FINK! STILL AT LARGE

The DSM-5 promises to change the practice of psychiatry in a big way. What do you think of the proposal to eliminate Asperger's disorder and to put it under the heading of autism spectrum disorders?

BY PAUL J. FINK, M.D.

When I started working in psychiatry 50 years ago, Asperger's disorder was a recognized diagnosis. During that period, the diagnosis drifted into my consciousness through conferences, articles, and discussions with colleagues.

Sometimes, I was asked to evaluate an adult who had difficulty socializing and learning all of his life, and someone had labeled the man with Asperger's disorder. It has become part of the psychiatrist's nomenclature and diagnostic system for a group of patients who otherwise would have been dumped into many other places. The label has provided us with an ability to split and share concepts in a helpful way.

I became very conscious of the illness when we realized that a neighbor's son at 55 years of age had the disorder. He was friendly in a very superficial way; he was peculiar in his looks and manner; and he was the kind of person one might tend to avoid.

He had no friends, no social life, and no seemingly useful activities. We were convinced that he had Asperger's.

He died while in his early 60s, and no one on our street expressed one word of regret that this odd man was no longer on the road. I think that it would have been difficult to call him autistic, so the plan to take Asperger's out and make it part of the autism spectrum disorders will take a great deal of learning on the part of 40,000 psychiatrists and several thousand patients after the DSM-5 is published.

For me, what is most interesting about this is how the diagnosis arrived and might leave in the course of my career. I, like many people in the field, do not understand the rationale of the task force in proposing this change.

Controversy Is Nothing New

I commend the task force members and their efforts, however, in refining this important document. After all, this volume plays a major role in the care and treatment of patients as well as with insurers with regard to getting paid for the work we do.

Each of the previous DSM editions caused much controversy, as this version is doing. Many praise it, and many will be highly critical of the efforts. Preparing a diagnostic and statistical manual takes a great deal of effort, time, and money, and it is one of the most important activities of the American Psychiatric Association. The manual becomes a trusted instrument used by almost everyone after it has been approved and published.

This year, the task force has done something that has never been done before and put a draft outline on the Internet. The APA has invited comments, reactions, and criticism. After the viewing period is over, the final work of editing will begin, and the DSM-5 will be published in 2013.

Psychiatric diagnosis is extremely controversial. I think it is important to say that both Dr. David J. Kupfer nd Dr. Darrel A. Regier are very sincere in their desire to produce a useful volume that will serve both the research and clinical communities well.

Everything I've read leads me to believe that the DSM-5 will be the easiest of all for clinicians to use.

The previous two DSMs were seen as being written for researchers, which made it a little more difficult for the clinician to fit his patient neatly into one of the descriptive groups. Some of the inventions of DSM-III and DSM-IV were thought to be useless by a large number of us who see patients.

And the precision of some of the categories was foolish—at least for me. I saw no value in schizotypal, for example, but I know that younger clinicians found the category very useful.

Calls for Transparency

Both of the previous task force chairs, Dr. Robert Spitzer and Dr. Allen J. Frances, have decried the secrecy of the work of the hundreds of people involved in creating the DSM-5. They kept calling for transparency in a way that brought some discredit on them. Now this entire volume is available for all to see and comment upon.

Transparency might be important to people who played an important role in writing previous DSMs but not to most of us in the field.

Our concerns have been more about how the new DSM will change what we do each day, and how will the manual affect the treatment of people who are very sick, and need correct diagnoses and treatment in order to re-enter life.

Preparing a diagnostic and statistical manual takes a great deal of time, effort, and money, and it is one of the most important activities of the American Psychiatric Association.

We don't want big changes that will have us running to the DSM-5 on a daily basis to be sure that we know what the experts are thinking about a term we've been using for 40 or 50 years.

The power of DSM throughout the world should not be underestimated, and it is the problem for all the psychiatrists of the future—at least until the DSM-6 is written.

