Esquizofrenia no DSM IV – categorial ou dimensional

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Conflitos de Interesse

	Research Grants	Speaker/ Board	Shareholder
Private Companies			
Astra Zeneca		*	
Janssen	*	*	
Eli Lilly	*	*	
Lundbeck	*	*	
Novartis	*	*	
Roche	*		
Radiopharmacus Ltda.			*
Biomolecular Technology Ltda.			*
Research Agencies			
FAPESP	*		
CNPq	*		
CAPES	*		
Fundação Safra	*		
Fundação ABADS	*		

DSM-V

- designed to better **reflect scientific advances** in our understanding of psychiatric disorders
- to make **diagnosis easier** and more **clinician-friendly**

Proposed DSM-5 Organizational Structure

- Neurodevelopmental Disorders
- **Schizophrenia Spectrum and Other Psychotic Disorders**
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom Disorders
- Feeding and Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control, and Conduct Disorders
- Substance Use and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilias
- Other Disorders

DSM-V: Schizophrenia Spectrum and other Psychotic Disorders

- This proposal is under examination as part of the DSM-5 Field Trials, and the work group hopes to gather significant feedback from the public about this recommendation.
- We appreciate your review and comment on these disorders.

- B 00 Schizophrenia
- B 01 Schizotypal Personality Disorder
- B 02 Schizophreniform Disorder
- B 03 Brief Psychotic Disorder
- B 04 Delusional Disorder
- B 05 Schizoaffective Disorder
- B 06 Attenuated Psychosis Syndrome
- B 07-14 Substance-Induced Psychotic Dis.
- B 15 Psychotic Dis Ass. Gen. Medical Cond.
- B 16 Catatonic Dis Ass. Gen. Medical Cond.
- B 17 Other Specified Psychotic Disorder
- B 18 Unspecified Psychotic Disorder
- B 19 Unspecified Catatonic Disorder

Chair: William Carpenter, M.D

Members:

- Carpenter, William T., Jr., M.D.
- Barch, Deanna, Ph.D.
- Bustillo, Juan R., M.D.
- Gaebel, Wolfgang, M.D.
- Gur, Raquel E., M.D., Ph.D.
- Heckers, Stephan H., M.D.
- Malaspina, Dolores, M.D., M.S.P.H.
- Owen, Michael, Ph.D., M.D.
- Schultz, Susan K., M.D.
- Tandon, Rajiv, M.D.
- Tsuang, Ming T., M.D., Ph.D
- Van Os, Jim, M.D

Histórico do Conceito

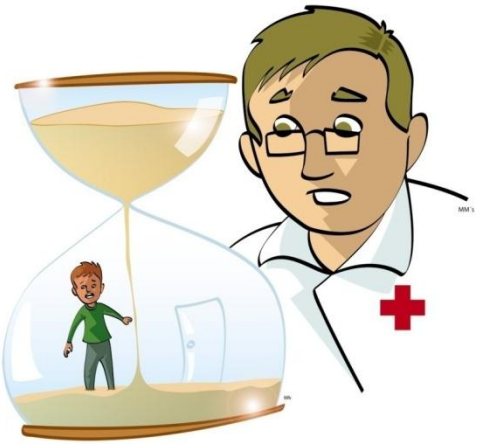
- Emil Kraepelin (1893) – Dementia Praecox *vs.* *Psicose Maníaco Depressiva*
- Eugen Bleuler (1911) – Grupo das Esquizofrenias
- Kurt Schneider (1959) – Sintomas de Primeira Ordem
- T. Crow (1980) – Síndrome Positiva e Negativa

Kraepelin, Tratado de Psiquaitria, 4ª Ed, 1893; Bleuler, O Grupo da Esquizofrenias 1911;
Schneider, Clinical Psychopathology 1959; Crow, Br J Psychiatry 1980

Critérios Diagnósticos Operacionais

DSM IV e CID 10

- Delírios / Alucinações
- Desagregação do Pensamento
- Sintomas Negativos
- Prejuízo do funcionamento social
- Duração: ≥6 meses *vs.* ≥1 mês



American Psychiatric Association, 1994; World Health Organization, 1992

Categorial vs. Dimensional

SAÚDE

DOENÇA

Glicemia de Jejum = 90g/dL

DSM-V: Schizophrenia

A. Characteristic symptoms: 2 symptoms, for a significant portion of time during a 1-month period (or less if successfully treated). At least one include 1-3

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly abnormal psychomotor behavior, such as catatonia
5. Negative symptoms, i.e., restricted affect or avolition/asociality

B. Social/occupational dysfunction:

- For a significant portion of the time since the onset of the disturbance
- One or more major areas of functioning (work, interpersonal, or self-care are markedly below the level achieved prior to the onset)

C. Duration: Continuous signs of the disturbance persist for at least 6 months:

- At least 1 month of symptoms (or less if successfully treated) that meet Criterion A (active-phase symptoms)
- May include periods of prodromal or residual symptoms manifested by only negative symptoms or two or more attenuated symptoms (odd beliefs, unusual perceptual experiences)

DSM-V Rationale

Criterion A (Five characteristic symptoms)

•Removal of disorganized behavior from grossly disorganized and catatonic behavior

•Clarification of **negative symptoms**:

- Flat affect → Restricted affect
- Avolition/asociality - distinguishable dimension

•Elimination of requirement that only 1 characteristic symptom need be present if that is a bizarre delusion or a Schneiderian first-rank symptom hallucination.

•Schizophrenia is a psychotic disorder and psychosis is defined by reality distortion (**delusions** and **hallucinations**) and severe disorganization (**disorganized speech**).

•We considered adding **cognitive impairment** – refused due to lack of specificity. Considered a key aspect of schizophrenic psychopathology, recommended as one key dimension to be measured across patients with a psychotic disorder.

DSM-V: Schizophrenia

No changes in criteria B-F are recommended

- Criterion B (**social and occupational dysfunction**) – Considered elimination, but NO because of the absence of compelling data.
- Criterion C (**duration**). Reduction the required duration from 6 months to 1 month (~ICD), but NO to get greater diagnostic stability.
- Criterion D (**schizoaffective disorder and mood disorder exclusion**) – Retaining this exclusion but have recommended revisions in the criteria for schizoaffective disorder in an effort to better demarcate that condition.
- Criterion E (**substance/general medical disorder exclusion**) - NO changes
- Criterion F (**pervasive developmental disorder**) - Considered elimination (~ICD), but NO due to absence of data

DSM-V: Schizophrenia

D. Schizoaffective and Mood Disorder exclusion: have to be ruled out!

- (1) no Major Depressive or Manic Episodes have occurred concurrently with the active phase symptoms
- (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion:

- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder:

- History of Autistic Disorder or another Pervasive Developmental Disorder or other communication disorder of childhood onset
- Additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

DSM-IV Schizophrenia Subtypes…

295.30 Paranoid Type

295.10 Disorganized Type

295.20 Catatonic Type

295.90 Undifferentiated Type

295.60 Residual Type

Episodic With Interepisode Residual Symptoms. This specifier applies when the course is characterized by episodes in which Criterion A for Schizophrenia is met and there are clinically significant residual symptoms betweenthe episodes. **With Prominent Negative Symptoms** can be added if prominent negative symptoms are present during these residual periods.
Episodic With No Interepisode Residual Symptoms.
This specifier applies when the course is characterized by episodes in which Criterion A for Schizophrenia is met and there are no clinically significant residual symptoms between the episodes.
Continuous. This specifier applies when characteristic symptoms of Criterion A are met throughout all (or most) of the course. **With Prominent Negative Symptoms** can be added if prominent negative symptoms are also present.
Single Episode In Partial Remission. This specifier applies when there has been a single episode in which Criterion A for Schizophrenia is met and some clinically significant residual symptoms remain. **With Prominent Negative Symptoms** can be added if these residual symptoms include prominent negative symptoms.
Single Episode In Full Remission. This specifier applies when there has been a single episode in which Criterion A for Schizophrenia has been met and no clinically significant residual symptoms remain.
Other or Unspecified Pattern. This specifier is used if another or an unspecified course pattern has been present.

