

# Psychiatric diagnoses: Why no one is satisfied

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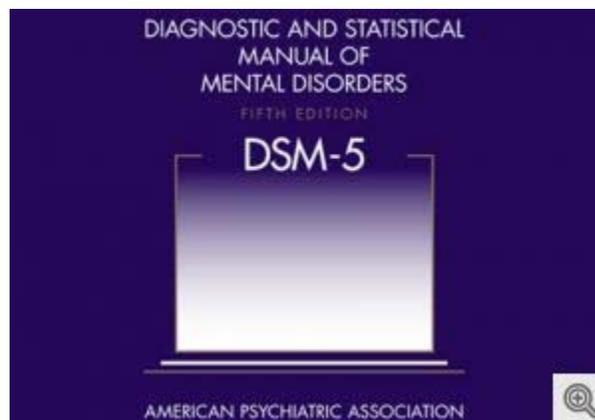
Written by Diane Swanbrow



ANN ARBOR, Mich.—As the Diagnostic and Statistical Manual of Mental Disorders is revised for the first time since 1994, controversy about psychiatric diagnosis is reaching a fever pitch.

Suggested changes to the definitions of autism spectrum disorders and depression, among others, are eliciting great concerns. However, there are larger concerns about the DSM as a whole.

“Almost no one likes the DSM, but no one knows what to do about it,” said University of Michigan psychiatrist Randolph Nesse.



The current round of revisions is the fifth since the DSM was originally published by the American Psychiatric Association in 1952.

“A huge debate over when depression is abnormal seems likely to be resolved by removing the so-called ‘grief exclusion,’” Nesse said. “At the moment, depression is not diagnosed in the two months after loss of a loved one.

“The result of this proposed change would be that people experiencing normal grief will receive a diagnosis of major depression. Doing this would increase consistency in diagnosing depression, but at the cost of common sense. It’s clear that bereavement is not a mental disorder.”

Nesse is the co-author with University of Cape Town psychiatrist Dan Stein of an article in the current issue of BMC Medicine titled “Towards a genuinely medical model for psychiatric nosology.”

The article provides a diagnosis of the difficulty of categorizing mental disorders that the authors expect will displease many of their colleagues.

“The problem is not the DSM criteria,” Nesse said. “The problem is that the untidy nature of mental disorders is at odds with our wish for a neat, clean classification system.”

The proposed abolition of the grief exclusion in diagnosing major depression is just one example of a push to define psychiatric disorders according to their causes and brain pathology.

But Nesse and Stein point out that the rest of medicine recognizes many disorders that do not have specific causes.

“Conditions such as congestive heart failure can have many causes,” Nesse said. “This doesn’t bother physicians because they understand what the heart is for, and how it works to circulate blood.”

Furthermore, he said, physicians recognize symptoms such as fever and pain as useful responses, not diseases.

“These symptoms can be pathological when they’re expressed for no good reason, but before considering that possibility, physicians look carefully for some abnormality arousing such symptoms,” Nesse said. “Likewise, the utility of anxiety is recognized, but its disorders are defined by the number and intensity of symptoms, irrespective of the cause.

“It’s vital to recognize that emotions serve functions in the same way that pain, cough and fever do, and that strong negative emotions can be normal responses to challenging or anxiety-provoking situations.”

So, as the DSM is revised once again, Nesse urges his colleagues and concerned members of the public to adopt realistic expectations.

“Instead of specific diseases with specific causes, many mental problems are somewhat heterogeneous overlapping syndromes that can have multiple causes,” he said. “Most are not distinct species like birds or flowers. They are more like different plant communities, each with a typical collection of species. Distinguishing tundra from alpine meadow, arboreal forest and Sonoran desert is useful, even though the categories are not entirely homogenous and distinct.”

Nesse is the co-author with George Williams of the book “Why We Get Sick: The New Science of Darwinian Medicine.” He is a professor of psychiatry at the U-M Medical School and a professor of psychology at the U-M College of Literature, Science, and the Arts. He also directs the Evolution and Human Adaptation Program, sponsored by the U-M departments of Psychology and Psychiatry, LSA and the Research Center for Group Dynamics at the U-M Institute for Social Research.

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