But the most important mission of the DSM for me is to identify mistakes and flaws, and correct the concepts that have proven to be incorrect over the last 16 years.

Psychiatric research has continued throughout that time, and new ideas, therapies, and approaches have evolved around specific diagnostic categories.

This evolutionary process is very important for the field and is taken seriously by the new set of authors brought together for the DSM-5.

Importance of the PDM

Several years ago, the Psychodynamic Diagnostic Manual (PDM) was published with Dr. Stanley Greenspan as the primary author ("Manual's Breadth May Aid Diagnosis," March 2006, p. 1). He recruited many of the senior analysts in America to help in producing the volume. The ostensible reason for all the work was Stan's feeling, shared by many, that the DSM's approach is too mechanical and mathematical, and inadequately describes the mental and emotional functioning of the patient with a given illness.

The most important mission of the DSM for me is to identify mistakes and flaws, and correct concepts that have proven to be incorrect over the last 16 years.

I think this publication, which was assembled by a committee of leaders within the American Psychoanalytic Association, the International Psychoanalytical Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, the division of psychoanalysis of the American Psychological Association, and the National Membership Comittee on Psychoanalysis in Clinical Social Work, is important.

After all, the PDM opens up a lot of ideas about what a patient with a given illness feels, thinks, and senses, and it provides a great deal of insight into the inner workings of the individual. Its approach to mental illness is dimensional rather than categorical.

I helped write a little of it, and I was shocked by the number of ways we found to describe things that go on inside of a person. None of it is in previous DSMs and most likely will not be in the DSM-5.

I suspect that in some instances, the DSM-5 changes will tighten up areas that have been too vague and difficult to nail down. The concentration on aggressive behaviors is terrific, in my opinion.

We all have evaluated and treated people with various kinds of aggressive behavior with no clear-cut category into which to put them. If the new DSM leads to research that will help us categorize such patients, it will be a blessing.

Many years ago, a couple came in to see me because the wife had taken an ax and destroyed her husband's car. There was no recognized therapy at the time that could guarantee an end to her impulsive outbursts of aggression. The borderline personality disorder diagnosis had not yet come on the scene. Now there are several places to put such patients in the diagnostic scheme, but no real in-depth understanding of why and how the behavior can be treated and stopped.

Role of Politics

What I think is important at this moment in the evolution of the DSM-5 is to realize that many of the controversies are and will be political with proponents on each side of the issue. All of us love rhetoric that seems reasonable to the reader.

One such area is parental alienation syndrome (PAS). I am personally involved in opposing the inclusion of this bit of junk science invented by a psychiatrist in the 1980s, the late Dr. Richard A. Gardner.

All of his books and most of his papers were published by his own publishing company. He protected child sexual abusers in court and was very abusive to the mothers of the children caught up in custody hearings.

Many children and mothers have been hurt by this man's beliefs, but over 15 years, he developed many converts to his beliefs, including judges, lawyers, guardians *at litem*, and psychologists who liked the neat packaging of his ideas.

In recent years, the ball has been picked up by "father's rights" groups who don't like to be interfered with when they are sexually abusing their children. This group has petitioned the DSM task force to include PAS in the publication.

This is a good example of the political activity into which DSM is drawn. The task force members want to be fair to all parties, so we are now involved in putting together data around this issue to disprove it to the DSM task force.

During the development of the DSM-IV, the question of whether homosexuality was an illness was hotly debated. In that instance, wise heads helped sort out the best route to take, and I am hopeful that the same process will be used with regard to PAS. For more information about PAS, go to the Web site of the Leadership Council on Child Abuse and Interpersonal Violence, which is www.leadershipcouncil.org.

Over the next few months, those of you who are spectators will see many battles taking place on the pages of journals and psychiatric newspapers (such as this one), as we continue to discuss and argue about issues that raise our emotional hackles and require a fight. ■

DR. FINK *is a consultant and psychiatrist in Bala Cynwyd, Pa., and professor of psychiatry at Temple University. He can be reached at cpnews@elsevier.com.*