Dimensional Assessment of Symptoms

Logic and Justification

•Heterogeneity of the symptoms, variability across individuals

•Poor boundaries between nosological entities (≠ Kraepelin, 1971) – common dimensions of genetic variation, human behavior and neurobiological function *(Owen et al. 2007)*

•Dimensional assessments of all Criterion A symptoms:

- help diagnosticians make reliable decisions
- help clinicians attend to the clinically meaningful variation in the severity of these symptoms
- help with treatment planning, prognostic decision making, and research on pathophysiological mechanisms. ”

Dimensions

- 0-4 scale cross-sectionally (past month): - treatment-response, - prognostic implications, - course.
- The relative severity of symptoms across these domains varies across th ss and among patients.

	Hallucination	Delusions	Disorganization	Abnormal Psychomot or Be	Restricted E				ania
0	Not Present	Not Present	Not Present						esent
1	Equivocal	Equivocal							ivocal
2					xpressivity, prosody	ut mild in self-initiated behavior	Present, but mild	Present, but mild	Present, but mild
3	Pr mo			Present and moderate	Present and moderate decrease in facial expressivity, prosody	Present and moderate in self-initiated behavior	Present and moderate	Present and moderate	Present and moderate
4	Present and severe	Present and severe	Present and severe	Present and severe	Present and severe decrease in facial expressivity, prosody	Present and severe in self-initiated behavior	Present and severe	Present and severe	Present and severe

- **This is a major change that will potentially be of great clinical value and will also be of additional research utility.**

Cognitive function

- Important for understanding **functional status**, as well as other psychotic disorders, including bipolar
- Cognitive deficits **are not well treated** by current antipsychotic medications
- Highlight the potential **need for additional treatments** specifically targeting cognitive remediation
- We will be recommending that it is optimal to **obtain a formal neuropsychological** assessment in individuals with psychosis to fully understand the nature and severity of their cognitive impairments.
- Recommending: clinicians conduct a brief the **Digit Symbol Substitution Test** (under 5 minutes): are highly reliable, and are strong predictors of cognitive impairments

Dimensions

Depression and Mania

- There is growing evidence that schizoaffective disorder does not represent a distinct nosological category separate form schizophrenia (e.g., Malhi et al. 2008; Owen et al. 2007; Peralta and Cuesta 2009).
- Good evidence that the severity of the mood pathology – prognosis and outcome (Bowie et al. 2006; Crumlish et al. 2005)
- Treatments specifically targeting these mood symptoms (e.g., Addington et al. 1998; Peralta and Cuesta 2009)
- Serve to alert clinicians to look for the presence of mood pathology and treat it were appropriate.

Dimensões psicopatológicas

S. Positivos
Delírios
Alucinações

Desorganização
Transtorno do Pensamento

S. Negativos
Déficit Afetivo
Alogia
Abulia
Anedonia

S. Cognitivos
Déficit atenção
Déficit memória
Déficit funções executivas

Humor/Ansiedade
Depressão/Exaltação
Ansiedade (TOC)

Liddle et al., Br J Psychiatry 1987; Lindenmyer et al., Schizophr Res 1995

EA: Psicoeducação

S. Positivos
Delírios
Alucinações

Gabriel

Desorganização
Transtorno do Pensamento

S. Negativos
Déficit Afetivo

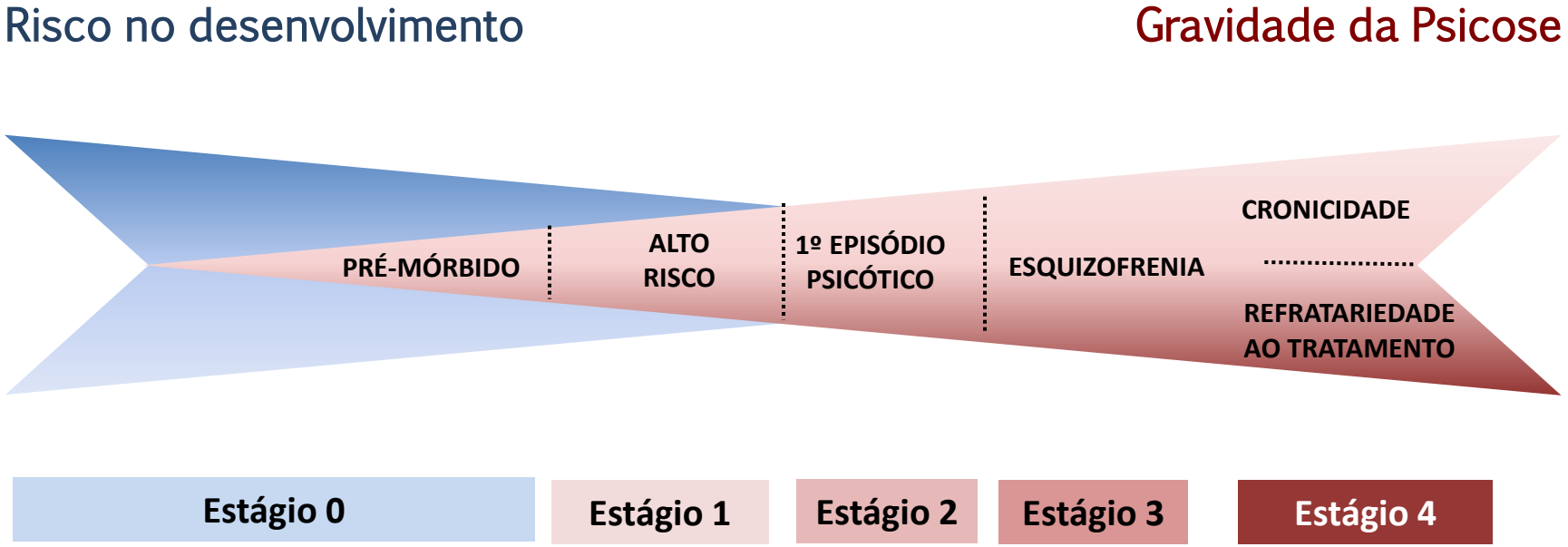
Esquizofrenia

S. Cognitivos

Humor/Ansiedade
Depressão/Exaltação

Assis, Villares, Bressan, Entre a Razão e a Ilusão 2008

Estadiamento da Esquizofrenia



Novidade

- Prodromal phase → Ultra High Risk phase
- This can be defined using standardised diagnostic criteria

