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Does your patient meet criteria? Reflection on contemporary psychiatric practice

Seu paciente preenche critérios? Reflexão sobre a prática psiquiátrica contemporânea

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The publication of the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III)[1] in 1980 was a milestone in psychiatry. This unprecedented nosographic system establishing explicit and conventional criteria to operationally define entities as mental disorders would allow us to overcome one of the problems that had historically been most embarrassing for the discipline: the lack of reliability of diagnostic categories. With this new system, minimally uniform parameters were established to achieve shared agreement about diagnostic labels and their related clinical symptoms. Additionally, psychiatry would have a conventional, supposedly atheoretical, language for psychopathologic hypotheses that would explain the nature of the disorders, offering clinicians and researchers of different orientations a minimal alignment of empirical referents for each diagnosis. The traditional Babel of psychiatric morbid entities would finally be overcome through pragmatic agreement in the field of nosography.

Notwithstanding, the psychiatric community and those responsible for creating the DSM identified the risks and possibilities for deviations in its use. The introduction to the latest edition, DSM-5,[2] includes the following recommendation (page 19):

> *The case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological, and biological factors that may have contributed to developing a given mental disorder. Hence, it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis*.

Indeed, use of the DSM system has been progressively distorted, going from a list of diagnostic categories with operational criteria to constituting the basis of the teaching of psychopathology in many services around the world. This abuse of the DSM has been reducing

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psychiatric practice to mere automatic application of the nosographic manual. This is coupled with mechanical prescription of conducts that are entirely oriented by pre-established protocols and in which the psychiatrist does not establish any effective clinical mediation between the protocol and the singular reality of each patient.

Furthermore, the existing systems' approach to classification and diagnosis has resulted in a lack of interest in searching for explanations, in an attitude that can be summed up by the following question, "Why should we worry about a deeper understanding of the case if we have already made a diagnosis (by checking off diagnostic criteria) and we know how to treat it (with the medications indicated by the protocols)?"

Two of the foremost critics of this misuse of the DSM and of its limitations are Paul McHugh and Phillip Slavney, psychiatry professors at Johns Hopkins University. In their book *The perspectives of psychiatry*,[3] they present a more comprehensive model and understanding of mental disorders, suggesting that patients with psychiatric problems should be considered within a wide, articulate, and logical conceptual system in which the *disease* is only one of four issues. The other three are *dimensions*, *behaviors*, and *life history*.

Taking into consideration that psychiatric patients are not a homogenous group, their disorders may have completely distinct origins, consequent to what the patient "has" (*diseases*), what he "is" (*dimensions*), what he "does" (*behavior*), and what he "experiences" (*life history*), and to understand and treat them we should use different reasoning methods (different perspectives).

The *disease* perspective looks for the origin of the problem in a particular type of biological dysfunction, a "defect" that could be responsible for mental damage. Some psychiatric disorders, such as schizophrenia and bipolar disorder, fit this perspective. However, to believe this perspective can explain completely all disorders that afflict our patients is to ignore their other components, such as motivation, constitution, learning, and several conflicts decisively present in all of them, including in those who have schizophrenia or bipolar disorder.

Unlike the *disease* perspective, in which a qualitative abnormality is behind the symptoms, the *dimensional* perspective is determine quantitatively by exaggerated "normal" emotional responses. It is particularly useful in formulating cases and in therapeutic planning for diagnoses such as mental retardation, as well as traits, such as dimensions and personality disorders.

Under the *behavioral* perspective, mental health professionals do not treat people for what they *have* (*diseases*) nor by what they *are* (*dimensions*), but for what they *do* (*behavior*). Any *behavior* in which the capacity to control and to choose have been affected and hamper adaptation could be considered *abnormal* and be the subject of clinical attention: alcohol dependency, eating disorders, gambling addiction, and suicidal behavior. These *behaviors* are not only linked to an impulse, but also to learning. They interact with social forces (some are obvious, some are subtle).[1] Disorders of this nature usually cause conceptual and ethical dilemmas that, intrinsically, are part of the epistemological basis and practices of psychiatry.

The *life history* perspective emphasizes that some clinical presentations are due to psychological reactions to life events, commonly a loss or other traumatic circumstances. From this perspective, the psychiatrist uses the logic of the narrative to help the patient to understand the origin of his psychiatric condition. The *life history* consists of the psychological products resulting from meetings every individual experiences throughout their lives. One should always take this approach into consideration when considering any other dimensions since "even if there is a disease to be treated, there is still a person to be taken care of."[1,2]

A second book,[4] written by students of McHugh and Slavney, systematizes this proposal for clinical practice based on five essential characteristics of a good psychiatric evaluation: a) to obtain a detailed patient history; b) to present this story in a specific sequence; c) to use multiple sources of information; d) to perform a systematized psychiatric examination; and e) to make a careful differentiation between observations and interpretations.

These two books complement each other and reading and studying them undoubtedly contribute to good psychiatry practice. They make it clear that the psychiatric medical history cannot be restricted to an evaluation against a checklist to decide whether or not the patient fulfills the criteria for a given disorder. To achieve a complete and individualized formulation and develop a comprehensive therapeutic strategy one should consider all perspectives for each patient, in the knowledge that they are not exclusive, but complimentary. Three steps that McHugh & Slavney repeatedly recommend synthesize this attitude: "Know your patient. Think about the causes of his problems. Institute your treatment rationally."

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