

Letter to the Editors

Why the DSM?

Jean-Yves Cozic

Summary

The psychological experience is not always in register to pathology. Classification must be as close as possible to the clinical examination, but also respectful of human principles. For a long time classifications have had a Linnaean feel; the concern of psychiatrists with little leeway for therapeutic action. Professor PELICIER was accustomed to saying that this classifications could be called “herbarium of the flowers of Evil”, with a capital letter on Flowers, recalling one of our great poets, Charles Baudelaire, who described melancholy so well: “When the low, heavy sky weighs like a lid on the groaning spirit, victim of long ennui”.

American Psychiatric Association / DSM 5 / classifications in psychiatry

Under this admittedly slightly provocative heading, I am inviting you to share a few thoughts on classifications in psychiatry.

You all observed how long it took to draft the DSM5 and what a struggle it proved to arrive at an agreement. The American Psychiatric Association painfully reached the end, bringing new pathologies to our attention in doing so:

Grief: following the fifteenth days after the loss of a loved-one, the sadness felt can be called a major depressive episode, which implicitly suggests the prescription of drugs.

Binge-eating disorder: if you have a bout of greediness once a week for three months, you suffer from this. This is going to be tough in RABELAIS' country.

The “skin picking disorder” is the repeated urge to pick at your own skin to remove blackheads or spots. Almost every teenager suffers from this!

If I quote some of the new pathologies that have appeared in the DSM 5, it is not purely out

of irony. It is primarily to emphasize how the approach at work denies psychological experience, by considering everything that emerges from a decreed standard (a psychological lowland in which everything is dull and quiet) to be a disorder requiring treatment, preferably by drugs.

As soon as the DSM5 was published, there was a strong reaction in the U.S.A. (notably, with the reproach that this classification is not scientific enough) but also in Europe. In reaction to these criticisms, some tried to compare the opponents to the DSM to adherents of an anti-psychiatry movement. Quite the contrary. Among the psychiatrists and psychologists to dispute the legitimacy of the DSM5, the large majority is convinced of the interest, and even need for classifications in psychiatry, to develop a sort of cross-border common language, as much for clinical description as for epidemiology and research.

The APA published its first classification in 1934. Like many psychiatry schools at the time, this tried to maintain a precarious balance with the juxtaposition of symptomatic, evolutionary and etiological criteria. The APA distinguishes:

- Psychoses of organic origin (infectious, toxic, traumatic, arteriopathic, etc...)
- Dementia praecox

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- Psychoneuroses as used at the time to refer to neuroses
- Manic-depressive psychosis
- Paranoia
- Psychopathies
- The retarded.

As Henri EY reminds us in his study No. 20, these are “nomenclatures, which were drawn up for statistical purposes” and he adds: “this kind of classification-cum-nomenclature is fatally incoherent, since, because it has no basis in a well-defined idea, it reflects the disorder of the very subjects it aims to organize”.

With every issue of the DSM, its colour has changed and we have become accustomed to saying that the DSM III was a turning point that imploded the very concept of neurosis and considerably extended the field of mood disorders. This is not without significance, as Professor Edouard ZARIFIAN pointed out. It is true that the connections between pharmaceutical firms and some of the experts behind the recent issues of the DSM result in a “conflict of interest”, as we say today in a politically correction fashion. The very principle of a classification of mental disorders cannot be disputed. The medical specialization of psychiatry cannot dispense with a classification of the phenomena which form its subject; to be specific, mental disorders.

According to Henri EY, to draw up a suitable classification, we must obey two basic principles:

We must not confuse the clinical classification of syndromes with the classification of etiological factors. In fact pathologies often correspond to a multiplicity of such factors.

We must have a model, i.e. a theory which constitutes its taxonomic plan (Henri EY compares this with the characterization of stamens which guided Linnaeus in his botanical classification).