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

The case for including Attenuated Psychotic Symptoms Syndrome in DSM-5 as a psychosis risk syndrome

Scott W. Woods*, Barbara C. Walsh, John R. Saksa, Thomas H. McGlashan

Why Mind?
Prevention of Psychiatric Disorders

Y-MIND

CENTER FOR PREVENTION
OF MENTAL DISORDERS

IX Congresso Brasileiro
de Psicopedagogia da ABPp

I Simpósio Internacional
de Neurociências, Saúde Mental e Educação

Diálogos entre **neurociências, saúde mental e educação.**

De 5 a 8 de julho de 2012 - São Paulo

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PROESQ
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PRISMA
PAPIA
PROGRAMA DE ATENÇÃO A PSICOSE NA INFÂNCIA E ADOLESCIÊNCIA
Itiro Shirakawa
Homenagem ao nosso mestre
08/12/2009

HIPÓTESE

Bloqueio NMDA

↓

Diminuição da atividade da nNOS

↓

Decréscimo nos níveis de NO

↓

Efeitos induzidos por PCP/Psicoses

DSM-V Rationale

- Dimensions of schizophrenic psychopathology have been further clarified.
- The boundaries with schizoaffective disorder are better defined
- Recommendation to eliminate subtypes and instead utilize dimensions
- Better delineate variations in course of schizophrenia is made

Acta Psychiatr Scand. 2009 Nov;120(5):363-72.

'Salience syndrome' replaces 'schizophrenia' in DSM-V and ICD-11: psychiatry's evidence-based entry into the 21st century?

van Os J.

Source

Department of Psychiatry and Neuropsychology, South Limburg Mental Health Research and Teaching Network, EURON, Maastricht University Medical Centre, Maastricht, the Netherlands. j.vanos@sp.unimaas.nl

Abstract

OBJECTIVE:

Japan was the first country to abandon the 19th century term of 'mind-splitting disease' (schizophrenia). Revisions of DSM and ICD are forthcoming. Should the rest of the world follow Japan's example?

METHOD:

A comprehensive literature search was carried out in order to review the scientific evidence for the validity, usefulness and acceptability of current concepts of psychotic disorder.

RESULTS:

The discussion about re-classifying and renaming schizophrenia and other psychotic disorders is clouded by conceptual confusion. First, it is often misunderstood as a misguided attempt to change societal stigma instead of an attempt to change iatrogenic stigma occasioned by the use of misleading and mystifying terminology. Second, the debate is misunderstood as purely semantic, whereas in actual fact it is about the core concepts underlying psychiatric nosology. Third, it has been suggested that the debate is political. However, solid scientific evidence pointing to the absence of nosological validity of diagnostic categories lies at the heart of the argument. Fourth, there is confusion about what constitutes a syndrome (a group of symptom dimensions that cluster in different combinations in different people and for which one or more underlying diseases may or may not be found) and a disease (a nosologically valid entity with specific causes, symptoms, treatment and course).

CONCLUSION:

Scientific evidence favours a syndromal system of classification combining categorical and dimensional representations of psychosis. The concept of 'salience' has the potential to make the public recognize psychosis as relating to an aspect of human mentation and experience that is universal. It is proposed to introduce, analogous to the functional-descriptive term 'Metabolic syndrome', the diagnosis of 'Salience syndrome' to replace all current diagnostic categories of psychotic disorders. Within Salience syndrome, three subcategories may be identified, based on scientific evidence of relatively valid and specific contrasts, named Salience syndrome with affective expression, Salience syndrome with developmental expression and Salience syndrome not otherwise specified.

Psychol Med. 2009 Dec;39(12):1943-55. Epub 2009 Jul 23.

Combining dimensional and categorical representation of psychosis: the way forward forDSM-V and ICD-11?

Demjaha A, Morgan K, Morgan C, Landau S, Dean K, Reichenberg A, Sham P, Fearon P, Hutchinson G, Jones PB, Murray RM, Dazzan P.

Source

Division of Psychological Medicine, Institute of Psychiatry, King's College, London, UK. a.demjaha@iop.kcl.ac.uk

Abstract

BACKGROUND:

There is good evidence that psychotic symptoms segregate into symptom dimensions. However, it is still unclear how these dimensions are associated with risk indicators and other clinical variables, and whether they have advantages over categorical diagnosis in clinical practice. We investigated symptom dimensions in a first-onset psychosis sample and examined their associations with risk indicators and clinical variables. We then examined the relationship of categorical diagnoses to the same variables.

METHOD:

We recruited 536 patients as part of a population-based, incidence study of psychosis. Psychopathology was assessed using the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). A principal axis factor analysis was performed on symptom scores. The relationship of dimension scores with risk indicators and with clinical variables was then examined employing regression analyses. Finally, regression models were compared to assess the contribution of dimensions versus diagnosis in explaining these variables.

RESULTS:

Factor analysis gave rise to a five-factor solution of manic, reality distortion, negative, depressive and disorganization symptom dimensions. The scores of identified dimensions were differentially associated with specific variables. The manic dimension had the highest number of significant associations; strong correlations were observed with shorter duration of untreatedpsychosis, acute mode of onset and compulsory admission. Adding dimensional scores to diagnostic categories significantly increased the amount of variability explained in predicting these variables; the reverse was also true but to a lesser extent.

CONCLUSIONS:

Categorical and dimensional representations of psychosis are complementary. Using both appears to be a promising strategy in conceptualising psychotic illnesses.

Schizophr Bull. 2007 Jul;33(4):912-20. Epub 2007 Jun 13.

How should DSM-V criteria for schizophrenia include cognitive impairment?

Keefe RS, Fenton WS.

Source

Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Box 3270, Durham, NC 27710, USA. richard.keefe@duke.edu

Abstract

Neurocognitive impairment is considered a core component of schizophrenia and is increasingly under investigation as a potential treatment target. On average, cognitive impairment is severe to moderately severe compared with healthy controls, and almost all patients with schizophrenia demonstrate cognitive decrements compared with their expected level if they had not developed the illness. Compared with patients with affective disorders, cognitive impairment in schizophrenia appears earlier, is more severe, and tends to be more independent of clinical symptoms. While the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, description of schizophrenia includes several references to cognitive impairment, neither the diagnostic criteria nor the subtypology of schizophrenia include a requirement of cognitive impairment. We forward for consideration a proposal that the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria include a specific criterion of "a level of cognitive functioning suggesting a consistent severe impairment and/or a significant decline from premorbid levels considering the patient's educational, familial, and socioeconomic background." The inclusion of this criterion may increase the "point of rarity" with affective psychoses and may increase clinicians' awareness of cognitive impairment, potentially leading to more accurate prognosis and better treatment outcomes. Future research will need to address the validity of these possibilities. The reliable determination of cognitive impairment as part of a standard diagnostic evaluation may present challenges to diagnosticians with limited resources or insufficient expertise. Various cognitive assessment methods for clinicians, including brief assessments and interview-based assessments, are discussed. Given the current emphasis on the development of cognitive treatments, the evaluation of cognition in schizophrenia is an essential component of mental health education.

Schizophr Bull. 2010 Jan;36(1):36-42. Epub 2009 Sep 23.

