Wither Psychiatry and its Nosology?

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AND IN 2013 COMES DSM-5

• What should we expect?
  - It’s not going to be good.
  - Here’s why.
WHAT DSM-III WROUGHT

• The diagnostic move of *DSM-III*
  – Mental disorders are to be identified by their presentations
  – Not by *any* aspect of their causal generation

• The Central Dogma of *DSM-III*
  – “For most [psychiatric] disorders the etiology is unknown”
  – What did that entail?
ICD-10

"Whereas the ICD is a systematic classification, the DSM is a nomenclature."

–Morton Kramer

*DSM* Is a “Field Guide”
From Roger Tory Peterson
“Blackbirds”
This approach is crashing!
The Realization

“We have allowed the bio-psycho-social model to become the bio-bio-bio model.”
Steven Sharfstein – President of the APA

– Question: Why be surprised given that no one proposes psychologic or social generative concepts to explain any ‘Axis I’ condition or to distinguish by nature groups of disorders within ‘Axis I’ from each other?

– Indeed the Central Dogma of DSM-III/IV says one cannot.
Depression and Baltimore ECA Clinical Reappraisal

- All depressed persons 5.9%
- DSM-III Depressive Disorders 4.5%
  - Major Depression 1.1%
  - Other DSM-III Depressive Disorders 3.4%
- Depressive symptoms
  - no DSM-III Depressive Disorder 1.4%

# DIS/DSM-III One-Month Diagnoses and Psychiatrists’ CR/DSM-III One-Month Diagnoses (N=810)*

<table>
<thead>
<tr>
<th>DSM-III Category</th>
<th>k</th>
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</thead>
<tbody>
<tr>
<td>Alcohol-use disorder</td>
<td>0.35 (0.21, 0.49)</td>
</tr>
<tr>
<td>Major depressive episode</td>
<td>0.25 (0.19, 0.32)</td>
</tr>
<tr>
<td>Phobic disorders</td>
<td>0.24 (0.16, 0.31)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.19 (-0.005, 0.29)</td>
</tr>
<tr>
<td>Manic episode</td>
<td>0.09 (-0.004, 0.22)</td>
</tr>
<tr>
<td>Drug-use disorders</td>
<td>0.08 (0.03, 0.20)</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>0.05 (-0.006, 0.14)</td>
</tr>
<tr>
<td>Panic disorder†</td>
<td>-0.02 (…, …)</td>
</tr>
</tbody>
</table>

DSM-5 Proposals

We’ll all just do the same
Maybe something will change.
Eleven “indicators” for DSM-5

- Neural substrates
- Genetic risk factors
- Specific environmental risk factors
- Biomarkers
- Temperamental antecedents
- Abnormalities of emotional and cognitive processing
- Treatment response
- Familiality
- Symptom similarity
- Course of illness
- High comorbidity

Kupfer, DJ et al Cerebrum 2010 p90-91
Response

• Is that all? How about:
  – Drives, hungers, cravings etc (i.e. physiological psychology)
  – Developmental stages and social vulnerabilities (i.e. developmental psychology)
  – Learning and conditioning (i.e. behavioral psychology)
  – Epigenetics
  – Etc.

• Can not these “indicators” be better organized so as to bring coherence to what looks like a shopping list? How about:
  – Intrinsic factors (genes, proteins, neurons, brains etc.)
  – Self-factors (intelligence, temperament, maturation etc)
  – Teleological factors (drives, learning, choices etc.)
  – Extrinsic factors (life events, social networks, etc.)
Psychiatry should move beyond a field guide – DSM-5 by itself will not!
Names are not enough.
Mind is not brain.
Psychiatrists are not neurologists.
What is ‘mind’?

• Key: Mind is an “emergent property” of the brain not a “product” such as is urine from the kidney.
  – That is: Mind is a domain of living evoked by the integrative actions of elements of the brain.
  – All the features of mind – faculties, drives, responses etc. – are ‘contingent’ upon the brain and how its elements are organized but they take roles and responsibilities in the life of the person that will not be completely ‘reducible’ to the isolated brain parts

• This fact justifies separating the disciplines of psychology and psychiatry that study those features from neuroscience and neurology.
Psychology reveals:

• Four compound factors forge consciousness.
  • “Intrinsic factors” – i.e. memory, language, perception etc.
  • “Self factors” – i.e. intellect, temperament, maturation, etc.
  • “Teleological factors” – i.e. drives, choices, learning, etc.
  • “Experiential factors” – i.e. life events, social networks, etc.

• From these factors – that combine in mental life and have their own ways of being disrupted – psychiatrists must ultimately explain the disorders of mind and behavior they encounter in their patients.

