The Synapse: Intercollegiate science magazine

Volume 3 | Issue 1 Article 14

2013

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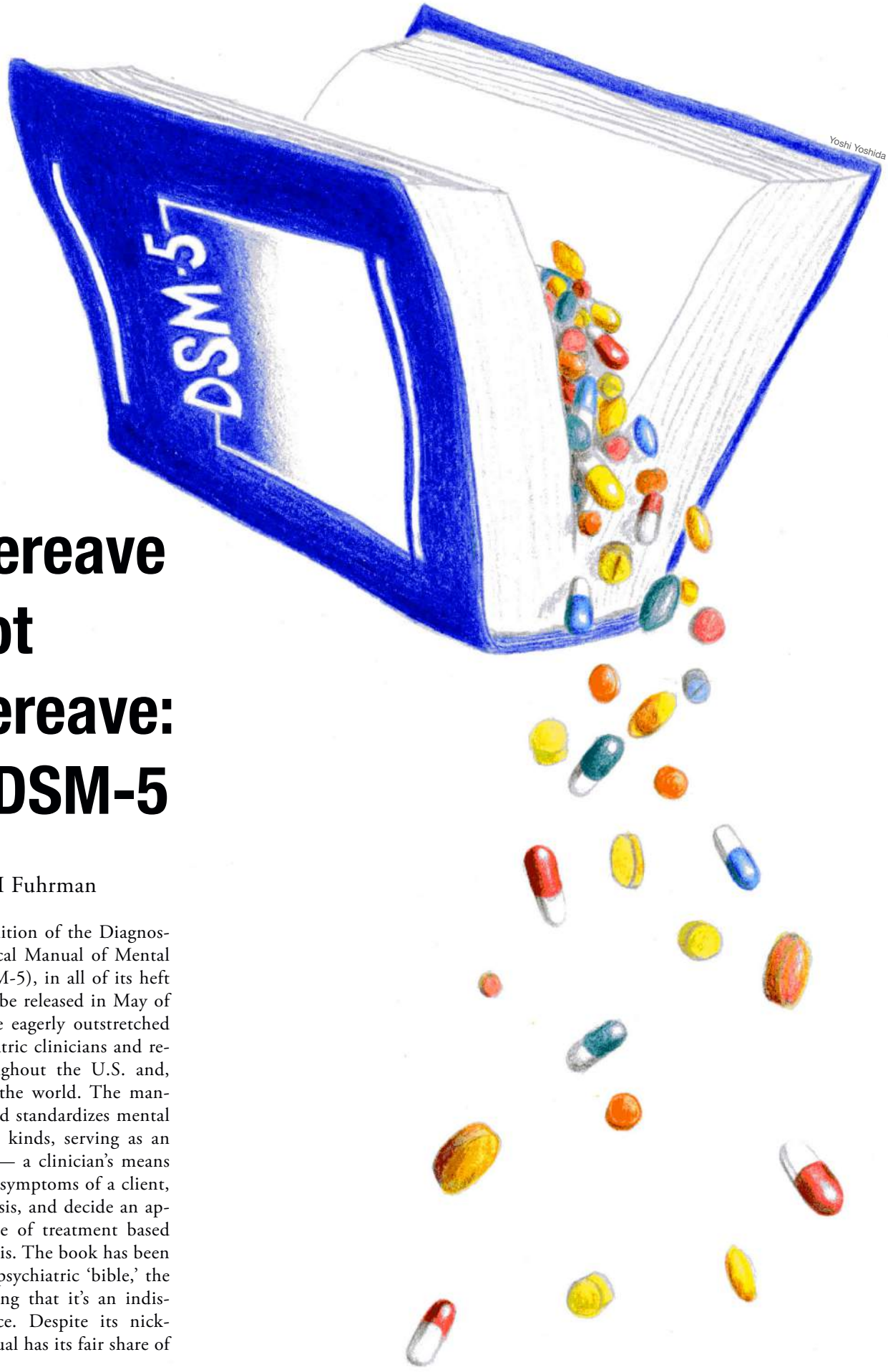

To Bereave or not to Bereave: The DSM-5

By Isaac H H Fuhrman

The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), in all of its heft and glory, will be released in May of this year to the eagerly outstretched arms of psychiatric clinicians and researchers throughout the U.S. and, more sparsely, the world. The manual classifies and standardizes mental disorders of all kinds, serving as an index of sorts — a clinician's means to evaluate the symptoms of a client, assign a diagnosis, and decide an appropriate course of treatment based on that diagnosis. The book has been christened the psychiatric 'bible,' the implication being that it's an indisputable resource. Despite its nickname, the manual has its fair share of

non-believers. This edition, the most recent iteration since 2000 (the DSM-IV-TR is currently in use) marks the fifth revision to the text since its first publication in 1952.

So why update now? What about our understanding of mental disorders has inspired a revamping of the Manual for the first time in thirteen years? The American Psychiatric Association (APA, the professional organization of psychiatrists that publishes the Manual) states on its webpage that the 5th edition is the culmination of "an agenda to expand the scientific basis for psychiatric diagnosis and classification." The idea was first hatched thirteen years ago, and I like to imagine a few 'elite' psychiatrists called a clandestine meeting of the minds to launch the project in the wee hours of the night; research testing the validity of planned disorders has been ongoing ever since. Now, after countless trials, the APA is ready to publish what it considers to be a finished product — an unerring inventory of all known psychiatric disorders.