Cognitive impairment in schizophrenia and affective psychoses: implications for DSM-Vcriteria and beyond.

Bora E, Yücel M, Pantelis C.

Source

Melbourne Neuropsychiatry Centre, Department of Psychiatry, The University of Melbourne and Melbourne Health, Alan Gilbert Building NNF Level 3, Carlton 3053, Australia. boremre@gmail.com

Abstract

It has recently been suggested that the diagnostic criteria of schizophrenia should include specific reference to cognitive impairments characterizing the disorder. Arguments in support of this assertion contend that such inclusion would not only serve to increase the awareness of cognitive deficits in affected patients, among both clinicians and researchers alike, but also increase the "point of rarity" between schizophrenia and mood disorders. The aim of the current article is to examine this latter assertion in light of the recent opinion piece provided by Keefe and Fenton (Keefe RSE, Fenton WS. How should DSM-V criteria for schizophrenia include cognitive impairment? Schizophr Bull. 2007;33:912-920). Through literature review, we explore the issue of whether cognitive deficits do in fact differentiate the major psychoses. The overall results of this inquiry suggest that inclusion of cognitive impairment criteria in Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (DSM-V) would not provide a major advancement in discriminating schizophrenia from bipolar disorder and affective psychoses. Therefore, while cognitive impairment should be included in DSM-V, it should not dictate diagnostic specificity--at least not until more comprehensive evidence-based reviews of the current diagnostic system have been undertaken. Based on this evidence, we consider several alternatives for theDSM-V definition of cognitive impairment in schizophrenia, including (1) the inclusion of cognitive impairment as a specifier and (2) the definition of cognitive impairment as a dimension within a hybrid categorical-dimensional system. Given the state of current evidence, these possibilities appear to represent the most parsimonious approaches to the inclusion of cognitive deficits in the diagnostic criteria of schizophrenia and, potentially, of mood disorders.

Fase Pré-Mórbida

- Déficit Cognitivo
  - ↓ QI baixo, ↓ Rendimento Escolar
  - Dificuldades de Linguagem
- Traços de Personalidade
  - ↓ Afetivo ou ↑ Ansiedade Social
  - ↑ Sensibilidade ou ↑ Suspeição
- Dificuldade Comportamentais
  - Isolamento social
  - Dificuldade Interpessoal
  - Crenças Pouco Usuais (idiossincráticas)

Jones et al., Lancet,1994; Poulton et al,. Arch Gen Psychiatry 2000

Estado da Arte – Tratamento

- Remissão → Recuperação → Empoderamento

Reconhecimento Precoce

- Baixa Adesão → Medicação de Depósito
- Refratariedade → Clozapina

Estágios Precoces

Diagnóstico Psiquiátrico

Psychological Medicine (2010), **40**, 1759–1765.
doi:10.1017/S0033291709992261

EDITORIAL

What is a mental/psychiatric disorder? From DSM-IV to DSM-V

D. J. Stein[1]*, K. A. Phillips[2], D. Bolton[3], K. W. M. Fulford[4], J. Z. Sadler[5] and K. S. Kendler[6]

Table 2. *DSM-V proposal for the definition of mental/psychiatric disorder*

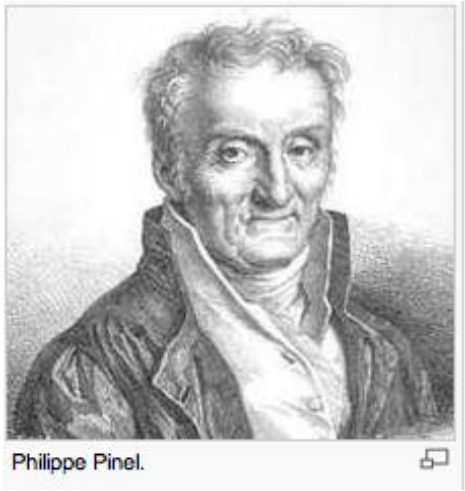
Features	
A	A behavioral or psychological syndrome or pattern that occurs in an individual
B	The consequences of which are clinically significant distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning)
C	Must not be merely an expectable response to common stressors and losses (e.g. the loss of a loved one) or a culturally sanctioned response to a particular event (e.g. trance states in religious rituals)
D	That reflects an underlying psychobiological dysfunction
E	That is not primarily a result of social deviance or conflicts with society
Other considerations	
F	That has diagnostic validity on the basis of various diagnostic validators (e.g. prognostic significance, psychobiological disruption, response to treatment)
G	That has clinical utility (e.g. contributes to better conceptualization of diagnoses, or to better assessment and treatment)
H	No definition perfectly specifies precise boundaries for the concept of either 'medical disorder' or 'mental/psychiatric disorder'
I	Diagnostic validators and clinical utility should help to differentiate a disorder from diagnostic 'nearest neighbors'
J	When considering whether to add a mental/psychiatric condition to the nomenclature or delete a mental/psychiatric condition from the nomenclature, potential benefits (e.g. provide better patient care, stimulate new research) should outweigh potential harms (e.g. hurt particular individuals, be subject to misuse)

Diagnóstico Psiquiátrico

A Escola Francesa do século 19

- *Annales Medico-Psychologiques* (1843):

- ✓ Mania
- ✓ Hipomania
- ✓ Monomania
- ✓ Dementia
- ✓ Paralytic Insanity
- ✓ Idiocy


Philippe Pinel.

Berrios, 2009

Diagnóstico Psiquiátrico

A escola Alemã dos séculos 19 e 20:

- Psicose Maníaco Depressiva & Demência Precoce
- Fenomenologia
- Fundamento para a Psicopatologia Moderna

Berrios, 2009

Diagnóstico Psiquiátrico: Desafios do Presente

BJPsych | The British Journal of Psychiatry (2009)
195, 382–390. doi: 10.1192/bjp.bp.108.060822

Special article

Harmonisation of ICD–11 and DSM–V: opportunities and challenges†

Michael B. First

Background
Differences in the ICD–10 and DSM–IV definitions for the same disorder impede international communication and research efforts. The forthcoming parallel development of DSM–V and ICD–11 offers an opportunity to harmonise the two classifications.

Aims
This paper aims to facilitate the harmonisation process by identifying diagnostic differences between the two systems.

Method
DSM–IV–TR criteria sets and the ICD–10 *Diagnostic Criteria for Research* were compared and categorised into those with identical definitions, those with conceptually based differences and those in which differences are not conceptually based and appear to be unintentional.

Results
Of the 176 criteria sets in both systems, only one, transient tic disorder, is identical. Twenty-one per cent had conceptually based differences and 78% had non-conceptually based differences.

Conclusions
Harmonisation of criteria sets, especially those with non-conceptually based differences, should be prioritised in the DSM–V and ICD–11 development process. Prior experience with the DSM–IV and ICD–10 harmonisation effort suggests that for the process to be successful steps should be taken as early as possible.

Declaration of interest
M. F. consults with pharmaceutical companies to provide diagnostic training for clinical trials. In the past 12 months, he has consulted with AstraZeneca, Eli Lilly, Cephalon, Wyeth, Roche, Novartis, Glaxo SmithKline, Memory Pharmaceuticals and Medavante.

