Wither Psychiatry and its Nosology?

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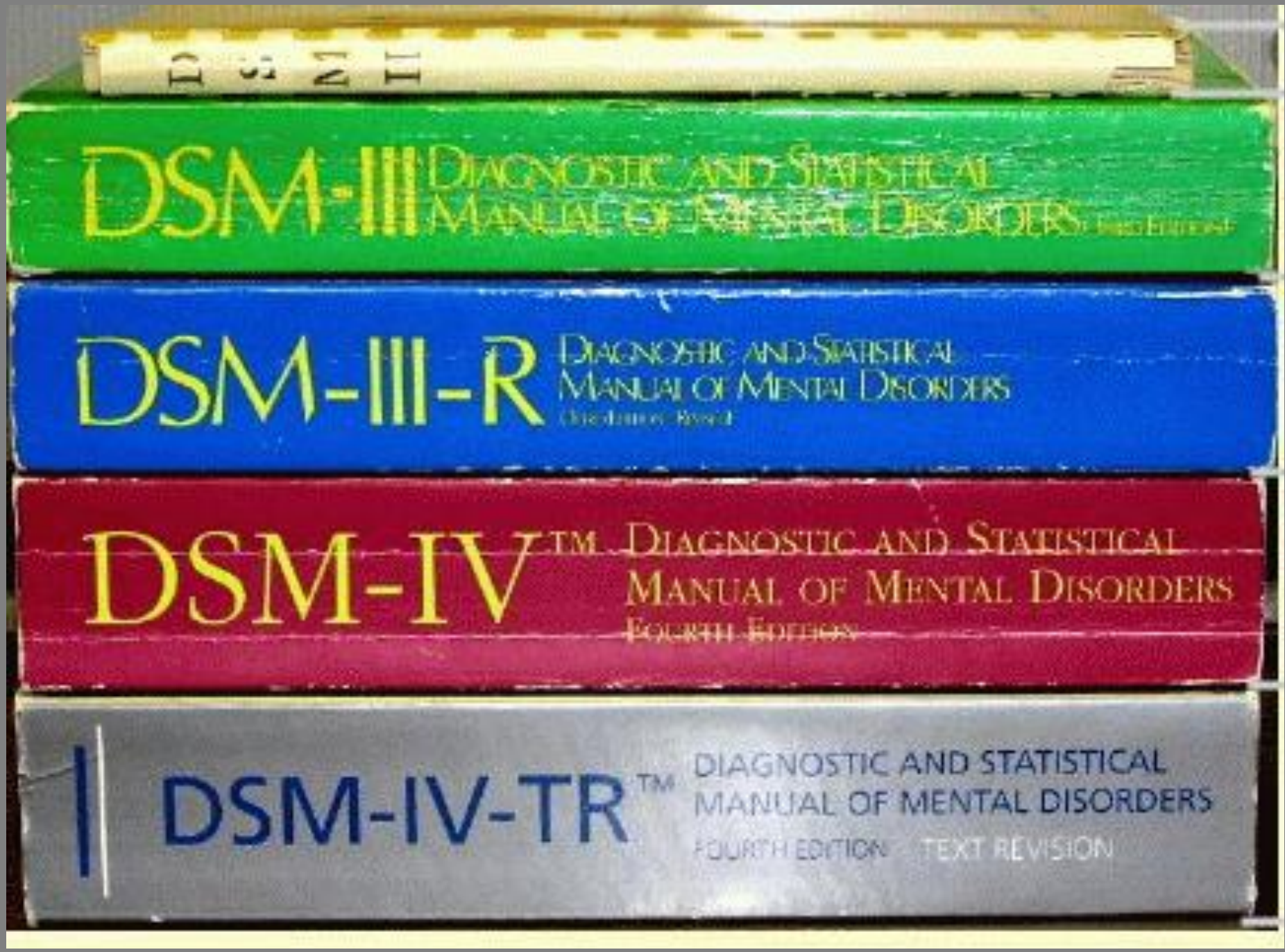
DSM-III
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MANUAL OF MENTAL DISORDERS
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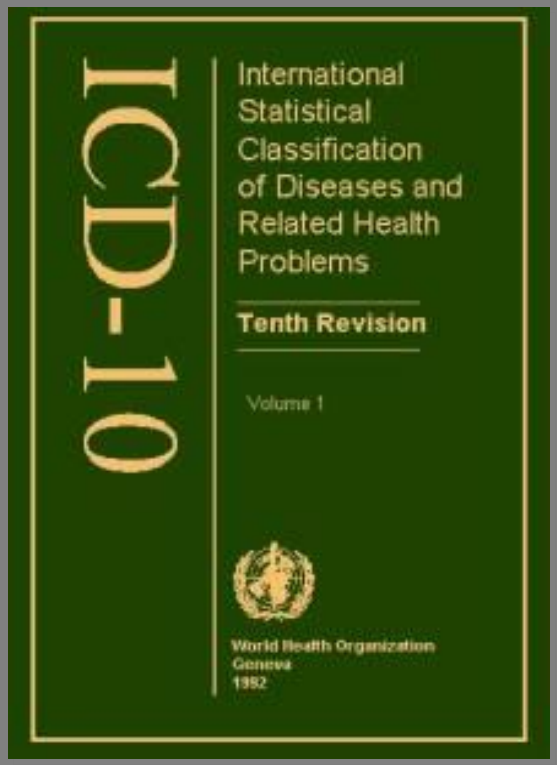
AND IN 2013 COMES DSM-5