There is an issue of transparency here, however. The APA has declined to reveal many details of its research, and how exactly those findings translate into added, deleted, and modified conditions included in the Manual. Without access to the DSM-5 work groups' empirical sources, many a critic has prematurely assumed the worst: hasty decisions founded on deficient evidence. Dr. Allen Francis, former chair of the DSM-IV task force, writes, "this is the saddest moment in my 45 year career of studying, practicing, and teaching psychiatry." Francis bemoans much about the new manual, and his largest complaint is perhaps the exclusion of the bereavement clause for the diagnosis of major depressive disorder (MDD). Currently, the clause advises against a diagnosis of MDD for a profoundly grieving and depressed individual within two months after the death of a loved one. The new manual will replace this timeframe with a more immediate one, and recommend a diagnosis after a few weeks of these symptoms, regardless of their origin.

Grieving after the loss of a loved one is seen as a perfectly normal and necessary coping mechanism, one that shouldn't be pathologized and treated with psychotropic medication. (Francis satirically envisions a drug of the future called GrieveAway, designed to counteract the neural workings that produce grief.) The issue raised is one of social treatment — how we view individuals who are labeled with a diagnosis such as MDD, and the dehumanizing stigma attached to it. The diagnosed are likely to incur social and occupational prejudice for a condition that has no place being thrust upon them. For example, in formally requesting a leave of absence from a job, a person with MDD may have to divulge that feelings of depression have significantly impeded his job performance. A diagnosis like MDD, when viewed as intrinsic to a person's character, has the potential to make the already-alienated feel even more so.

This is a valid concern. Yet it may be useful to keep in mind the first necessary condition for a diagnosis to be made: a (bereaved) individual must approach a clinician in earnest, seeking help in some form of treatment, whether it be mere guidance, talk therapy, or medication to alleviate his suffering. There is no such organization as the psychiatric police who can detect the onset of clinical depression, thunder into a person's home, and issue a diagnosis on the spot. By the same token, a diagnosis is also not ordained by a talking Diagnostic and Statistical Manual; it is a conscientious judgment made by a well-trained clinician. This clinician has the license to use her discretion on a case-by-case basis; she evaluates the severity of an individual's grief, the prognosis for its amelioration, and whether or not the resulting depression poses an immediate threat to the patient's safety. She treats the specifics of the patient and does not look for a set of symptoms to match a definition in the Manual. If these are measures a psychiatrist does not take, she should not be practicing. In such cases, we should be condemning clinicians' inflexible adherence to the guidelines of the DSM, which are not meant to be unconditional regulations. The 'bible' possesses no inherent power without agents to breathe life into its pages.

The exclusion of the bereavement clause in the DSM-5 is considered to be emblematic of our society's general 'overmedicalization' of normal human behavior. The new manual will reduce the threshold for number and severity of symptoms required to make a diagnosis; it will add more novel psychiatric conditions than it will delete irrelevant ones. The proportion of the mentally ill will grow, and that of the mentally normal will shrink. Francis and fellow opponents claim this widening grants psychiatry access where it does not belong, or rather, to people for whom psychiatry is not appropriate: those individuals who experience emotional disruption within the spectrum of 'normal' moodiness. In other words, the DSM-5 will make psychiatric mountains out of everyday emotional molehills.

This is a troublesome thought for many, especially those who consider mental health in black and white distinctions. These folks believe that there exist two groups of people in this world, the mentally healthy and the mentally ill, and that the ill are lesser in some way than the healthy. And many argue that the DSM only augments this absolutist way of thinking. We are all anxious, sad, and neurotic to a certain degree; why should an arbitrary boundary dictate whether or not we're branded with a psychiatric diagnosis? The truth is, a threshold for diagnosis is a necessary precursor to treatment. Without one, there would be no standard practice to identify good candidates for treatment; if a patient consults multiple clinicians, he may receive multiple diagnoses. This has the potential to uproot the patient, who presumably seeks out therapy to gain emotional stability, and without a standardized threshold, ambiguity may breed confusion.

The difference between the DSM's classification of the mentally ill vs. the healthy and the social response to it is that the DSM makes no value judgment of the people implicated within its pages. Ironically, in condemning psychiatric diagnosis, skeptics of the practice—the ones who cry "social construction!" and a lack of objectivity—only furnish the stigma they wish to disband. They accomplish this by implying that mental illness is a source of shame. In their minds, a 'damning' diagnosis—of MDD or otherwise—adversely impacts a person's sense of self-worth. Being labeled as having a mental disorder outweighs the potential benefits of the diagnosis. Yet the treatment in question intends nothing more than to alleviate a patient's problems and improve their quality of life.

These are challenging issues to grapple with. Clearly, there is no single correct way to catalogue the criteria of psychiatric conditions. This is the unfortunate plight of the DSM-5's architects. The creation of the manual represents a Herculean task, one that is bound to precipitate the ire of those who don't agree with its content. But until these critics propose an explicit, alternative solution to the problem of mental disorder classification, I suggest they redirect their criticism away from the DSM itself. Agents who abuse its power — inflexible clinicians, avaricious pharmaceutical companies, and the forces of stigma — these are the true arbiters of negativity that surround psychiatric diagnosis.