Diagnóstico Psiquiátrico: Desafios do Presente

THE JOURNAL OF
CHILD PSYCHOLOGY AND PSYCHIATRY
ACAMH
Journal of Child Psychology and Psychiatry 49:3 (2008), pp 237–250 doi:10.1111/j.1469-7610.2007.01854.x

Psychiatric diagnosis – is it universal or relative to culture?

Glorisa Canino[1] and Margarita Alegría[2]
[1]University of Puerto Rico Medical School, Puerto Rico, USA; [2]Harvard Medical School, USA

Background: There is little consensus on the extent to which psychiatric disorders or syndromes are universal or the extent to which they differ on their core definitions and constellation of symptoms as a result of cultural or contextual factors. This controversy continues due to the lack of biological markers, imprecise measurement and the lack of a gold standard for validating most psychiatric conditions. **Method:** Empirical studies were used to present evidence in favor of or against a universalist or relativistic view of child psychiatric disorders using a model developed by Robins and Guze to determine the validity of psychiatric disorders. **Results:** The prevalence of some of the most common specific disorders and syndromes as well as its risk and protective factors vary across cultures, yet comorbid patterns and response to treatments vary little across cultures. Cross-cultural longitudinal data on outcomes is equivocal. **Conclusions:** The cross-cultural validity of child disorders may vary drastically depending on the disorder, but empirical evidence that attests for the cross-cultural validity of diagnostic criteria for each child disorder is lacking. There is a need for studies that investigate the extent to which gene–environment interactions are related to specific disorders across cultures. Clinicians are urged to consider culture and context in determining the way in which children's psychopathology may be manifested independent of their views. Recommendations for the upcoming classificatory system are provided so that practical or theoretical considerations are addressed about how culture and ethnic issues affect the assessment or treatment of specific disorders in children. **Keywords:** Child psychiatric diagnosis, cultural differences, universalist approach, relativistic approach.

Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys

The WHO World Mental Health Survey Consortium*

ALTHOUGH SURVEYS OF MENtal disorders have been carried out since the end of World War II,[1-3] cross-national comparisons were hampered by inconsistencies in diagnostic methods. This situation changed in the 1980s with the development of the Diagnostic Interview Schedule (DIS), the first psychiatric diagnostic interview designed for use by lay interviewers.[4] The DIS was initially used in the US Epidemiologic Catchment Area (ECA) Study and subsequently in similar surveys carried out in other countries in the 1980s.[5-8] The results were brought together in the early 1990s in a series of important cross-national articles that showed mental disorders to be highly prevalent.[9-12] Indeed, prevalence of mental disorder was generally higher than that of any other class of chronic conditions.[13,14] This was striking in light of research documenting that mental disorders have greater effects on role functioning than many serious chronic

Context Little is known about the extent or severity of untreated mental disorders, especially in less-developed countries.

Objective To estimate prevalence, severity, and treatment of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* mental disorders in 14 countries (6 less developed, 8 developed) in the World Health Organization (WHO) World Mental Health (WMH) Survey Initiative.

Design, Setting, and Participants Face-to-face household surveys of 60 463 community adults conducted from 2001-2003 in 14 countries in the Americas, Europe, the Middle East, Africa, and Asia.

Main Outcome Measures The *DSM-IV* disorders, severity, and treatment were assessed with the WMH version of the WHO Composite International Diagnostic Interview (WMH-CIDI), a fully structured, lay-administered psychiatric diagnostic interview.

Results The prevalence of having any WMH-CIDI/*DSM-IV* disorder in the prior year varied widely, from 4.3% in Shanghai to 26.4% in the United States, with an interquartile range (IQR) of 9.1%-16.9%. Between 33.1% (Colombia) and 80.9% (Nigeria) of 12-month cases were mild (IQR, 40.2%-53.3%). Serious disorders were associated with substantial role disability. Although disorder severity was correlated with probability of treatment in almost all countries, 35.5% to 50.3% of serious cases in developed countries and 76.3% to 85.4% in less-developed countries received no treatment in the 12 months before the interview. Due to the high prevalence of mild and subthreshold cases, the number of those who received treatment far exceeds the number of untreated serious cases in every country.

Conclusions Reallocation of treatment resources could substantially decrease the problem of unmet need for treatment of mental disorders among serious cases. Structural barriers exist to this reallocation. Careful consideration needs to be given to the value of treating some mild cases, especially those at risk for progressing to more serious disorders.

JAMA. 2004;291:2581-2590 www.jama.com

Diagnóstico Psiquiátrico: Desafios do Presente

J Med Philos. 2011 Apr;36(2):187-205. Epub 2011 Feb 28.

Whose disorder?: a constructive MacIntyrean critique of psychiatric nosology.

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Abstract

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) has for decades been a locus of dispute between ardent defenders of its scientific validity and vociferous critics who charge that it covertly cloaks disputed moral and political judgments in scientific language. This essay explores Alasdair MacIntyre's tripartite typology of moral reasoning--"encyclopedia," "genealogy," and "tradition"--as an analytic lens for appreciation and critique of these debates. The DSM opens itself to corrosive neo-Nietzschean "genealogical" critique, such an analysis holds, only insofar as it is interpreted as a presumptively objective and context-independent encyclopedia free of the contingencies of its originating communities. A MacIntyrean tradition-constituted understanding of the DSM, on the other hand, helpfully allows psychiatric nosology to be understood both as "scientific" and, simultaneously, as inextricable from the political and moral interests--and therefore the moral successes and moral failures--of the psychiatric guild from which it arises.

DSM-V Draft Released, Pharmaceutical Industry Influence Questioned

February 16, 2010 by healthscitechadmin

By Mark Griffin

Last week, the American Psychiatric Association released its draft of the next Diagnostic and Statistical Manual of Mental Disorders, better known as the DSM. As The Economist astutely notes:

> "Mental illness carrying the stigma that it does, and the brain being as little-understood as it is, revising the DSM is always a controversial undertaking."

Diagnóstico Psiquiátrico: Desafios do Presente

- **O prejuízo deve fazer parte do diagnóstico?**

✓ DSM-IV: O prejuízo está presente dentro dos critérios diagnósticos para a maioria dos transtornos mentais

- Trava para aumento da prevalência

✓ Confusão entre prejuízo e psicopatologia descritiva

✓ Não há equivalência na Medicina

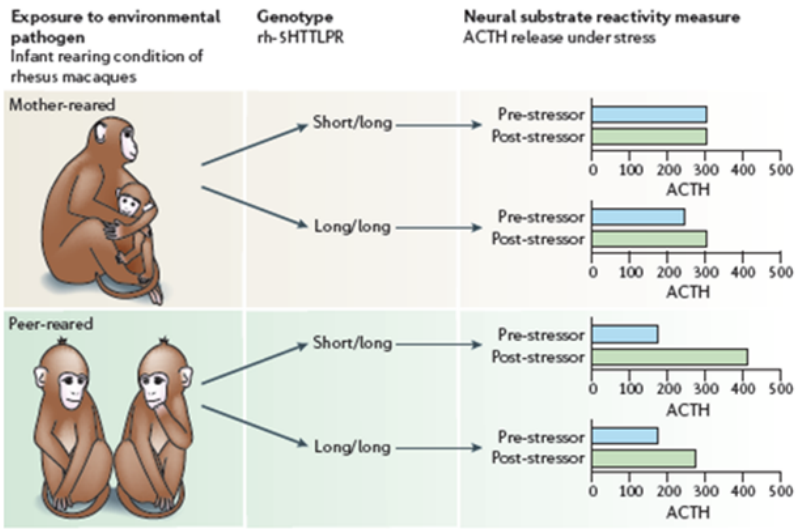
✓ Definição de prejuízo: média populacional vs. potencialidade individual