• That is: work from known factors to cases.
The Perspectives of Psychiatry
Their Logical Approach and Essences

• Perspective of disease
  – Logic of categories
    • What the patient has
• Perspective of dimensions
  – Logic of gradation and quantification
    • What the patient is
• Perspective of behaviors
  – Logic of teleology and goals
    • What the patient does
• Perspective of the life story
  – Logic of narrative
    • What the patient encounters
Classifying psychiatric disorders

• Diseases: what a patient ---- **Has**
• Dimensions: what a patient-- **Is**
• Behaviors: what a patient --- **Does**
• Stories: what a patient -------- **Encountered**
Defining the Perspectives

• The ‘Perspectives’ identify the explanatory propositions psychiatrists use.
• These propositions are operations followed when rendering intelligible the sources – cause or mechanism – of mental disorders.
• They are distinguished from one another by 1) their elements, 2) the conditions to which they apply and 3) their implications for therapeutics and research.
• We can depict each ‘proposition’ as a ‘triad’ of engendering, interactive elements.
Disease Perspective

Pathogenesis

Etiology

Pathological entity ("broken part")

Pathophysiology

Clinical syndrome
Psychiatric Diseases Linked to Basic Brain Functions

- Delirium (Consciousness)
- Dementia (Cognition)
- Korsakoff Syndrome (Memory)
- Aphasia (Language)
- Bipolar Disorder (Affect)
- Schizophrenia (Executive, Integrative Functions)
Dimensional Perspective

Potential (Personality) ↔ Provocation (Life circumstances) ↔ Response (Neurotic symptoms)
Problematic Dispositions

- Suboptimal Cognitive Capacity (IQ < 85)
  Educational Deficit/Illiteracy

- Affective Vulnerabilities (e.g., NEO scores)
  High "Neuroticism"
  Extreme Extraversion/Introversion
  Low Conscientiousness

- Immaturity
Behavior Perspective

Choice

Physiologic drive

The “push”

Conditioned learning
Kinds of “Behavior Disorders”

- Developed from disorganized innate drives
  - Paraphilic sexual disorders, sleep disorders, eating disorders
- Developed from disorganized acquired drives
  - Expressed in abuse or dependence on alcohol, heroin, nicotine
- Provoked by social attitude resting on assumptions, overvalued ideas, or role search
  - Suicide, anorexia nervosa, hysteria, gender identity disorder, crime
- Developed from the emotional arousal (“thrill”) their expression provokes
  - Truancy, kleptomania, pathologic gambling, pyromania
Life Story Perspective

- Setting
- Sequence
- Outcome
What Conditions Are Best Grasped by Life Story Perspective

- Grief
- Demoralization/discouragement
- Homesickness
- Jealousy
- PTSD
- “The life story appears in every disorder”
Relative Losses

- Study tracking profitability\(^a\) changes after deaths in the families of CEOs at Danish companies (n=75,000)

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Change (vs 2 years before)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>-21.4%</td>
</tr>
<tr>
<td>Spouse</td>
<td>-14.7%</td>
</tr>
<tr>
<td>Any family member</td>
<td>-9.4%</td>
</tr>
<tr>
<td>Parent</td>
<td>-7.7%</td>
</tr>
<tr>
<td>Mother-in-law(^b)</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

\(^a\) Operating return on assets in the 2 years after the death vs the 2 years before.

\(^b\) Not statistically different from 0.

Ultimate Systematic Psychiatry

- Psychiatric disorders can be classified (and taught!) such that those with similar generative derivations are clustered together
  - Classification system would begin to resemble medicine
    - Clear affinities for treatment and research of infectious, neoplastic, autoimmune, vascular, nutritional, genetic disorders
  - Psychiatrists would think about, investigate, and treat
    - Diseases as faculty defects
    - Dimensions as emotional vulnerabilities
    - Behaviors as “driven” deviations
    - Life stories as influential encounters
  - A “bottom up” systematic classification would emerge
Hierarchical, Interactive Levels of Mental Life

Components, Disorders, and Treatments

<table>
<thead>
<tr>
<th>Components of psychological life</th>
<th>Derived mental disorders</th>
<th>Treatment aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal development</td>
<td>Disruptive life stories</td>
<td>Rescript</td>
</tr>
<tr>
<td>Motivational urges</td>
<td>Behavior disorders</td>
<td>Interrupt</td>
</tr>
<tr>
<td>Constitutional dimensions</td>
<td>Problematic dispositions</td>
<td>Guide</td>
</tr>
<tr>
<td>Cerebral faculties</td>
<td>Psychiatric diseases</td>
<td>Remedy</td>
</tr>
</tbody>
</table>
Forging Explanatory Linkages in Psychiatry

**Biological Sciences**
- Structural
- Replicative
- Metabolic

**Behavioral Sciences**
- Psychology
- Anthropology
- Sociology

**Patient "Perspective"**
- Diseases
- Dimensions
- Behaviors
- Life Stories

**Epidemiology**
- Descriptive
- Analytic
- Experimental

**Clinical Associates**
- Neurology
- Medicine
- Pediatrics

Abbreviation:
Invest. = Investigator
My View?

Demand that the DSM-5 editors bring something better to the table

Specifically a classification that serves heuristic functions as do the Perspectives
Officially don’t discard DSM criteria but rather rearrange the diagnoses so that they fit in families.
## DSM Disorders by “Perspectival” Nature

<table>
<thead>
<tr>
<th>Diseases</th>
<th>Behaviors</th>
<th>Dimensions</th>
<th>Life Stories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium</td>
<td>Alcohol-depend.</td>
<td>Subnormal IQ</td>
<td>Bereavement</td>
</tr>
<tr>
<td>Dementia</td>
<td>Drug-depend.</td>
<td>Borderline P.D.</td>
<td>Adjustment dis.</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Sex. paraphilia</td>
<td>Personality dis. (A,B,C clusters)</td>
<td>PTSD</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Anorexia/bulemia</td>
<td></td>
<td>Et cetera</td>
</tr>
<tr>
<td><em>Et cetera</em></td>
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