- 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

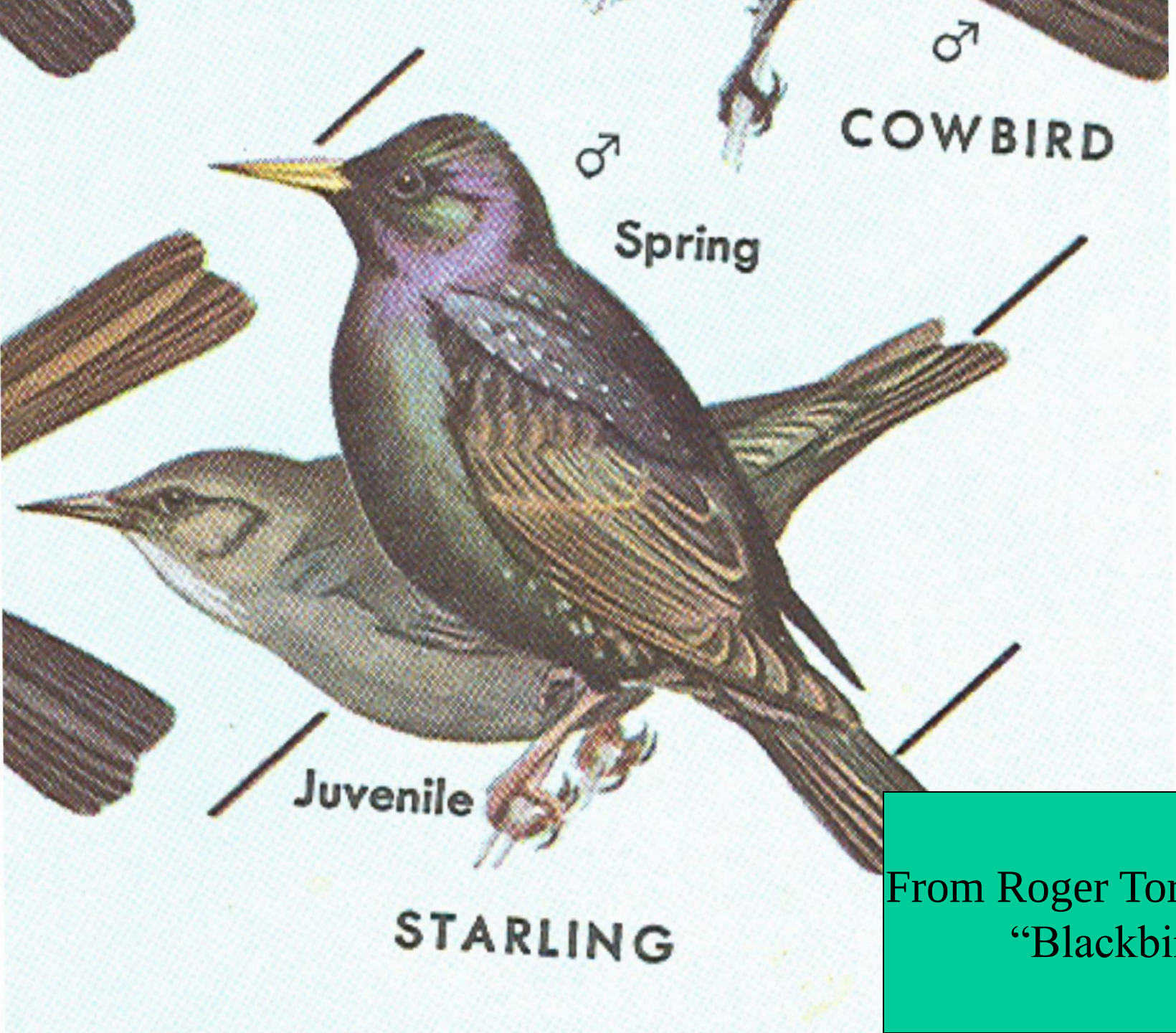


"Whereas the *ICD* is a systematic classification, the *DSM* is a nomenclature."

–Morton Kramer

ICD, International Classification of Diseases and Related Health Problems.

