UNIVERSITEIT GENT

FACULTEIT PSYCHOLOGIE EN PEDAGOGISCHE WETENSCHAPPEN

DSM-diagnostiek onder de loep

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Faculteit Psychologie en Pedagogische Wetenschappen

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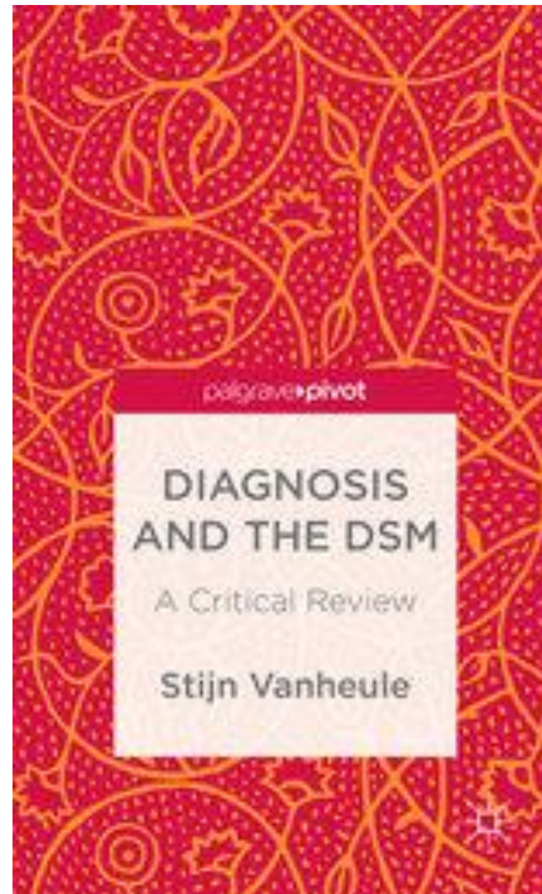

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Betrouwbaarheid DSM-diagnostiek

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- Heroïsche vooruitgang t.a.v. Babylonische spraakverwarring, dankzij eenduidige criteria? “DSM has been the cornerstone of substantial progress in reliability” (DSM-5, p. 5).
- Pre-DSM: prototypische diagnostiek: gelijkenis/verschil met klinische beelden in handboeken wordt gecheckt
- Eerste helft 20e eeuw: evolutie naar classificatie
- Jaren ’70 20e eeuw: psychiatrie in crisis
- DSM-III: biomedisch discours centraal → betere betrouwbaarheid?

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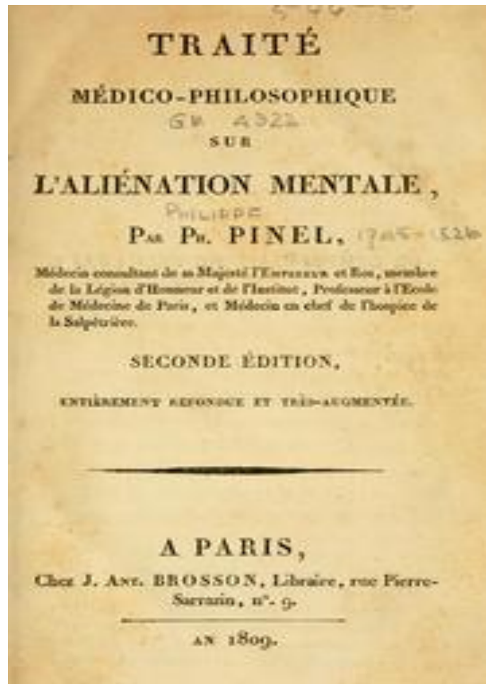
Pinel, 1809



TRAITÉ

MÉDICO-PHILOSOPHIQUE

SUR

L'ALIÉNATION MENTALE,

PAR PH. PINEL,

Médecin consultant de sa Majesté l'Empereur et Roi, membre de la Légion d'Honneur et de l'Institut, Professeur à l'École de Médecine de Paris, et Médecin en chef de l'hospice de la Salpêtrière.