Ro & Clark, 2009

Diagnóstico Psiquiátrico: Desafios do Presente

- ✓ Diagnóstico baseado em checklists: o esquecimento da psicopatologia fundamental
- ✓ Balança **CÉREBRO**/mente: diagnóstico descontextualizado

Interação Gene x Ambiente



Caspi & Moffitt ,Nature Reviews Neuroscience ,2006

Epigenética

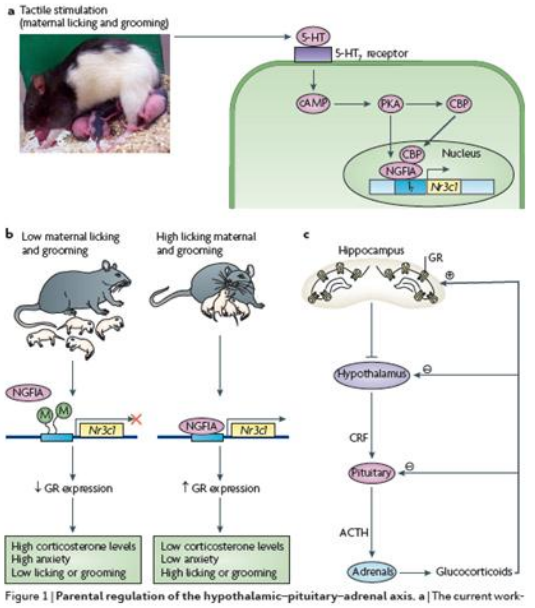


Figure 1 | **Parental regulation of the hypothalamic–pituitary–adrenal axis. a** | The current work-

Hackman et al. Nature Rev, 2010

Diagnóstico Psiquiátrico: Contexto para o planejamento do futuro

Special Article

A New Intellectual Framework for Psychiatry

Eric R. Kandel, M.D.

In an attempt to place psychiatric thinking and the training of future psychiatrists more centrally into the context of modern biology, the author outlines the beginnings of a new intellectual framework for psychiatry that derives from current biological thinking about the relationship of mind to brain. The purpose of this framework is twofold. First, it is designed to emphasize that the professional requirements for future psychiatrists will demand a greater knowledge of the structure and functioning of the brain than is currently available in most training programs. Second, it is designed to illustrate that the unique domain which psychiatry occupies within academic medicine, the analysis of the interaction between social and biological determinants of behavior, can best be studied by also having a full understanding of the biological components of behavior.

(Am J Psychiatry 1998; 155:457–469)

Diagnóstico Psiquiátrico: O futuro a curto prazo

- O início do desenvolvimento da DSM-5 foi lançado como uma mudança de paradigma na Psiquiatria com a promessa de resgatar a validade do diagnóstico psiquiátrico através da ligação do mesmo a patofisiologia dos transtornos mentais.

Diagnóstico Psiquiátrico: O futuro a curto prazo

BJPsych | The British Journal of Psychiatry (2009)
195, 391–392. doi: 10.1192/bjp.bp.109.073932

Reappraisal

Whither DSM–V?

Allen Frances

Summary
The DSM–V development process started with a grand ambition to provide a 'paradigm shift' in psychiatric diagnosis, based initially on the identification of biological markers. This is clearly unattainable, and so energy has now been diverted into developing other major changes, including the development of dimensional ratings and the formal diagnosis of prodromal and subthreshold disorders. It is argued that this process could lead to false positive 'epidemics' with harmful excessive treatments. The better, more modest, alternative is to reassess the text descriptions of the disorders and join with ICD–11 in creating a single nested system for both DSM–V and ICD–11.

Declaration of interest
A.F. was Chair of the DSM–IV Task Force

Diagnóstico Psiquiátrico: O futuro a curto prazo

- Retirada da exigência de prejuízo como parte dos critérios diagnósticos

- Inclusão aspectos dimensionais:

  - Ideia de espectro para alguns grupos de transtornos (ex.,Transtorno do Espectro Autista)

  - Medidas dimensionais gerais – atenção, humor, impulsividade

  - Medidas de gravidade especificas para os diagnósticos

www.dsm-5.org

Diagnóstico Psiquiátrico: O futuro a curto prazo

Psychological Medicine (2009), **39**, 2099–2103. © Cambridge University Press 2009
doi:10.1017/S0033291709991292

COMMENTARY

A meta-commentary on the proposal for a meta-structure for DSM-V and ICD-11

A commentary on 'A proposal for a meta-structure for DSM-V and ICD-11'

A. Jablensky*

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- ✓ Neurodevelopmental disorders
- ✓ Schizophrenic Spectrum and other Psychotic Disorders
- ✓ Bipolar and Related Disorders
- ✓ Depressive Disorders
- ✓ Anxiety Disorders
- ✓ OCD, Stereotypic and Related Disorders
- ✓ Trauma and Stressor Related Disorder
- ✓ Dissociative Disorder
- ✓ Somatic Symptom Disorders

- ✓ Somatic Symptom Disorder
- ✓ Feeding and Eating Disorders
- ✓ Elimination Disorder
- ✓ Sleep-wake disorders
- ✓ Gender Incongruence
- ✓ Disruptive, Impulsive control, and Conduct Disorders
- ✓ Substance Use and Addictive Disorders
- ✓ Neurocognitive Disorders
- ✓ Personality Disorders
- ✓ Paraphilias
- ✓ Other Disorders

www.dsm-5.org

Diagnóstico Psiquiátrico: O futuro a curto prazo

- Retirada da exigência de prejuízo como parte dos critérios diagnósticos

- Inclusão aspectos dimensionais:

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  - Medidas de gravidade especificas para os diagnósticos

www.dsm-5.org

Diagnóstico Psiquiátrico: O futuro a curto prazo

- Opção por 1 único manual – clínico
- Diagnóstico por protótipos clínicos
- Não há definições claras ainda sobre as questões diagnósticas especificas
- A OMS propõem diretrizes diferentes para sintomas e avaliação funcional:
  - CID
  - International Classification of Functioning, Disability, and Health (ICF; WHO, 2001)

www.who.int/classifications/icd/revision/

Diagnóstico Psiquiátrico: o futuro a longo prazo

Diagnóstico Psiquiátrico: o futuro a longo prazo

Reviews and Overviews

Explanatory Models for Psychiatric Illness

Kenneth S. Kendler, M.D.