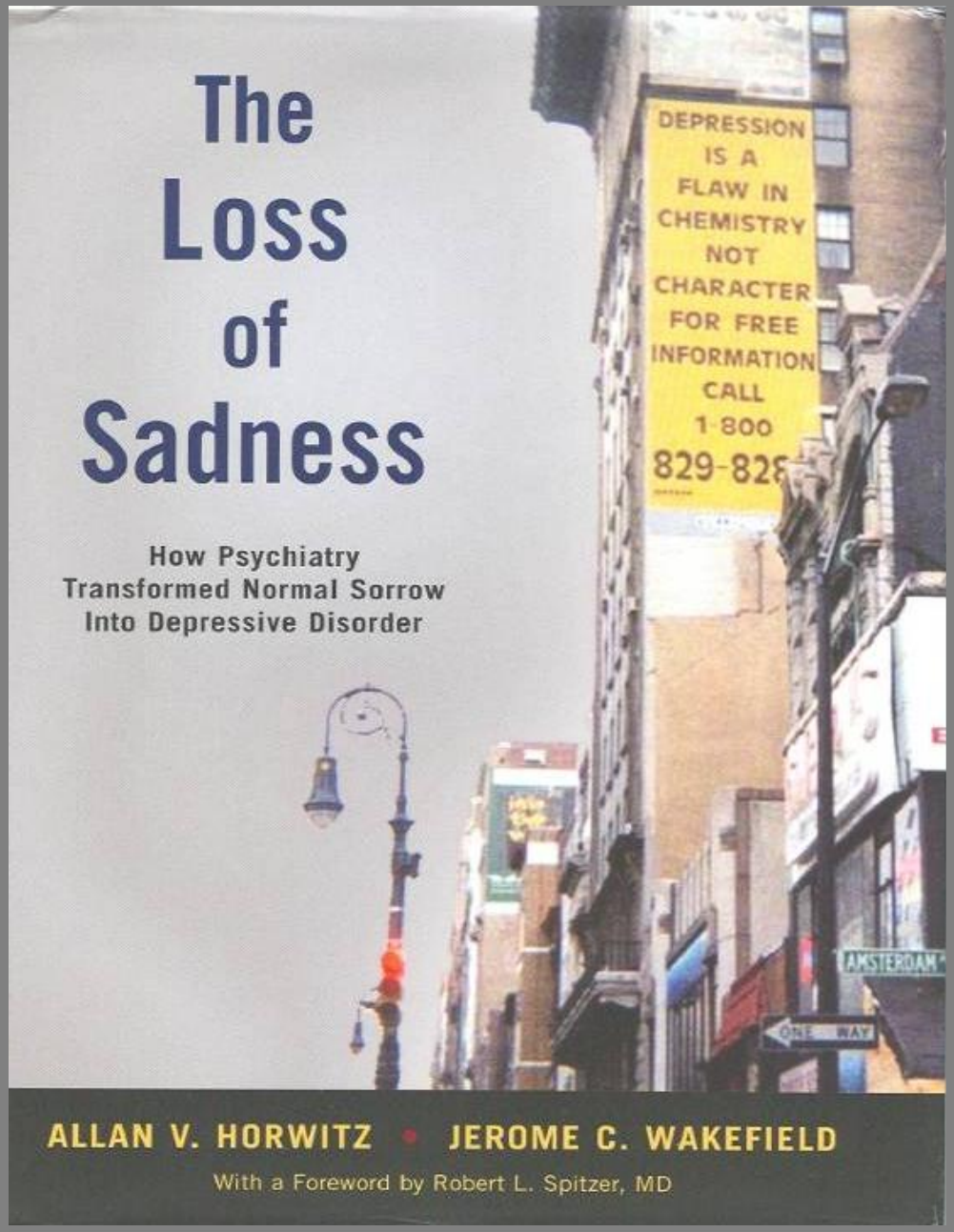
DSM Is a "Field Guide"



From Roger Tory Peterson
"Blackbirds"

Wall Street Journal 11/3/07

This approach is crashing!