SECONDE ÉDITION,

ENTIÈREMENT REFONDUE ET TRÈS-AUGMENTÉE.

A PARIS,

Chez J. Ant. BROSSON, Libraire, rue Pierre-Sarrazin, n°. 9.

AN 1809.

88. La manie peut se marquer, non par une privation totale d'affections morales et d'idées, mais par leur succession rapide et leur instabilité extrême. Une jeune fille de vingt-deux ans, qu'un amour malheureux a jetée dans l'égarement de la raison, conserve encore toute la vivacité du regard et passe avec la rapidité de l'éclair d'une idée à une autre tout-à-fait différente : ce sont quelquefois des expressions tendres et pleines de décence, puis des propos obscènes et une provocation non voilée aux plaisirs de l'amour ; un instant après c'est toute la bouffissure de la vanité et un ton de hauteur et de commandement ; bientôt elle croit être reine, sa démarche est fière et majestueuse, et elle regarde avec dédain ses compagnes d'infortune ; avis, remontrances, tout est inutile, elle ne paroît rien entendre, et cédant aux desirs fugaces du moment, elle court quelquefois avec rapidité, chante, crie, danse, rit, frappe ceux qui l'environnent, mais sans dessein et sans malice, et s'abandonne à toutes ces petites extravagances avec l'instinct d'une sorte d'enfantillage.

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→ Prototype = focus op:

- patronen, gehelen van kenmerken
- Illustratieve casussen, vignetten

→ Sinds DSM-III focus op:

- Individuele symptomen en tekens, los van hun samenhang → additief; meer criteria = ernstiger → kwalitatieve ernstbeleving?

→ DSM-I en DSM-II: rudimentaire prototypes → klinische psychiatrie = holistisch, individu-gericht

Commotie in de psychiatrie: diagnostiek onder vuur jaren ’70 20e eeuw

→ Kritische denkers (Szasz, Foucault)
→ Maatschappelijke veranderingen
→ Empirische studies

Onderzoek Temerlin (1968):

- Acteur speelt normaal mens in anamnestisch interview
- Eminente collega merkt op '*patiënt komt neurotisch over maar is eigenlijk compleet psychotisch*'
- 25 psychiaters, 25 psychologen, 45 studenten psychologie geven diagnose
- Resultaat:

psychiaters: 15 psychose; 10 neurose

psychologen: 7 psychose; 15 neurose; 3 normaal

studenten: 5 psychose, 35 neurose; 5 normaal

- 3 Replicatiestudies:

(1) Eminente collega zegt dat hij normaal is → 20 professionals: normaal

(2) Zonder suggestie door eminente collega → 21 professionals: 9 neurotisch; 12 normaal.

(3) Zonder suggestie → 12 leken: 12 normaal

→ Groot suggestie-effect: weinig interne standaarden, kennis vertekent

→ Enkel goede notities door degenen met correct oordeel

Spitzer & Fleiss 1974: 1726 patiënten, 2 clinici, dat uit 6 studies (‘50-’70) kappa-statistiek

→ Kappa coëfficiënt = “*the difference between the probabilities of getting a second positive diagnosis between those with a first positive and those with a first negative diagnosis.*” (Clarcke 2013)

→ 2 beoordelaars, 100 patiënten, 2 condities:	2 beoordelaars, 100 patiënten 5 condities:
K = 0 = 50%	K = 0 = 20%
K = .25 = 62%	K = .25 = 40%
K = .50 = 75%	K = .50 = 60%
K = .75 = 87%	K = .75 = 80%

Geen ‘vaste’ kappanormen; Spitzer & Fleiss maakte de eerste set → historische evolutie!

