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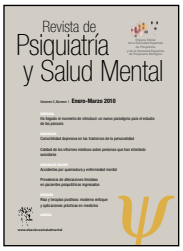

EDITORIAL

Towards New Diagnostic Systems: Process, Questions, and Dilemmas

Hacia nuevos sistemas de diagnóstico: proceso, preguntas y dilemas

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Fascinating and crucially important for many, blurred and uncertain for others, the topic of diagnosis in psychiatry is rapidly becoming a central point of interest in academic, clinical, and other circles around the world. It is well-known that two powerful entities, the American Psychiatric Association (APA) and the World Health Organization (WHO) are engaged in a collaborative effort towards new editions of their diagnostic manuals, the fifth version of APA's Diagnostic and Statistical Manual of Mental Disorders (DSM-V), and the Mental Health section of the eleventh edition of the International Classification of Diseases (ICD-11), respectively. The workgroups and committees addressing this very complex area are also trying to answer extremely interesting questions, and to solve increasingly complex dilemmas. Overall, the process is not only intellectually challenging but also socially, culturally and even politically important considering circumstances such as globalization, migration, political differences, conflicts, natural disasters, economic crisis, and many more.[1,2]

Taking the DSM-IV-TR as an example, different areas of psychiatric diagnoses face, firstly, significant limitations. It is well known that DSM-IV-TR is based primarily on descriptive diagnostic criteria, due to lack of consistent information about etiology and pathophysiology of mental disorders; however, the criteria are a mix of symptoms and behavioral features leading to diagnostic systems based on ubiquitous "expert consensus."[3] Furthermore, there are unclear relationships between validity, severity, disability, and some desirable quantitative aspects of diagnoses. The delineation of "cross-cutting points" in terms of severity, for instance, would face extremely conflicting opinions at different points of the clinical spectra[4] advocated for use in all the main groups of mental disorders.

There is, on the other hand, an increasing acceptance of the fact that, in spite of significant advances in the neuroscientific bases of mental disorders, well-defined biological markers are currently not available in clinical psychiatry. Several decades will still pass for this to happen.[5] This, together with a well-recognized lack of pathognomonic signs or symptoms in psychiatry, has led to clinical realities such as high comorbidity levels, excessive numbers of "Not Otherwise Specified (NOS)" diagnoses, heterogeneity among patients who supposedly carry the same labels, and a clinical course that, because of the way the diagnostic process goes on, can appear to be predetermined and artificial.[6] Under these circumstances, the differential diagnosis, an essential clinical exercise in a good practice, may be difficult and confusing.

The current multiaxial approach does not capture all of the main components of the diagnostic categories. The entities identified at the diagnostic encounter can

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also be different according to age and a number of developmental variables that, for reasons of convenience, may be ignored: the diagnosis, therefore, is the result of an eminently cross-cutting, not longitudinal consideration.[7] To complicate matters, the absence of, or weaknesses in the assessment of socio-cultural components adds a significant gap in the diagnostic process.[8,9] A psychiatric diagnosis, unlike its equivalents in other branches of medicine, does not offer the possibility of unequivocal "target symptoms" for treatment due, among other reasons, to an absent or useless criterion of clinical response. The damaging result of all this is the abuse of polypharmacy, a practice that reflects what many would, unfairly, consider the irrelevance of diagnosis in psychiatry.[10]

The negative consequences of a deficient diagnostic system are manifold. Together with an emphasis on the most frequently studied clinical features of any condition, a failure in current psychiatric education programs is the use of the diagnostic manuals as if they were textbooks of clinical psychiatry, which leads to a reification of diagnostic criteria as "sacred principles," and the above-mentioned excessive comorbidity and polypharmacy phenomena. Clinical epidemiological studies of many origins do offer similarities but more than anything else, significant variations that interfere with a better organized diagnostic approach in a given population. That cultural differences of the original samples decisively contribute to these findings has only been paid token attention, covered up by statements on "ethnic and racial considerations."[11] Clinical subtypes, subthreshold conditions, and the subjective, unstable, and non-empirical invocation of old and new criteria contribute to a knowledge that is heterogenous, different even within the same country or world region, confusing and, in many cases, arbitrary.