The
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How Psychiatry
Transformed Normal Sorrow
Into Depressive Disorder
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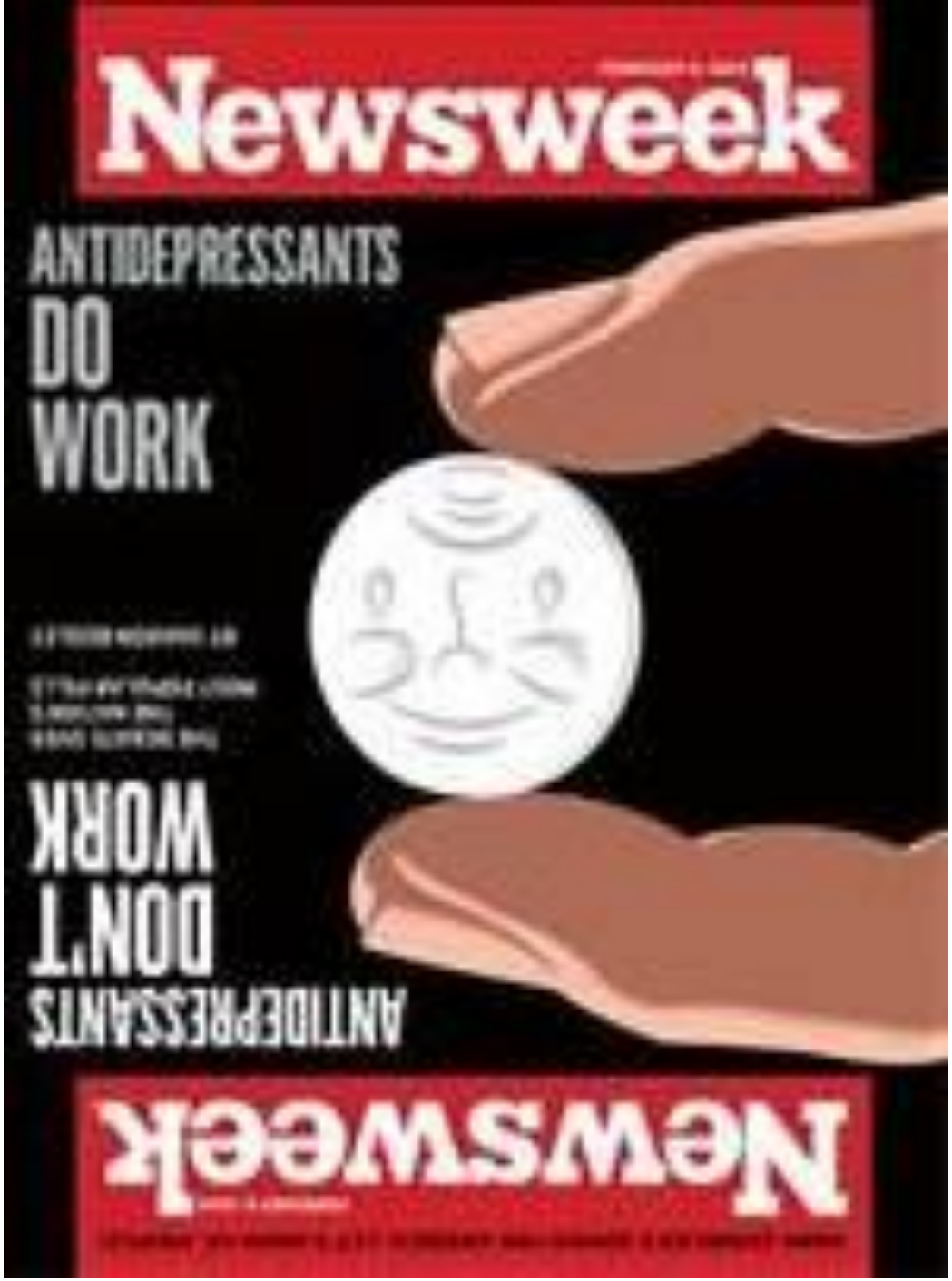
With a Foreword by Robert L. Spitzer, MD

Fournier J.C. DeRubeis RJ, Hollon SD, et al. JAMA 303:47-53,2010



Fournier J.C. DeRubeis RJ, Hollon SD, et al. JAMA 303:47-53,2010

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%

Romanoski A.J. et al Psychological Med. 22: 629,1992

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

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

Anthony JC, et al: Arch Gen Psych: 1985; 42:667- 675

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.

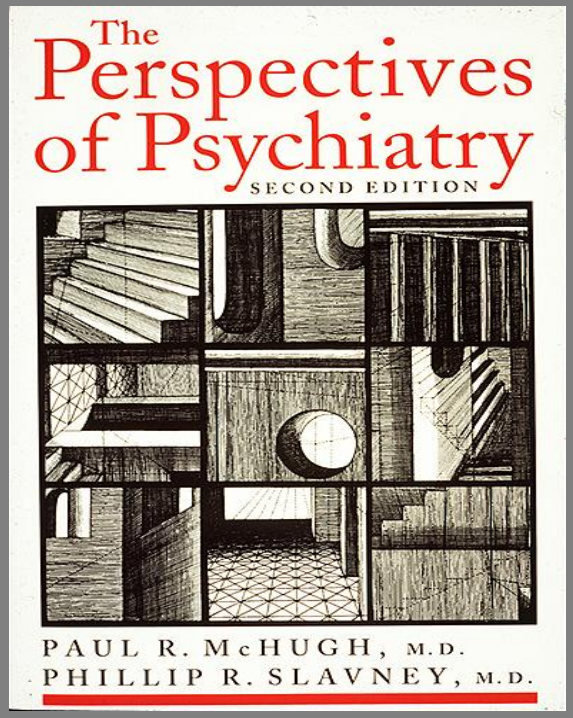
Psychology reveals:

- 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



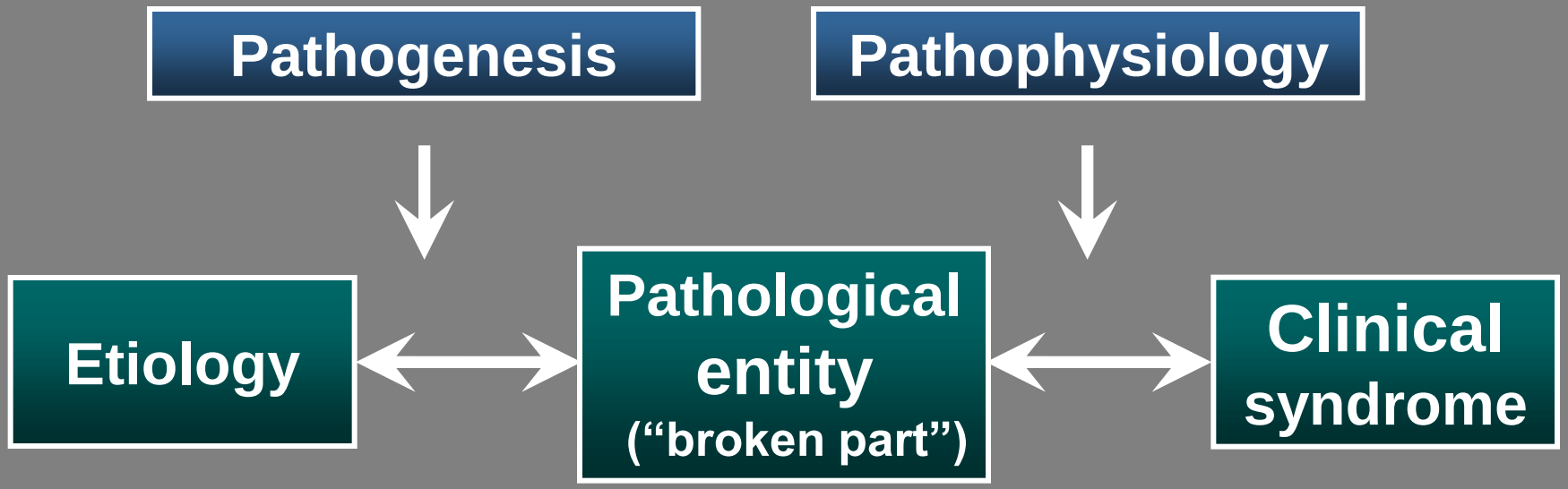
Classifying psychiatric disorders

- 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



Psychiatric Diseases Linked to Basic Brain Functions

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

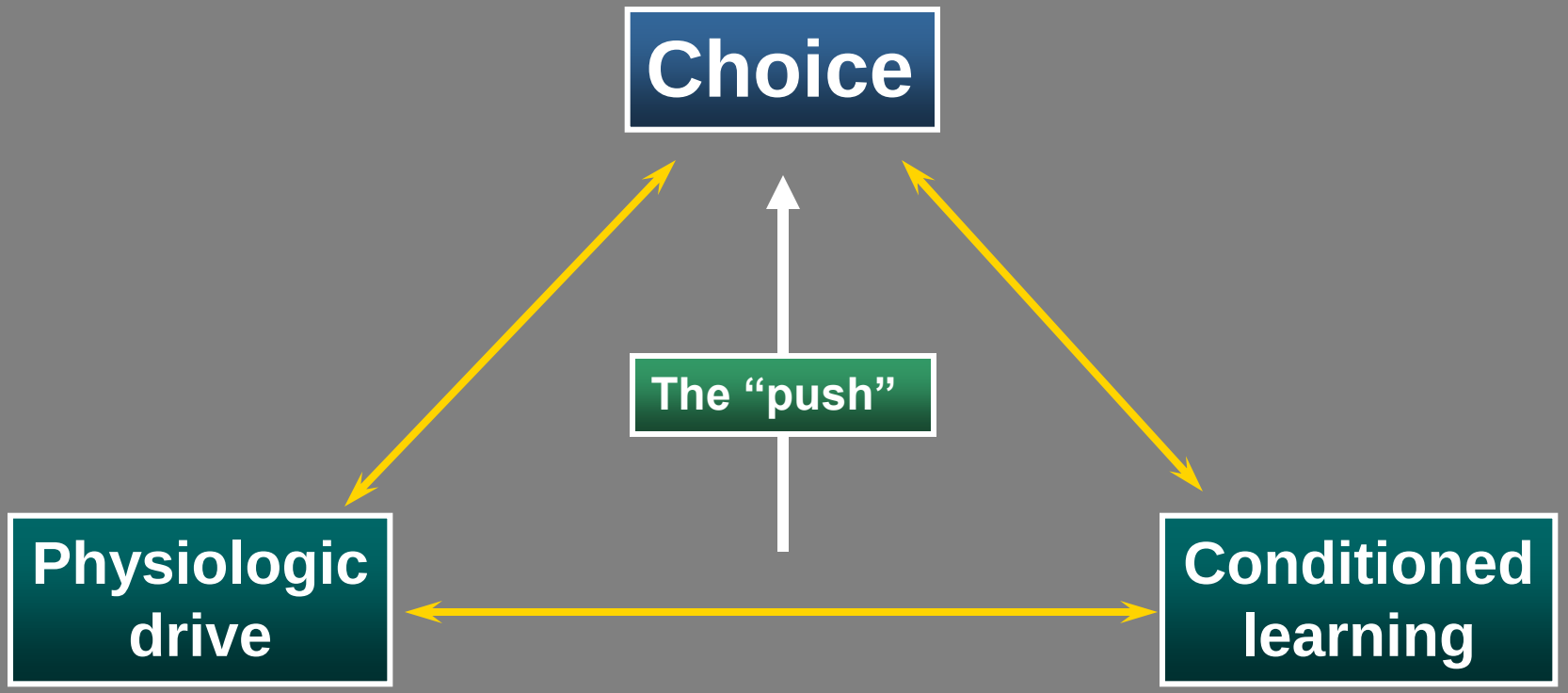
Dimensional Perspective

(Personality) (Life circumstances) (Neurotic symptoms)

Problematic Dispositions

- Suboptimal Cognitive Capacity (IQ < 85)
  - Educational Deficit/Illiteracy
- Affective Vulnerabilities (eg, NEO scores)
  - High "Neuroticism"
  - Extreme Extraversion/Introversion
  - Low Conscientiousness
- Immaturity