Authors	Cutoff points
Spitzer and Fleiss (1974)	≥ .90: excellent .70–.90: satisfactory ≤ .70: unacceptable
Landis and Koch (1977)	≥ .75: excellent .40–.75: fair too good ≤ .40: poor
Clarke and colleagues. (2013)	≥ .80: excellent .60–79: very good .40–.59: good .20–.39: questionable ≤ .20: unacceptable

Resultaten Spitzer & Fleiss: 15/18 onaanvaardbaar: probleem

Echter:

- Eigen normen
- Nomenclatuur als oorzaak? → checklists
- Andere normen → andere conclusies (bijv. neurose): DSM-5 normen: 6/18 onaanvaardbaar

Disorder category	Kappa	Interpretation Spitzer & Fleiss (1974) norms	Interpretation Landis & Koch (1977) norms	Interpretation Clarke et al. (2013) norms
Mental deficiency	.72	Satisfactory	Fair to good	Very good
Organic brain syndrome	.77	Satisfactory	Excellent	Very good
Acute brain syndrome	.44	Unacceptable	Fair to good	Good
Chronic brain syndrome	.64	Unacceptable	Fair to good	Very good
Alcoholism	.71	Satisfactory	Fair to good	Very good
Psychosis	.55	Unacceptable	Fair to good	Good
Schizophrenia	.57	Unacceptable	Fair to good	Good
Affective disorder	.41	Unacceptable	Fair to good	Good
Neurotic depression	.26	Unacceptable	Poor	Questionable
Psychotic depression	.24	Unacceptable	Poor	Questionable
Manic-depressive	.33	Unacceptable	Poor	Questionable
Involutional depression	.30	Unacceptable	Poor	Questionable
Personality disorder or neurosis	.44	Unacceptable	Fair to good	Good
Personality disorder	.32	Unacceptable	Poor	Questionable
Sociopathic	.53	Unacceptable	Fair to good	Good
Neurosis	.40	Unacceptable	Fair to good	Good
Anxiety reaction	.45	Unacceptable	Fair to good	Good
Psychophysiological reaction	.38	Unacceptable	Poor	Questionable

Herstel via Neo-Kraepelinianen

- St.-Louis groep pleit voor biomedische benadering: terugkeer naar descriptieve benadering Kraepelin, tegen verklarende psychoanalytische benadering; focus op biologie.
- Kraepelin: studie van vorm en essentie van cases: start, verloop, uitkomst, prevalentie, voorbestemmende en risico-factoren, erfelijkheid, hersenfunctioneren: "*Judging from our experience in internal medicine it is a fair assumption that similar disease processes will produce identical symptom pictures, identical pathological anatomy, and identical etiology*" (Kraepelin, 1907) → brein-symptoom link
- Later werk Kraepelin: focus op prognose, laat idee van categorisch onderscheid los.

Wat de Neo-Kraepelinianen centraal stellen:

1. Biomedisch denken

- "Concepts, strategies, and jargon of general medicine are applied to psychiatric disorders: diagnosis, differential diagnosis, etiology, pathogenesis, treatment, natural history, epidemiology, complications, and so on" (Guze)
- psychiatry "*looked* more like a medical specialty" (Spitzer, 2000)

2. Focus op brein

- "the medical model is without a priori theory, but does consider brain mechanisms to be a priority."

3. Criterium-gebaseerde diagnostiek

- "classification *is* diagnosis"

- DSM-5 field trial: eerste grote betrouwbaarheidsstudie sinds Spitzer & Fleiss (1974):

→ 27 van de 347 categorieën betrokken

→ 286 getrainde clinici beoordeelden paarsgewijs 1.466 volwassen patiënten, 616 kinderen; 11 klinieken

→ Patiënten vooraf gescreend of ze voor een van de 27 categorieën in aanmerking kwamen.

- "*if the diagnostic criteria defining a disorder in a given group of patients cannot be assessed reliably by two or more clinicians, then patients with those diagnoses cannot be expected to have common treatment responses or similar etiological and laboratory findings. In this sense, without reliability, there can be no validity of a diagnosis*".
- Objective: "good reliability": kappa > .40

DSM-5 Field trial resultaat volwassenen:

Disorder category	Kappa	Interpretation Spitzer & Fleiss (1974) norms	Interpretation Landis & Koch (1977) norms	Interpretation Clarke et al. (2013) norms
Schizophrenia	.46	Unacceptable	Fair to good	Good
Schizoaffective disorder	.50	Unacceptable	Fair to good	Good
Bipolar I disorder	.56	Unacceptable	Fair to good	Good
Major depressive disorder	.28	Unacceptable	Poor	Questionable
Mixed anxiety-depressive disorder	.00	Unacceptable	Poor	Unacceptable
Generalized anxiety disorder	.20	Unacceptable	Poor	Questionable
Posttraumatic stress disorder	.67	Unacceptable	Fair to good	Very good
Complex somatic disorder	.61	Unacceptable	Fair to good	Very good
Binge eating disorder	.56	Unacceptable	Fair to good	Good
Alcohol use disorder	.40	Unacceptable	Fair to good	Good
Mild neurocognitive disorder	.48	Unacceptable	Fair to good	Good
Major neurocognitive disorder	.78	Satisfactory	Excellent	Very good
Mild traumatic brain injury	.36	Unacceptable	Poor	Questionable
Anti-social personality disorder	.21	Unacceptable	Poor	Questionable
Borderline personality disorder	.54	Unacceptable	Fair to good	Good

Authors	Cutoff points
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DSM-5 Field trial resultaat kinderen en jongeren:

Authors	Cutoff points
Spitzer and Fleiss (1974)	≥ .90: excellent .70–.90: satisfactory ≤ .70: unacceptable
Landis and Koch (1977)	≥ .75: excellent .40–.75: fair too good ≤ .40: poor
Clarke and colleagues. (2013)	≥ .80: excellent .60–79: very good .40–.59: good .20–.39: questionable ≤ .20: unacceptable

Disorder category	Kappa	Interpretation Spitzer & Fleiss (1974) norms	Interpretation Landis & Koch (1977) norms	Interpretation Clarke et al. (2013) norms
Autism spectrum disorders	.69	Unacceptable	Fair to good	Very good
ADHD	.61	Unacceptable	Fair to good	Very good
Disruptive mood dysregulation	.25	Unacceptable	Poor	Questionable
Mixed anxiety-depressive disorder	.05	Unacceptable	Poor	Unacceptable
Major depressive disorder	.28	Unacceptable	Poor	Questionable
Avoidant/restrictive food intake	.48	Unacceptable	Fair to good	Good
Oppositional defiant disorder	.40	Unacceptable	Fair to good	Good

- Volgens de kappanormen van Spitzer & Fleiss: 14/15 diagnoses bij volwassenen en 7/7 bij kinderen onaanvaardbare betrouwbaarheid
- DSM-5 stelt: “DSM has been the cornerstone of substantial progress in reliability”
- Diagnose stemmingsstoornissen = problematisch (co-morbiditeit)
- Kappa’s voor 20/347 stoornissen → 4% (zeer) goede betrouwbaarheid.
- “For a general psychiatric practice, the diagnostic reliability data suggest that two-thirds of patients will receive a reliable DSM-5 principal diagnosis at the first visit.” (editoriaal AJP)

Validiteit DSM-diagnostiek

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De zoektocht naar biomedische referenten

- DSM: nooit theoretisch gefundeerd
- DSM-III schrapt ‘neurose’ ‘psychologische reactie’: “the approach taken in DSM-III is atheoretical with regard to etiology *or* pathophysiological process”

→ DSM-III: ‘verkocht’ zonder sterke epistemologische claims

→ DSM-5: “diagnoses in the DSM-III, DSM-III-R, and DSM-IV are best understood as useful placeholders, based on careful description, but not on deeper understanding” (Bernstein)

DSM-5: hoop op biomedische innovatie…

-*A Research Agenda for DSM-V* (2002): “a research and analytic agenda that would facilitate the integration of findings from research and experience in animal studies, genetics, neuroscience, epidemiology, clinical research, and cross-cultural clinical services – all of which would lead to the eventual development of an etiologically based, scientifically sound classification system.” → voorbij de conventie

-“carve nature at its joints” (Regier, 2009)

-“complex brain disorder”, “psychiatry = clinical neuroscience” (Reynolds, 2009)

DSM-5: de hoop op biomedische innovatie… loopt af op een sisser

- "we anticipated that these emerging diagnostic and treatment advances would impact the diagnosis and classification of mental disorders faster than what has actually occurred" (Kupfer, 2011)
- "While not central to the criteria themselves, this information [neurobiological] is nonetheless useful and informative for helping DSM provide a more precise picture of the clinical realities of psychiatric diagnosis" (Kupfer, 2011)

→ Het technologie-alibi (zie reeds Georget, 1820)

→ De facto geen grote veranderingen in criteria!

