



The Embryonic Classification of Dementia: Inclusion the DSM-5 in a Consequential Historical and Cultural Environment and Contemplative the Expectations of “Alzheimer’s

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ABSTRACT

Alzheimer’s disease is a 100-year-old concept. As a diagnostic label, it has evolved over the 20th and 21st centuries from a rare diagnosis in younger patients to a worldwide epidemic common in the elderly, said to affect over 35 million people worldwide. In this opinion piece, we use a constructivist approach to review the early history of the terms “Alzheimer’s disease” and related concepts such as dementia, as well as the more recent nosological changes that have occurred in the four major editions of the Diagnostic and Statistical Manual since 1952. A critical engagement of the history of Alzheimer’s disease and dementia, specifically the evolution of those concepts in the DSM over the past 100 years, raises a number of questions about how those labels and emergent diagnoses.

Keywords:- Alzheimer’s disease - Dementia - Diagnostic and Statistical Manual Constructivism - Brain aging

I. INTRODUCTION

A century ago, Alzheimer’s disease (AD) was formally established as a distinct nosology in an influential German psychiatry textbook. Since then, the concept has undergone various permutations, and its ongoing evolution carries important implications for the clinical treatment and cultural placement of persons who are given the diagnosis (Herskovits 1995; Whitehouse et al. 2000; George 2010). Today, AD is said to affect 35.6 million people worldwide and 5.3 million people in the United States (Prince and Jackson 2009). By 2040, AD is predicted to affect over 80 million people worldwide, 70% of whom will reside in developing countries (Essink-Bot et al. 2002). Alzheimer’s afflicts the genders differently with more women than men being affected (Barnes et al. 2005) and serving as caregivers for others with the condition (Alzheimer’s Association and National Alliance for Caregiving 2004). A recent meta-analysis (Plassman et al. 2010) of existing data has failed to identify a singular causal or preventive pathway for a condition that emergently appears to be heterogeneous and age related (Whitehouse and George 2008). Such findings cast doubt on the dominant Western biomedical model of AD, which regards the condition as singular and unrelated to aging (Richards and Brayne 2010).

Early Terminology of Dementia

The word ‘dementia’ stems from a Latin word and is now a very common way of describing the process through which the cognitive functions of the brain are impaired. There are many names for the different diseases causing



impairment of the brain. These may reflect the person who discovered that type of dementia (e.g. Alzheimer's disease after Alois Alzheimer), describe the part of the brain specifically affected (e.g. frontotemporal dementia), or the section of the population that is affected (e.g. younger onset dementia). Sometimes you might hear words that describe the stage of the disease: 'prodromal dementia' or 'early', 'moderate', 'advanced' dementia. Another source for dementia terminology is the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is used by many health professionals. It is published by the American Psychiatric Association and outlines the criteria a patient should meet (such as symptoms) in order to be diagnosed with a particular mental disorder. In this latest DSM-5 edition published in 2013, dementia has been renamed 'Major Neurocognitive Disorder'. The DSM-5 also recognises earlier stages of cognitive impairment as 'Mild Neurocognitive Disorder'.

Alzheimer, Kraepelin and the Tenuous Construction of "Alzheimer's Disease"

In 1906, Dr. Alzheimer, then a practicing psychiatrist, presented a lecture entitled "On a Peculiar, Severe Disease Process of the Cerebral Cortex" to the 37th Assembly of Southwest German Alienists [psychiatrists] in Tübingen, Germany (Maurer and Maurer 2003, p. 4). In his talk, he detailed his observations of a 51-year-old woman named "Auguste D," whom we now know was Auguste Deter, a patient whom he first treated in 1901 while serving as the director of the Irrenstalt [asylum] in Frankfurt, Germany. Upon conducting a postmortem investigation using a methyl blue-eosin staining technique and a silver chromate staining technique¹ refined by his colleague Franz Nissl, Dr. Alzheimer found high concentrations of plaques and tangles on her brain and a paucity of cells in the cerebral cortex (Tollis 1994, p. 49). The definitive demonstration of these structures and their interpretation as pathology set the medical understanding of dementia firmly on a path that privileged the material and conflated mind with brain (Chillibeck et al. 2011).

For the next several decades after the publication of "Alzheimer's disease" in Kraepelin's 1910 textbook, the diagnosis of AD remained obscure and was rarely applied by those in the medical profession (Gubrium 1986). Alzheimer's disease was considered a rare condition that affected young people exhibiting presenile dementia; "hardening of the blood vessels" was considered to be the main pathology for cognitive decline in the last decades of life. As many critics have pointed out, Alzheimer and Kraepelin's conception of Alzheimer's disease was strongly reductionist, exclusively privileging brain pathology in the etiology of dementia. This is not surprising given the institutional context in which they practiced. As Engstrom has written, German psychiatric clinics during this period were not intended to treat incurable patients, thus patients with dementia usually passed quickly through them on their way to institutions providing custodial care. To the extent that patients with dementia were found in the kind of teaching clinics in which Alzheimer and Kraepelin worked, they were there for their usefulness

either in providing training material for students or in providing pathological specimens upon autopsy (Engstrom 2007). Thus the institutional arrangement of the psychiatric clinics at which Alzheimer and Kraepelin tended to reinforce a biological reductionism over the type of psychosocial approach that might emerge in settings that allow for the development of a more robust, long-term relationship between doctors and people with dementia.