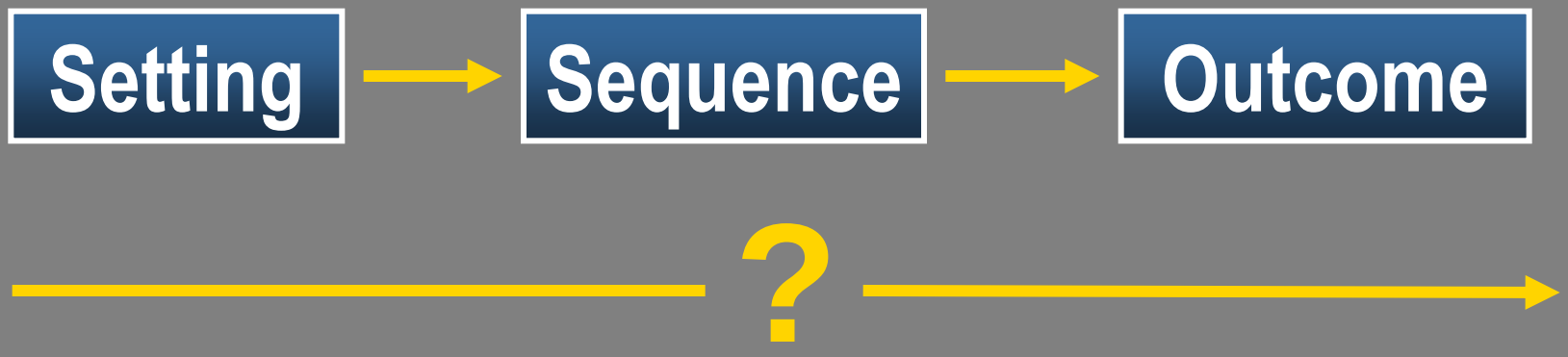
Behavior Perspective



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

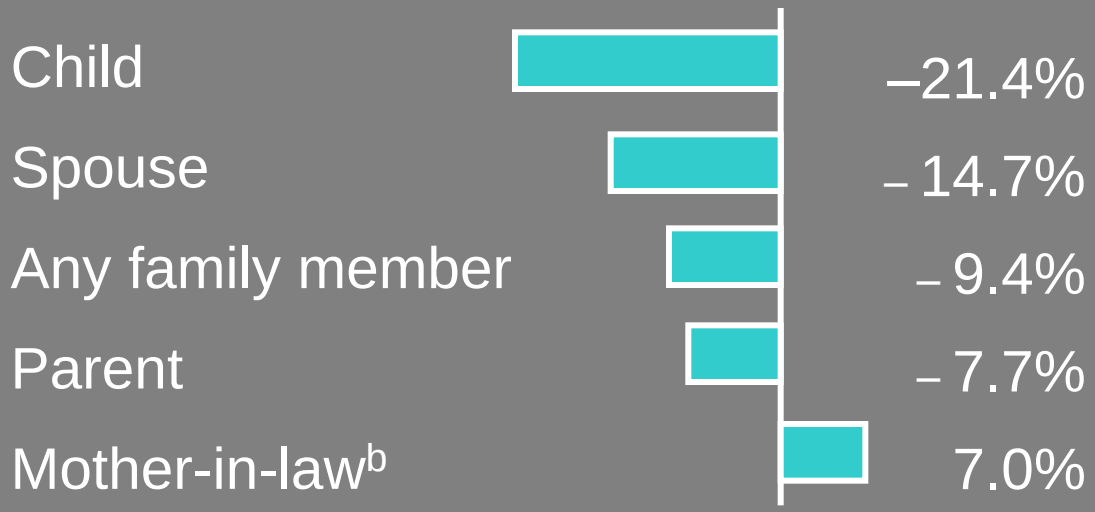


What Conditions Are Best Grasped by Life Story Perspective

- 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)