→ Idem andere innovaties bv. Clusters, persoonlijkheidsstoornissen

- Statuut van de DSM-criteria: "they are *intended* to summarize characteristic syndromes of signs and symptoms that *point* to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course" (DSM-5)

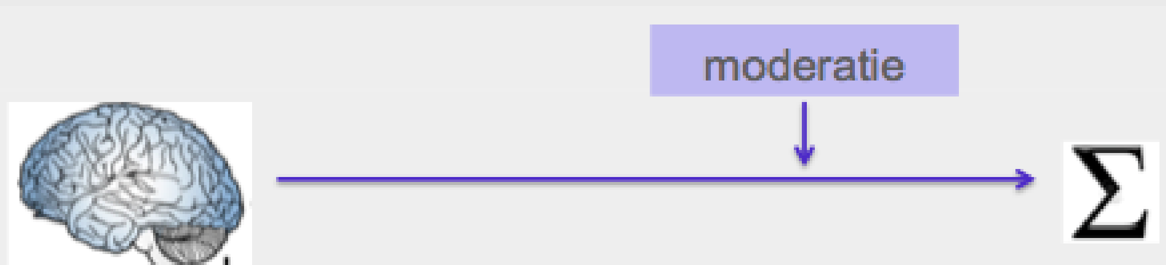
→ Stimuleert reïficatie

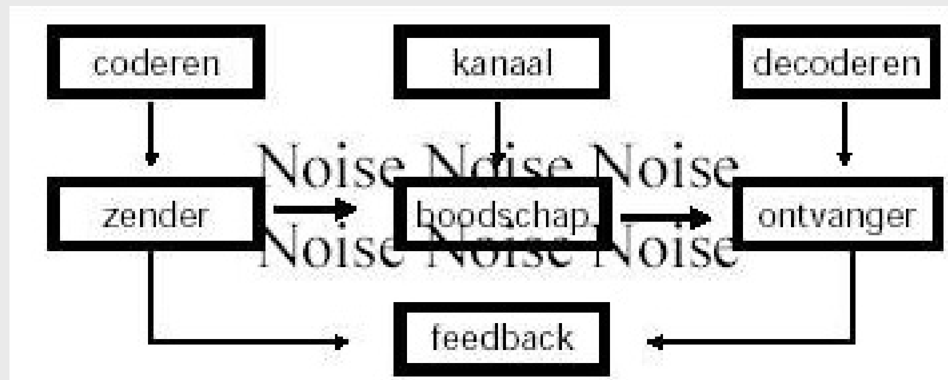
→ De illusie van 347 onderscheiden biologische patronen die samenhangen met polythetische syndromen

- NIMH: RDoC project: “RDoC are intended to ultimately provide a framework for classification based on empirical data from genetics and neuroscience” (Insel, 2010)
- “NIMH views RDoC as the beginning of a transformative effort that needs to succeed over the next decade and beyond to implement neuroscience-based psychiatric classification”
- “the RDoC framework assumes that data from genetics and clinical neuroscience will yield biosignatures that will augment clinical symptoms and signs for clinical management”
- Realistisch? “the field of psychiatry has thus far failed to identify a single neurobiological phenotypic marker or gene that is useful in making a diagnosis of a major psychiatric disorder or for predicting response to psychopharmacologic treatment.” (DSM-V Research Agenda) → technologie-alibi?

