That way, madness lies

A new manual for diagnosing diseases of the psyche is about to be unveiled.

ON FEBRUARY 10th the world of psychiatry will be asked, metaphorically, to lie on the couch and answer questions about the state it thinks it is in. For that is the day the American Psychiatric Association (APA) plans to release a draft of the fifth version of its Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Mental illness carrying the stigma that it does, and the brain being as little-understood as it is, revising the DSM is always a controversial undertaking. This time, however, some of the questions asked of the process are likely to be particularly probing.

The DSM, the first version of which was published in 1952, lists recognised psychological disorders and the symptoms used to diagnose them. In the United States, what is in it influences whether someone will be diagnosed with an illness at all, how he will be treated if he is so diagnosed, and whether his insurance company will pay for that treatment. Researchers in other countries generally defer to the DSM, too, making the manual's definitions a lingua franca for the science of medical psychology. And, perhaps most profoundly, the DSM influences how mental illness is understood by society at large.

A new DSM, then, is an important document. The APA has been working on the latest revision since 1999, and will not release the final version until May 2013. But some people are already accusing it of excessive secrecy and being too ambitious about the changes it proposes. Those critics will be picking over the draft next week to see if their fears have been realised.

Manual dexterity

The original DSM reflected the "psychodynamic" view of mental illness, in which problems were thought to result from an interplay between personality and life history. (Think Freud, Jung and long hours recounting your childhood and dreams.) The third version, which was published in 1980, took a more medical approach. Mental illnesses were seen as distinct and classifiable, like physical diseases. DSM-III came with checklists of symptoms that allowed straightforward, unambiguous diagnosis. Psychiatry began to seem less like an art form and more like a science.

DSM-III also introduced many more diagnoses than had appeared before. These included attention-deficit disorder (see article), post-traumatic stress disorder and social phobia. In fact, the number of specific diagnoses more than doubled between DSM-I and DSM-III, from 106 to 265. DSM-IV, published in 1994, increased the number to 297, but left the underlying model alone.

The APA's DSM-V task force, however, has suggested it would like to introduce a "new paradigm" into the manual. It wants to recognise that many conditions, such as anxiety and depression, tend to overlap, so that a diagnosis of only one or the other does not always make sense. The new version of the DSM is also expected to include a "dimensional" component, one that considers the severity as well as the nature of symptoms. This could lead to the paradoxical situation of a symptom (minor depression, for example) being classified as being below the threshold for the diagnosis of a disease, but nevertheless still being regarded as a problem—leaving the individual so diagnosed in a weird medical limbo.

The chairmen of two previous DSM task forces have been particularly critical of the present effort. In a letter to Psychiatric Times, written last June, for example, Allen Frances, a psychiatrist at Duke University who chaired the DSM-IV task force, accused his successors of being too secretive, and of closing themselves off from outside opinion. He also worried that

adding dimensional ratings to the DSM could lead to many more diagnoses based on symptoms that would previously have placed an individual in the normal range. Pharmaceutical companies, eager to expand their markets, would be tempted to pounce on these new “patients”. Dr Frances was supported by Robert Spitzer, a professor of psychiatry at Columbia University who was chairman of the DSM-III task force.

Members of the present task force, led by Alan Schatzberg, president of the APA, fired back a letter pointing out that they have held conferences, presented papers and consulted more than 200 outside advisers. They also accused Dr Frances and Dr Spitzer of having a financial interest in books based on the DSM-IV criteria. The two admit to receiving royalties, but say it has nothing to do with their criticism.

In the meantime, particular groups who may or may not be classified as “diseased” are also concerned about what ends up in the manual. Some of those with Asperger’s syndrome—who find it hard to “read” the emotional states and intentions of others, but have otherwise typical intellectual faculties—are worried by hints that their condition might be included under the more general heading of “autism spectrum disorder”. That would lump them with people whose intelligence is profoundly impaired. Transsexuals, meanwhile, want the diagnoses of “gender identity disorder” and “transvestic fetishism” that the new DSM is expected to promulgate changed to be more respectful and less judgmental. In fact, any changes to the list of sexual disorders, including a possible new category called “hypersexual disorder”, are bound to get attention.

February 10th will be the first chance most people, including the critics, have to look at the document. When they do, the criticism is likely to get louder. After all, the effort to classify and categorise disorders of something as complex as the human mind—especially when that categorisation is done by committee—is unlikely to please everybody. It will be interesting to see what direction the new DSM is going in, and whether it stands up to analysis.

Fonte: The Economist. Disponível em: <www.economist.com>. Acesso em: 8 fev. 2010.