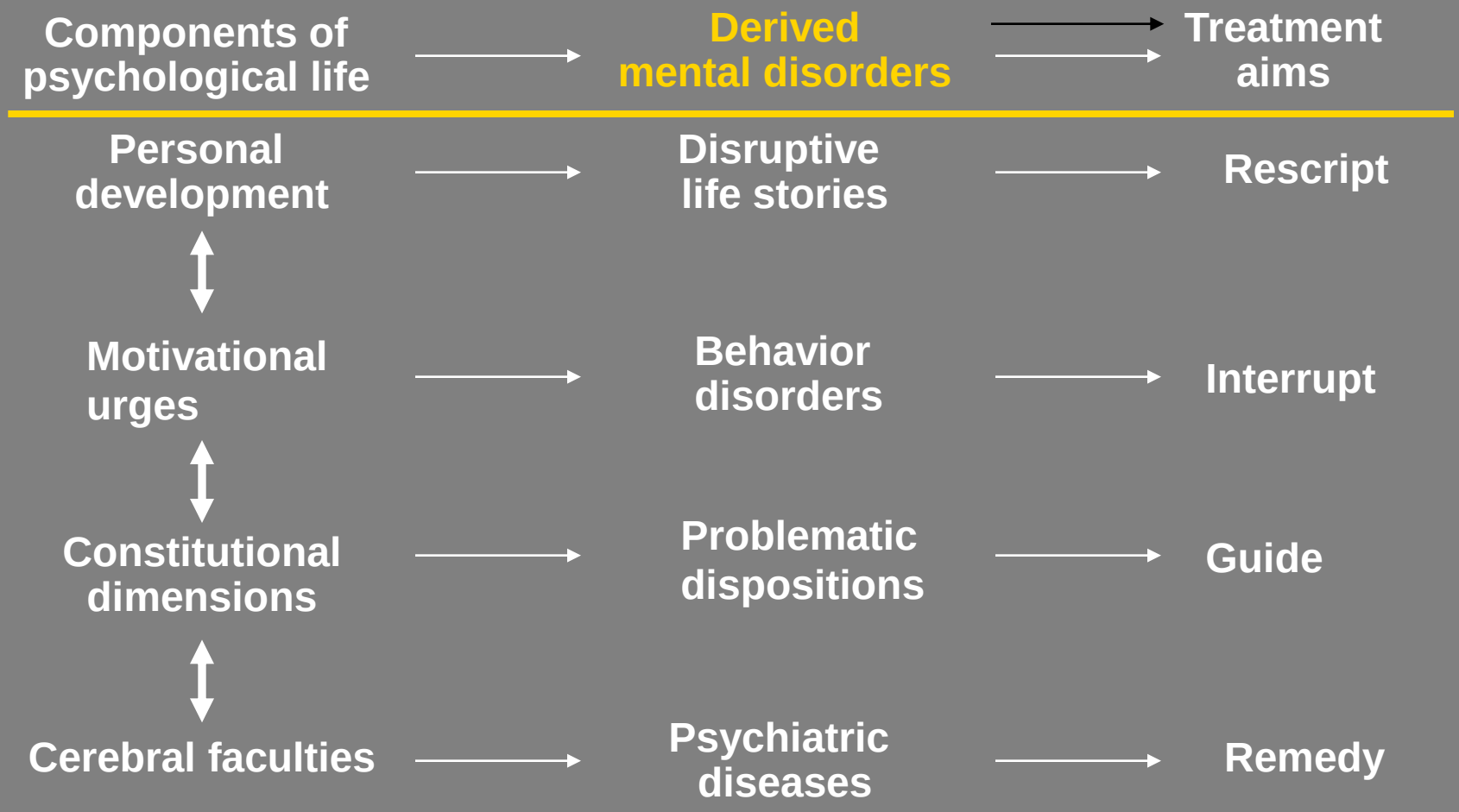
[a] Operating return on assets in the 2 years after the death vs the 2 years before.
[b] Not statistically different from 0.
Bennedsen M, et al. *MIT Sloan Manage Rev*. 2008;43:8-9.