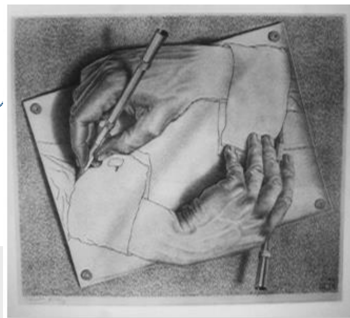
Diagnostiek op basis van tekens

- DSM = vertaling, elimineert idiosyncratische voorstellingen; geen context
- neo-positivistisch: vaste band betekenaar (symptoom) – referent (stoornis)
- Symptoom = teken, indexicale betekenaar: causaal
- Criteria "*point* to an underlying disorder" (DSM-5)



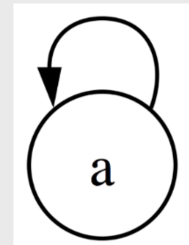


- Diagnosticus decodeert boodschap patiënt. DSM = code
- DSM: context = ruis, bepaalt ‘ernst en valentie’ van de criteria, modereert signaal/boodschap



Symptomen als persoonlijke constructies

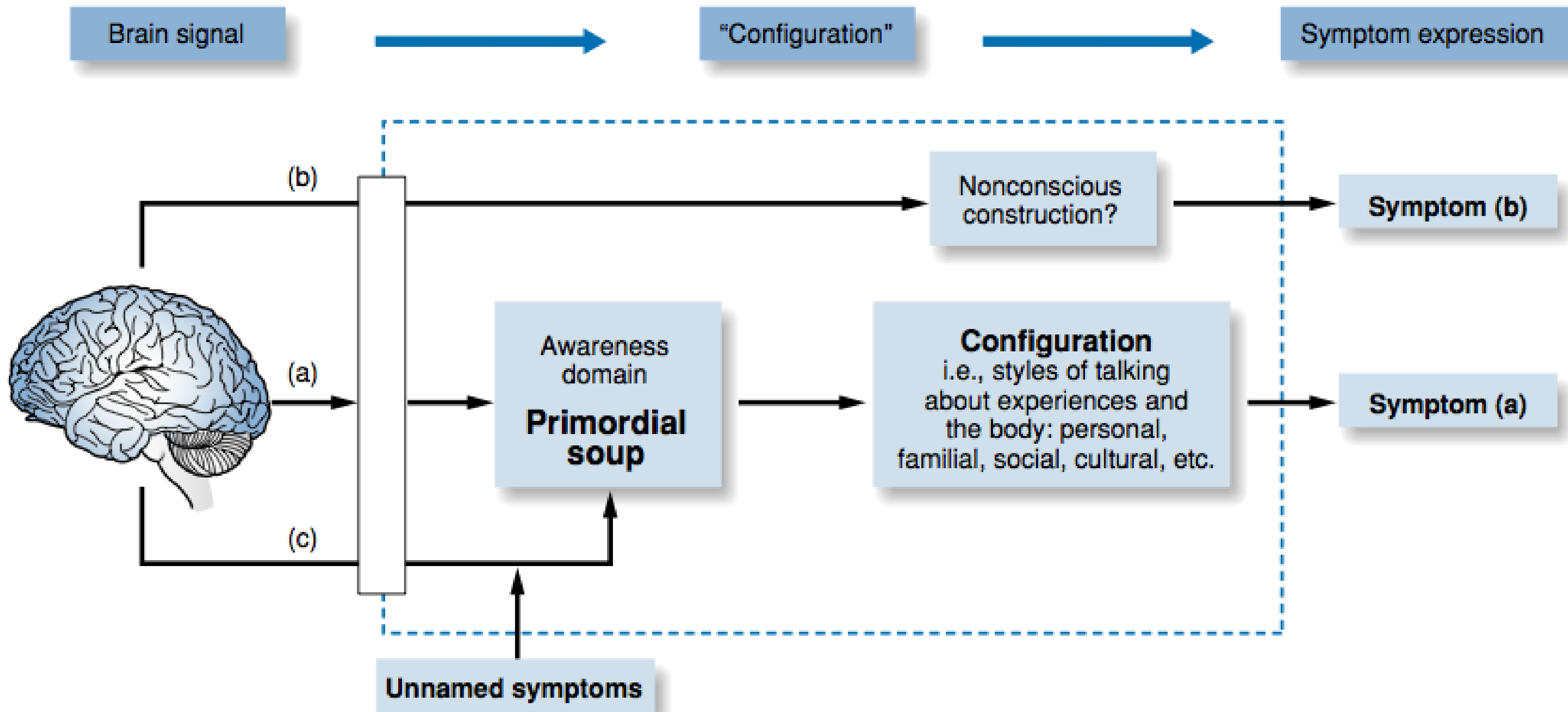
- Reflexieve relatie tot symptoom: “the human being is *both* an empirical object and a transcendental subject, that is a condition of possibility for its own study.” (Parnas)
- Mensen interpreteren hun psychische problemen
- Bijv. Onderzoek Beavan: 13% stemmen → psychotisch?
- van Os: symptoomervaring ≈ zorgnood → geen diagnose zonder lijden
- DSM: naturalistische attitude: symptoom = natuurlijk empirisch object; zelf-reflexieve relatie ≠ constitutief