Henry EY demonstrates that the first modern-day classification, by Paul ZACCHIAS (1584-1659), already made this mistake, which constitutes what he refers to as a “methodical error”: mixing the semiological and etiological criteria. Not dealing, as science is at present, with anatomical entities, we cannot place disorders defined by the clinical aspect in the same section, and others distinguished by such and such an etiological process. In the same study, No. 20, Henri EY has the same reproaches to make con-

cerning the Boissier de Sauvages (1767) classification. He considers the one by Cullen (1787) to be “more consistent” and Pinel’s (1801) one to be “coherent”.

For Henri EY, the organization of the psychic apparatus must form the principle of classification. He suggests “simple logical classification” distinguishing:

Severe mental illness in which there is a destructuring of the field of the consciousness (mania, melancholy, acute delirium, mental confusion).

Chronic mental disorders (neuroses, different forms of schizophrenia, paranoia, paraphrenia).

He insists on the fact that these are not “isolated types” and that there are cross forms, as well as the potential of reversibility. Henri EY took a particular interest in acute destructuring of the field of consciousness syndromes and, in particular, the field of acute psychoses.

From the 19th century, FALRET and PARCHAPPE established precise rules:

- A classification must not just be an ordinary nomenclature. It can be systematic, beginning with a correct definition of the mental illness and containing all the types that enter into the understanding of this concept.
- “Mental illness” can only be defined as a typical evolution of psychological disorders.
- We must distinguish the clinical types: subjects of a classification of the somatic processes that generate them and of a classification of pathogenic processes.
- Two aspects are to be distinguished; the pathology of the field of consciousness and the pathology of the personality.
- The pathology of consciousness is characterized by the disruptive or destructuring levels which its activity is divided into.
- The pathology of personality defines chronic mental disorders.

You are all aware of Kraepelin’s classification, which, in 1895, classed curable disorders and those considered incurable, as well as a third type, dementia praecox. Henri EY believes that this is “the best of his classifications” and he uses it himself.

Last year, a few years before he died, Professor Roger MISES, author of the CFTMEA, which Dr. Maria SQUILLANTE will be talking about in the context of this meeting, invited us to the

French Psychiatry Association, which I have the honour of chairing, to develop a new classification of adult psychiatric disorders. He was deeply concerned about the misuse of the DSM, initially a classification whose aim was epidemiological, taking on the status of clinical manual in many schools of psychiatry in France. Some aspects of the IDC-10 are interesting, but it could be faulted for only being a nomenclature and not taking the psychopathological processes and the human approach sufficiently into consideration.

It was in this context that a workgroup was set up at the French Association of Psychiatry under the aegis of Dr. François KAMMERER. We believe we are in a position to publish this new classification proposal by the end of the year. The essence of the great principles set forth by Henri EY guides this work as well as certain elements of the psychoanalytical concept. The group has chosen to keep the notion of the length of the disorder as a major effector with the distinction of acute versus long-term (to avoid saying chronic, which is often understood in a pessimistic way and synonymous with incurability in peoples' minds). It is clear that we intend to bring back mood disorders to their proper place. As traditionally, mania and melancholy are classed as severe disorders.

Always with regard to these mood disorders, it is clear that we do not intend to include movements and experiences inherent in human existence. Some types described by AKISKAL, seem to fall within a normal personality and not bipolar: One can very easily show signs of enthusiasm and vitality without being manic and a same subject can also experience moments of discouragement, or be pessimistic when thinking of the state of the earth without being in the nosography register of depression for all that. In short, the psychological experience is not always in the register of pathology.

To conclude, I would say that a classification must be as close as possible to the clinical examination, but also respectful of human principles. For a long time classifications have had a Linnaean feel; the concerns of psychiatrists with little leeway for therapeutic action. Professor PELICIER was accustomed to saying that these classifications could be called "herbariums of the Flowers of Evil", with a capital letter on Flowers, recalling one of our great poets, Charles Baudelaire, who described melancholy so well "When the low, heavy sky weighs like a lid on the groaning spirit, victim of long ennui"

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