DSM-V



The Diagnostic and Statistical Manual-5 (DSM-5), publishing in late May 2013, represents years of research, debate, and field testing. Called the “Bible of psychiatry,” the DSM-5 includes almost every single possible variation in human behavior, and then some. Although not yet seen by many people, if anyone, outside of the editors, a number of the changes anticipated in DSM-5 have already been previewed.

The changes from DSM-IV-TR, the previous version of the DSM-5 are already being heavily criticized, however, including two recent books on the topic. Psychology Today blogger Allen Frances, a member of the DSM-IV panel, has been perhaps the most outspoken and detailed in his objection to the new system. Activist groups have sprung up, including Boycott DSM-5, and many psychologists have signed onto petitions similarly challenging DSM-5’s publication. The American Psychological Association reports that the Center for Medicare and Medicaid Services (CMS) will require that all healthcare providers covered by HIPAA will be required to use the International Classification of Disease manual, not the DSM, starting in October 2014. NIMH Director Thomas Insel would like to see science driving the diagnoses, not clinical criteria.

My own experience with the DSM-5’s revision was in overhauling my abnormal psychology undergraduate text to reflect the new system. In the process of completing the text, I had the opportunity to delve into the DSM-5 in depth. I read every single diagnosis description, research article, and rationale, all published on the DSM-5 website (though not available anymore). Each new diagnosis was pegged to its old counterpart in the DSM-IV, and the authors of each subsection lavished extensive detail onto the information available to the public. Therefore, it was possible to see what I’ve called “the good, the bad, and the indifferent” which I share with you today. After looking at these, we’ll see what these changes will mean for you.

The Good

DSM-5 is eliminating what was a rather cumbersome five “axis” diagnostic system previously in use that required clinicians to rate each client according to criteria other than their main psychological disorder. Apart from the fact that no one truly could define the word “axis” (it was roughly a dimension), the previous DSM’s included a rather strange combination of personality disorders and “mental retardation” into one grouping. All other disorders were placed elsewhere. In addition, a collection of unrelated disorders that “originated in childhood” (but not “mental retardation”) were strung together in one section regardless of what the symptoms were. Eliminated the axes is probably a good thing as it will ease some of this confusion and messiness.

This brings up another good change. “Mental retardation” is no longer being used as a diagnosis but is being replaced by “Intellectual Disability,” which makes DSM-5 consistent with established practices in the field. Several other diagnoses with possibly stigmatizing terminology were also changed, including hypochondriasis (now called “illness anxiety disorder”) and the paraphilias (now called “paraphilic disorders”). The DSM-5 authors felt that these changes were warranted not only for the sake of being politically correct, but because the terms are more accurate. A set of similar changes were made within each of the major disorder categories.

Autistic disorder is now being eliminated as a diagnosis, and is replaced by “autistic spectrum disorder.” In the process of making this change, the DSM-5 authors also decided to eliminate the “Asperger’s Disorder” diagnosis. This has angered some groups, who feel that Asperger’s merits its own diagnosis. However, I’m including this change in the “good” (readers may disagree) because it’s been clear for a number of years that the “spectrum” concept is a useful one for the family of autistic disorders. In fact, many researchers believe that all



categories should be eliminated entirely in favor of dimensional ratings, and though this didn't happen, it might in future DSM's.

Another good set of changes involves reorganizing and eliminating some disorders that no longer made sense in the new framework. For example, obsessive-compulsive disorder now fits into its own grouping instead of being placed with anxiety disorders. The evidence didn't support the notion that anxiety is at the root of this disorder. Similarly, PTSD is now part of a new grouping called "Trauma and Stressor-Related Disorders" which, again, highlights the underlying nature of these disorders and groups it with others that bear a substantive relationship.

Guidelines for evaluating suicidality are also being included in DSM-5. This will provide clinicians with greater structure in assessing individuals who may present a risk to themselves.

In the area of schizophrenia, the DSM-5 authors believed that the distinctions among the 5 subtypes (e.g. "disorganized," "undifferentiated") were not supported by research evidence, nor could clinicians always reliably distinguish among them. This is particularly good news for the legions of undergraduates who no longer have to memorize these somewhat confusing terms. More importantly, however, other changes made within the schizophrenia diagnosis will allow clinicians to rate the severity of a client's symptoms in a way that does carry meaning.

The Bad

Many DSM-5 critics have their own legitimate gripes about the flaws of the new system. For example, the inclusion of "Mild Neurocognitive Impairment" has the very real potential to pathologize the normal age-related changes in cognition that many people experience and lead people with slight memory problems to rush to the conclusion that they have dementia (a term being eliminated, by the way). A "mild" anything seems like an odd term to include in a psychiatric diagnostic system.

Other changes drawing widespread criticism similarly include a general broadening of the nosological (meaning diagnostic) net or, put into lay terms, making what's normal seem sick. Broadening the diagnoses of, for example, major depressive disorder, the DSM-5 authors eliminated the so-called "bereavement exclusion" in which a grieving person had a up to 2 months to experience severe symptoms of depression without being diagnosed with a psychiatric disorder. The rationale for eliminating the exclusion is that a person who is vulnerable may have a depressive episode triggered by becoming bereaved but this explanation doesn't sit well with critics or other researchers. Similarly "Premenstrual dysphoric disorder" and "Disruptive mood dysregulation disorder" are two new depressive disorders that pathologize PMS and temper tantrums, according to critics.

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