- Marková & Berrios: symptomen en klachten = *persoonlijke constructies*

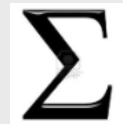
→ Σ = persoonlijk construct voor de patiënt "They are *constructs* in the sense that subjects create sense or construct a meaning out of an inchoate pre-conceptual and preverbal experience. They are *personal* in that, although social and cultural influences will help their articulation, the experiences themselves are unique to the individual and inaccessible to anyone else"

- → Σ = persoonlijk construct voor de diagnosticus: "This time the constructs involved relate to the judgments made by clinicians and we have seen how these will depend on manifold factors (e.g. experience, personal biases and mood) which, being neither fixed nor consistent, will serve to destabilize the structure itself"
- → Σ + ervaring = systemisch geheel <-> DSM
- → DSM: context en beleving = modererend
- → Marková en Berrios: context en beleving = constituerend: Cambridge model on Symptom Formation

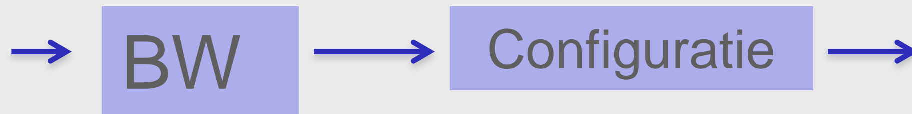

Brain signal
"Configuration"
Symptom expression
(b)
Nonconscious construction?
Symptom (b)
(a)
Awareness domain
Primordial soup
Configuration
i.e., styles of talking about experiences and the body: personal, familial, social, cultural, etc.
Symptom (a)
(c)
Unnamed symptoms

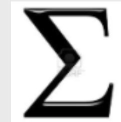
3 symptoommodellen

DSM:

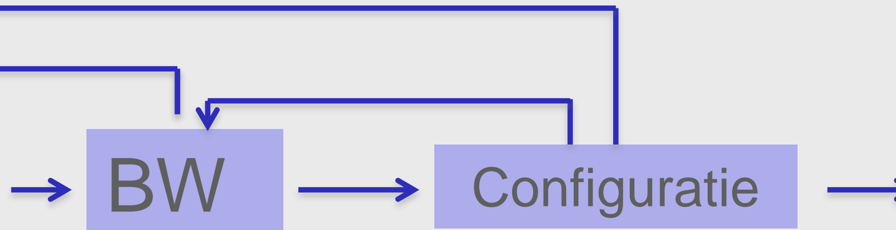


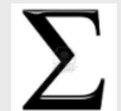
Berrios
Marková





Systemisch





Het betekende in rekening brengen: Lacan

- Betekende tot stand via articulatie betekenaars → diagnostische studie

→ *Hoe* wordt psychische lijden geconstrueerd en bewerkt?: proces van betekening

→ Verhaalde context:

- Symptoom/klacht fluctuaties
- Levensgeschiedenis
- Relaties

* Existentiële kwesties
* Sociale omstandigheden
* Culturele omstandigheden