How can we best develop explanatory models for psychiatric disorders? Because causal factors have an impact on psychiatric illness both at micro levels and macro levels, both within and outside of the individual, and involving processes best understood from biological, psychological, and sociocultural perspectives, traditional models of science that strive for single broadly applicable explanatory laws are ill suited for our field. Such models are based on the incorrect assumption that psychiatric illnesses can be understood from a single perspective. A more appropriate scientific model for psychiatry emphasizes the understanding of mechanisms, an approach that fits naturally with a multicausal framework and provides a realistic paradigm for scientific progress, that is, understanding mechanisms through decomposition and reassembly. Simple subunits of complicated mechanisms can be usefully studied in isolation. Reassembling these constituent parts into a functioning whole, which is straightforward for simple additive mechanisms, will be far more challenging in psychiatry where causal networks contain multiple nonlinear interactions and causal loops. Our field has long struggled with the interrelationship between biological and psychological explanatory perspectives. Building from the seminal work of the neuronal modeler and philosopher David Marr, the author suggests that biology will implement but not replace psychology within our explanatory systems. The iterative process of interactions between biology and psychology needed to achieve this implementation will deepen our understanding of both classes of processes.

(Am J Psychiatry Kendler; AiA:1–8)

Diagnóstico Psiquiátrico

- **Doença:** condição médica na qual os fatores causais ou a psicopatologia é conhecida;

- **Transtorno:** condição médica na qual os fatores causais ou a psicopatologia não é conhecida;

- **Diagnóstico:** opinião clínica de um profissional sobre a presença de uma doença/transtorno em um paciente particular.

Kraemer, 2007; Hyman, 2007

Diagnóstico Psiquiátrico

- **Psicopatologia:**

  - disciplina que estuda a fenomenologia dos transtornos mentais.

✓ Prove a base para o diagnóstico e classificação numa área onde a maioria das condições não são entidades etiologicamente definidas.

Stanghellini, 2009

Diagnóstico Psiquiátrico

- **Psicopatologia:**

✓ Psicopatologia Descritiva

- Busca a precisa descrição e caracterização das experiências anormais

✓ Psicopatologia Clínica

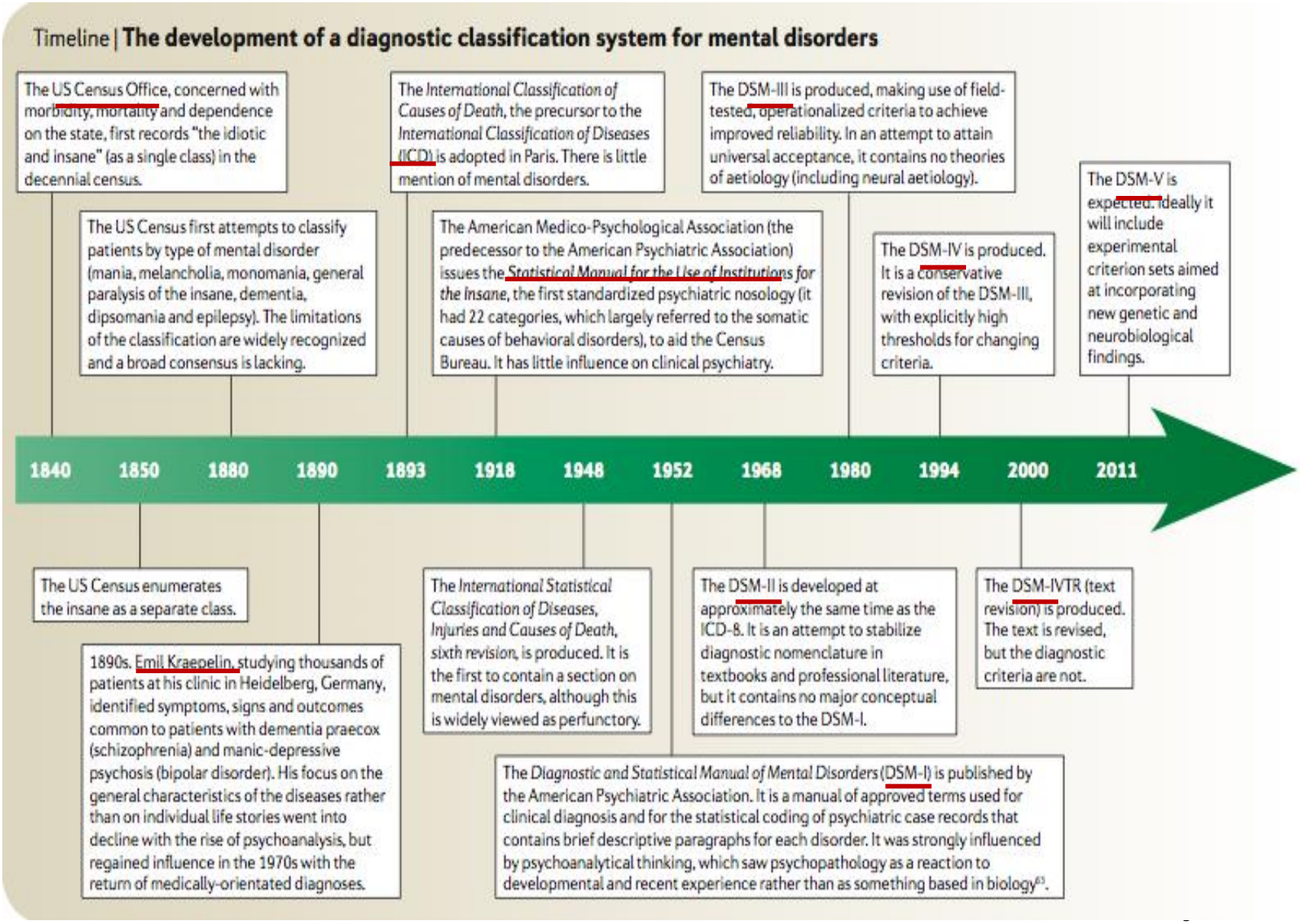
- Busca a identificação dos sintomas que são significativos em termo de distinções nosográficas

✓ Psicopatologia Estrutural

- Busca encontrar uma coerência significativa

Stanghellini, 2009

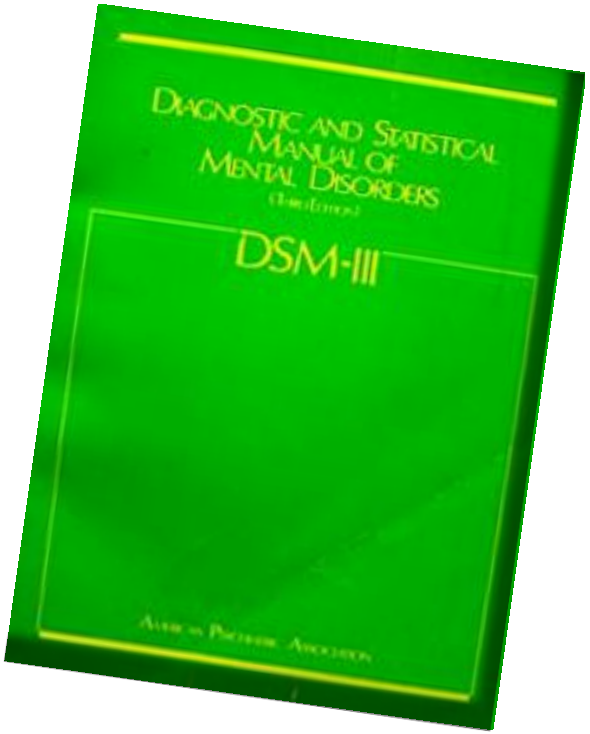
Diagnóstico Psiquiátrico



DSM-III

Contraponto a Psicanálise

- Resgatou a confiabilidade ao diagnóstico psiquiátrico
- Incorporou o modelo médico em Psiquiatria:
- Diagnóstico categórico



