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PSYCHIATRIC DIAGNOSIS AND HUMAN EMOTIONS

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Psychiatry is a human science and its subject matter is the individual's psychic reality which defies the degree of certainty and validity required of the discourse in natural sciences. However, modern psychiatry, as we know it, in the 21st century has moved from understanding the psychogenic cause of a symptom to a medical model of controlling and manipulating symptoms. An important reason for this shift was the increasing awareness that some medications (lithium carbonate, antipsychotics, antidepressants, anxiolytics) were of benefit to certain kinds of disorders, and the ongoing research in this area held a promise for better and more effective medications that could target many other mental disorders. Equally important was the dissatisfaction and conflict within the profession, as well as the attacks, in the 1950's, from the antipsychiatry movement that challenged the arbitrariness of psychiatric diagnosis which lacked a pathophysiologic explanation for the illness. An indication of the American Psychiatric Association's (APA) struggle to develop a credible classification system of psychiatric disorders is best reflected in the history of the Diagnostic Statistical Manual (DSM). This manual was first published in 1952, with subsequent revisions, the latest being the publication of DSM-5, in 2013. Until the 1970's the manuals (DSM-I and DSM-II) were conceived on a biopsychosocial model with a psychodynamic tilt influenced by Freud's theory of personality development and intrapsychic conflict, as well as Meyer's psychosocial model, which downplayed psychiatric disorders as discrete, specific pathological entities. This model had a significant impact in teaching and clinical practice with individual psychotherapy becoming an essential feature of psychiatry. However the shortcoming of this approach was that it lacked a clear demarcation between the mentally healthy and sick; this led to questions about the status and legitimacy of psychiatry as a medical science. Added to the grave doubts about the validity and reliability of psychiatric diagnosis was the embarrassment when in the early 1970's the gay rights movement lobbied against homosexuality being labeled as a disorder in DSM-II, which was later excluded from DSM III published in 1980. So the removal of a disorder was based on political pressure, rather than scientific research. DSM-III (followed by DSM-III-R, 1989) which was a significant turning point in the history of psychiatry in USA, adopted a descriptive, nosological approach which could be supported by research findings that lent greater reliability and validity to psychiatric constructs. Assessment through description of symptoms which were publicly visible was stressed over psychological etiology which by its very nature was private and invisible. This bold and creditable step by the APA was not free from criticisms, many of which were warranted. A most vocal critic of DSM-III-R, Dr. Paula Caplan a clinical and research psychologist, and a human rights advocate, forwarded a trenchant argument against the inclusion of diagnostic labels, such as Self-Defeating Personality Disorder (SDPD) and Premenstrual Dysphoric Disorder (PMDD). Both these disorders were applicable to a majority of women. The former (SDPD), facetiously referred to as "good wife syndrome", included characteristics such as putting needs of others ahead of one's own, feeling unappreciated etc. Interestingly, this "portrait" of SDPD is most germane to the accepted and desirable gender role for Pakistani women as well. The latter's (PMDD) diagnostic features consist of "bloating" breast tenderness coupled with irritability, fatigue, being "on edge" etc. Dr. Caplan questioned the scientific basis of inclusion of PMDD in a psychiatric manual, pointing out that it is just a fancy name for PMS. In lieu of the scathing criticism from feminists, the two diagnoses were not included in the main text of DSM-III-R and DSM-IV-TM (2004) but were instead placed in an appendix titled "Diagnostic Categories Needing Further Study." The publication of DSM-5 in 2013, nine years after DSM-IV-TM was awaited with much anticipation. Surprisingly, mental health professionals expressed concerns while DSM-5 was in the making. Most of these concerns were around newly introduced categories and the lowering of thresholds for many disorders which would invariably lead to over diagnosis of the existing disorders. Allen Frances, who chaired the task force of DSM-IV was the most forceful and potent critic of DSM-5. In his high profile articles he argued that many changes were arbitrary and scientifically untenable and with the expansiveness of diagnostic categories and diagnosis based on checklists of symptoms, would be more beneficial to drug companies than to the client themselves. He also bemoaned the fact that DSM's descriptive and atheoretical approach was biased in favor of medication and downplayed the role of psychotherapy and counseling. While it is not possible to address all the contentious changes in DSM-5, the elimination of bereavement exclusion from Major Depressive Disorder (MDD), increases

the probability of diagnosing normal grief reaction as MDD. To be diagnosed with MDD if a person has 5 out of the 9 symptoms (such as sadness, insomnia, difficulty in concentration and engaging in everyday activities etc.) which have persisted for more than 2 months, criteria of MDD has been met. The checklist of symptoms for MDD are similar to the anguish felt and observed in a person who has lost a loved one. In conclusion there is no denying that the DSM has provided psychiatrists with a common, agreed upon language which is indispensable if research has to keep pace with modern medicine. In lending clarity to the diagnosis of some major disorders the DSM has provided guidance to the diligent use of psychotropic medication. However, DSM with its ever- expanding list and confusing rearrangement of diagnostic categories has medicalized normal human emotions. In its quest to be scientific, it seems to have lost sight of the nature of psychological suffering, a construct that is fundamentally non-empirical.

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