The objectives being pursued by individuals and groups working on the new diagnostic systems emphasize greater focus on diagnostic validity, a system based on pathogenesis, an emphasis on neurobiological components and dimensional approaches, the clear inclusion and acceptance of public health and social/cultural perspectives, an inter-institutional and international collaboration, and, last but not least, the promotion of research in areas equally oriented towards clear diagnosis and more effective treatments.[12,13] In this context, the use of "evidence-based" literature findings to sustain any new changes or innovations in the systems is, of course, welcomed by everybody, as it is well-intentioned and heuristically solid.[14] Its "twin" concept, outcomes research, is also invoked repeatedly in the deliberations. Risk and protective factors, quality of life, environmental co-variables (as precipants or modifiers), developmental issues, gender and culture, and the like are repeatedly mentioned. There must be discussions about the definition of mental disorder, the fate of the multiaxial system, the total number of clinical entities to be included at the end of the process, the incorporation of the patient's subjective experience, the clinical utility of the new manuals, and what to do with information that is intuited, known by experienced clinicians, but due to a variety of reasons, not necessarily included as "evidence" in the literature.[15-17] The declaration that "the absence of evidence is not evidence of absence" resonates deeply in many clinical circles.

One of the central debates is what to do with the existing categorical model of diagnosis, and what the prospects are related to the strength of its antithesis, the dimensional model. It is well known that the categorical approach entails a precise, specific, and well-described set of symptoms and signs. Disability and distress are not intended to be part of the underlying clinical entity, and the diagnostic threshold does not necessarily have to be too high. Its main virtue, according to its advocates, but also its main defect, according to its critics, is that the categorical model is a "black or white," "yes or no" type of approach. The descriptive diagnostic criteria do not necessarily provide information about the etiology and pathophysiology of mental disorders; in efforts to be "thorough," the clinician may explore an inordinate number of areas and come up with numerous comorbid entities that do not necessarily reflect the clinical reality of any given patient.[18]

For the dimensional model, in turn, disability and distress are essential factors, the dimensions entail broadly encompassing aspects or areas of clinical significance, and the diagnostic threshold must be as high as necessary to have predictive value.[19] From a biological perspective, there should be either a large number of genes interacting with environmental precipitants, or several levels of penetrance, numbers of polymorphisms, and other variants that, even if identified, can make the management extremely difficult.[20] Similarly, the assessment of dimensions using long trait sets can make the task rather complex with subsequent potential logistic difficulties in clinical practice. With all its potential and even significant advantages, the dimensional model, however, shows still a somewhat scarce empirical evidence; the use of multiple scales and other instruments for treatment and clinical response can make the evaluation and management a rather onerous task.

Aware of the advantages and disadvantages, virtues and defects of the two models, the common sense solution would be a compromise between the two of them. A combination (hybrid model) of the categorical and dimensional approaches would include correlates of clinical significance, allow a gradual, clear identification of entities from the dimensional to the categorical, would make possible a better definition of endophenotypes, and treatment indications closely related to the severity of the condition and the competence of the provider.[21] It would also lead to joint research efforts that could help identify common neurobiological bases for different disorders, at a syndromic (or endophenotypical) level, therefore minimizing, or at least reducing the possibility of clinical heterogeneities. This is, indeed, the greatest challenge nowadays. Whether DSM-V and ICD-11 are similar enough to, eventually, lead to the adoption of a global diagnostic system,[22] or whether there are national or regional systems with elements common to core manifestations, but respecting of social and cultural differences in the etiopathogenesis and symptomology of any condition, the important thing is to abate clinical language differences, use similar and comparable measurement instruments, and reach an objective assessment of outcomes --this all, a prelude of the overall improvement of the patient's quality of life. Such are the ambitious but fair aspirations of

citizens and professionals, families, communities, nations, and the world at large.

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