Wilson, 2009

Background para a DSM-III

- The Robin & Guze criteria
- The Feighner criteria
- Research Diagnostic Criteria

Wilson, 2009

Robins & Guze

Critérios para validade de Transtornos Psiquiátricos:

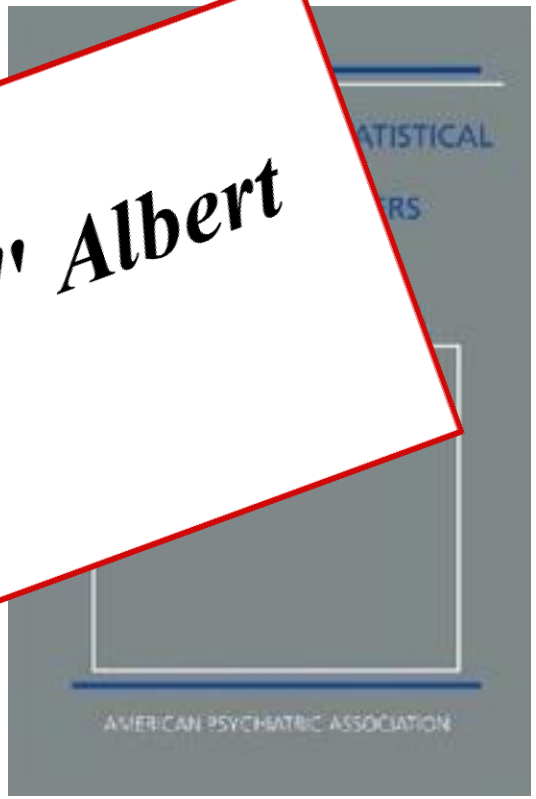
- Apresentação clínica
- Historia Familiar
- Resposta a Tratamento
- Curso / Evolução
- Achados Laboratoriais / Marcadores Neurobiológicos

Robins & Guze, 1970

DSM-IV

- Boa confiabilidade
- Maior crítica: falta de validade
- Diagnósticos baseados em decisões de comitês de "e

"Experts are just trained dogs." Albert Einstein



Frances et al., 1999

CID-10

- Cobertura transcultural
- Extensão do diagnóstico psiquiátrico aos cuidados primários
- Integração clínica, pesquisa e cuidados primários: as três versões

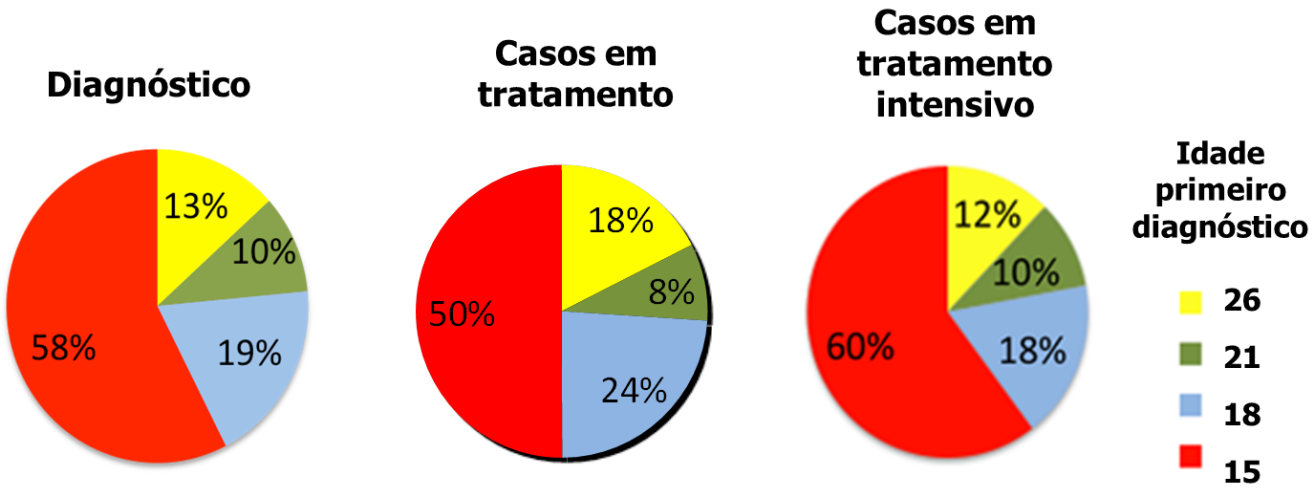
Wilson, 2009

DSM-IV e CID-10: não aumentaram a validade do diagnóstico psiquiátrico significativamente

- Prevalências populacionais absurdas
- Uso de diagnósticos NOS pelos clínicos
- Fronteiras mal definidas entre transtornos mentais: o caso do TAG e Depressão Maior em cuidados primários – 80% comorbidade

"As doenças mentais são doenças crônicas dos jovens"

Proporção de adultos com transtornos mentais e história de transtornos mentais na adolescência



Kim-Cohen et al. *Arch Gen Psychiatry* 2003; 60: 709-17.

The WHO World Mental Health Survey Consortium. JAMA 2004;291:2581-590

Pesquisa vs. Clínica

Mundo dos Pesquisadores

– Não há muita dúvida de que a visão categorial não é sustentada por dados empíricos suficientes. Ela resulta em perda de poder estatístico na pesquisa clínica fenomenológica.

Mundo Clínico

– As decisões diagnósticas categoriais são necessárias pragmaticamente no ambiente clinico, mesmo quando as distinções que elas determinam não tem raízes em descontinuidades objetivas. Mesmo na ausência de tal descontinuidade interna, a colocação de um limiar diagnóstico ainda pode não ser arbitrária se baseada num critério externo.

Quais sintomas tem peso (VPP e VPN) na captura do construto latente de um transtorno?

- Na conceitualização vigente da DSM-IV/CID-10, a maioria dos critérios diagnósticos pesam e contam da mesma forma para atingir o limiar diagnóstico; quais critérios são preenchidos é algo irrelevante, frequentemente só o numero de critérios preenchidos é que conta.

✓ O diagnóstico de Transtorno de Pânico na DSM-IV requer ataques de pânico recorrentes e inesperados. Para caracterização do ataque de pânico, são listados 13 potencias sintomas e um limiar diagnóstico de 4 sintomas. Como resultado existem 715 maneiras de se atingir o limiar diagnóstico, 7814 maneiras de ser diagnosticado e 8192 possíveis padrões de resposta aos 13 sintomas.

Cooper & Balsis, 2009

DSM-V

- designed to better **reflect scientific advances** in our understanding of psychiatric disorders
- to make **diagnosis easier** and more **clinician-friendl**

Your feedback on this revised structure is very important, and we encourage you to please submit comments on this proposed organization, including how you think it might impact patient care and research.

Proposed DSM-5 Organizatio

- Neurodevelopment
- **Schizo**
-
- ...pulsive and Related Disorders
- ...ma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom Disorders

...ders

...orders

...Wake Disorders

- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse Control, and Conduct Disorders
- Substance Use and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilias
- Other Disorders