Ultimate Systematic Psychiatry

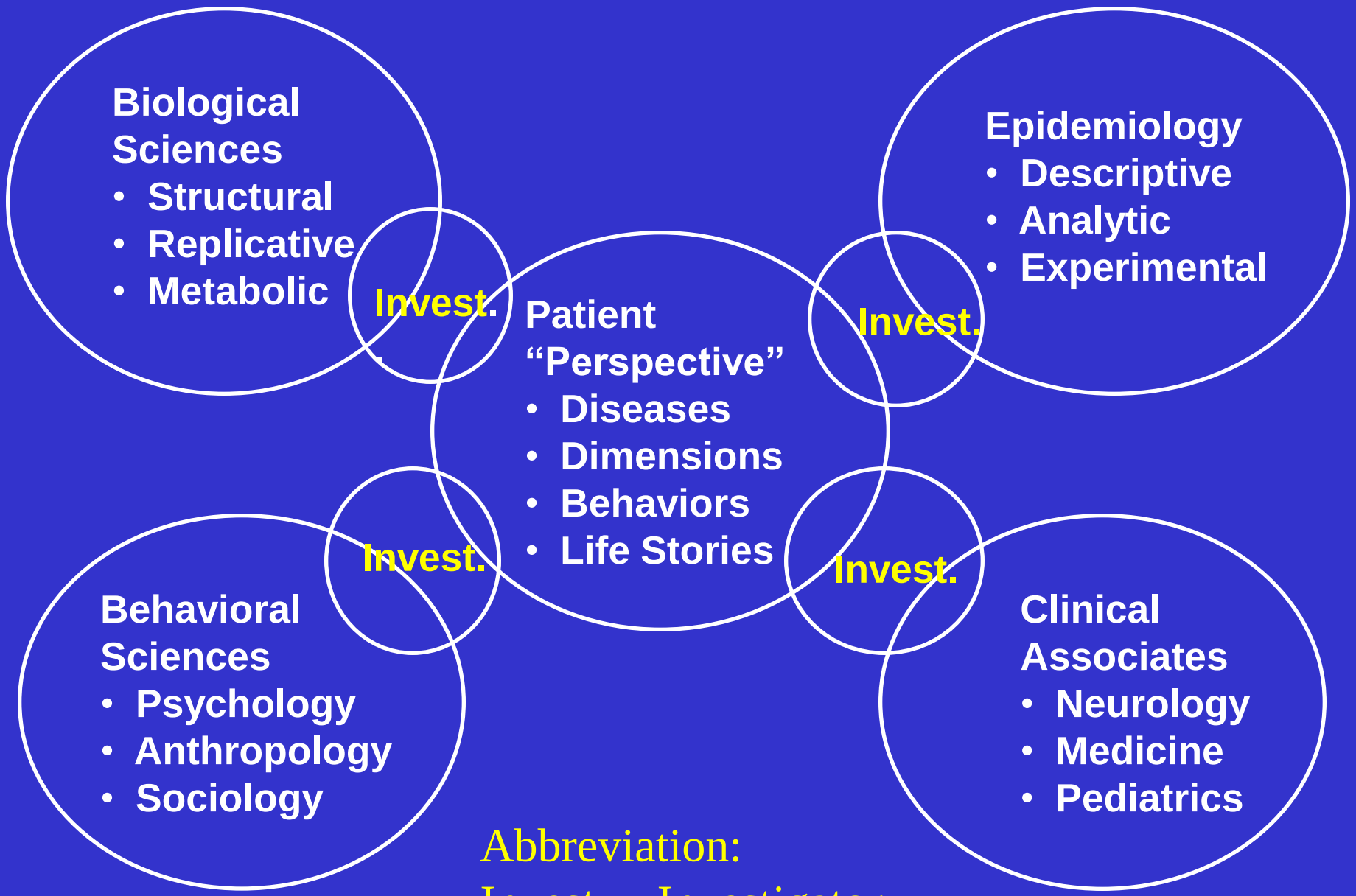
- Psychiatric disorders can be classified (and taught!) such that those with similar generative derivations are clustered together
  - Classification system would begin to resemble medicine
    - Clear affinities for treatment and research of infectious, neoplastic, autoimmune, vascular, nutritional, 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



Forging Explanatory Linkages in Psychiatry



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

Diseases	Behaviors	Dimensions	Life Stories
Delirium	Alcohol-depend.	Subnormal IQ	Bereavement
Dementia	Drug-depend.	Borderline P.D.	Adjustment dis.
Schizophrenia	Sex. paraphilia	Personality dis. (A,B,C clusters)	PTSD
Bipolar disorder	Anorexia/bulemia	*Et cetera*	*Et cetera*
Et cetera	*Et cetera*		