creep, shifting threshholds, and disease mongering, all processes helping to reclassify healthy people with mild problems or at low risk as sick" (Moniyhan et al., 2012). Overdiagnosis in general medicine is often generated through over-use of biological testing for disease (e.g., PSA testing for prostate cancer, blood tests for high cholesterol, or flowmeter tests for asthma). In contrast, there are no valid biological tests for mental disorders. Such diagnoses are made based on the clinical judgment of mental health providers, by performing clinical interviews while referring to the Diagnostic and

Statistical Manual of Mental Disorders (DSM). There is no compelling research demonstrating that clinicians reliably diagnose mental disorders in routine practice (Kutchins and Kirk, 1997). It has been argued that this subjective process of diagnosis is shaped by bias, both in terms of the psychiatric definitions of mental disorder used and their clinical implementation. Many types of potential bias have been identified, ranging from sexism to pharmaceutical company influence (Caplan and Cosgrove, 2004) to pseudosientific bioreductionism (Lacasse & Leo, 2006). Clearly the most overarching type of bias in Western societies is the increasing trend towards labeling and classification of disturbed and disturbing behaviors as mental disorders (Kutchins and Kirk, 1997). In the absence of objective, reliable and valid tests for mental disorder, this can lead to overdiagnosis.

Scholarly Debates Regarding Overdiagnosis

While it is argued that many different mental disorders are overdiagnosed, given the lack of objective tests, there is often no rigorous way to settle the issue. A consistent theme is found in the literature and public debate: One camp argues that a normative human experience or behavior is being medicalized and labeled as mental disorder, resulting in higher rates of diagnosis and potential harm from over-treatment; the other camp argues that vigilant screening and de-stigmatization efforts have been successful at identifying and treating a previously under-recognized mental disorder, leading to better outcomes for those so diagnosed. Debates regarding overdiagnosis thus usually revolve around dramatic increases in the estimate prevalence of mental disorders. Frances (2010) argues that pediatric bipolar disorder, attention-deficit hyperactivity disorder (ADHD), and autism are now overdiagnosed at epidemic levels.

Psychiatrist David Healy notes that the estimated prevalence of classic manic-depression was ten patients per million people, but that DSM-defined bipolar disorder now "...supposedly affects up to 50,000 per million" (Healy, 2012, p. 37). He argues that pharmaceutical companies have effectively 'captured' evidence-based treatment guidelines in order to sell "mood-stabilizing" drugs, which has an impact on diagnostic practice. Many mental health clients now diagnosed as bipolar would have received a less severe diagnosis (e.g., unipolar depression) in a different context, raising the question of overdiagnosis and over-treatment. The most dramatic rise in bipolar diagnosis, though, is

among children. Application of the pediatric bipolar label to disruptive and disturbing children increased 4000% from 1994 to 2003 (Moreno et al., 2007). Such an astonishing increase in such a short period of time clearly raises the question of overdiagnosis. This is of great importance because children labeled as bipolar are often prescribed antipsychotic medication with known iatrogenic effects. In the cases of both child and adult bipolar disorder, the influence of the pharmaceutical industry is a key factor: the popularity of these diagnoses coincides with aggresive efforts by drug companies to market on-patent drugs prescribed for these disorders.

However, putting pharmaceutical industry marketing aside, overdiagnosis can result from other factors. The empirical limitations of the DSM can lead to overdiagnosis. For example, over time, the DSM-defined diagnostic criteria for ADHD have become less restrictive, making it more likely that a child would qualify for a diagnosis of ADHD. Using the DSM-IV ADHD criteria, Kirk (2004) examined the false-negative (underdiagnosis) and false-positive (overdiagnosis) rates for a theoretical sample of 1,000 children with a 5% prevalence of ADHD. Assuming a sensitivity of 91% and a specificity of 61% (derived from field trial data), in this sample of 1,000 children, 371 children would be receive false-positive labels for ADHD, while only 5 children were false-negative (underdiagnosis) cases. The overdiagnosis rate for ADHD was thus 37% in this study, illustrating the point that the DSM criteria are biased towards overdiagnosis of ADHD. It is unknown whether clinicians are aware of this diagnostic inaccuracy embedded within the ADHD definition, or whether parents are informed of this when their children are asssessed.

The DSM-5 is scheduled to be released in May of 2013, and Frances (2010) has cautioned that several of the proposed categories may lead to overdiagnosis: Binge eating, hypersexuality, minor neurocognitive disorder, and mixed anxiety/depression are all arguably 'normal' experiences which may be medicalized by their inclusion in the DSM-5. Similarly, the bereavement exclusion will be removed from DSM-5. This means that in contrast to the DSM-IV, recently bereaved clients will be eligible for a diagnosis of Major Depression if they have clinical symptoms more than two weeks after the death of a loved one. Thus, it is likely that the overdiagnosis of mental disorder will increase in the DSM-5 era.

Keywords

Overdiagnosis; medicalization; deviance; pharmaceutical; psychiatric diagnosis; psychiatric medication; pediatric bipolar; attention deficit hyperactivity disorder; antipsychotic.

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