EDITORIAL

Coasting to DSM-5 - Parental Alienation Syndrome and Child Psychiatric Syndromes: We are what and who we define

I had heard through the rumour mill that DSM-5 might do away with the multi-axial system. When I shared this with a psychiatry resident he said- "They can't do that to us", while another one commented- "I'm glad that I am being examined on DSM-4". Sensing their existential distress, I thought about coming up with a new syndrome of my own - "attachment to old categories disorder". We will be losing some of our most beloved categories or, rather, there will be a re-ordering of the biblical laws of DSM. Dr. Asperger is definitely out. Nice to have known you! Meanwhile, our love-hate affair with Borderline Personality Disorder will - if I am reading the tea leaves correctly - be re-ordered, along with the other personality disorders and former Axis I and III veterans, into a one axis enchilada- What? That is sacrilege. But the logic is to re-align with ICD. A necessary trade-off, the backroom horse traders tell us. Bah Humbug!!!

Did anyone read about how to make personality diagnoses in DSM-5? While previous DSMs were cookbook and cookie cutter approaches, it will take a PhD to figure out personality disorders in DSM-5. It will be dimensional rather than categorical, and then it will require three assessments; level of personality function (self and interpersonal), a match to Personality Disorder Type and a match to one or more of 6 personality domains. Diagnosing personality foibles is serious business but suddenly I find myself yearning - and I thought I would never say this - for the simpler days of Axis II and previous DSMs.

In this re-ordering of the celestial bodies of classification, will we in child psychiatry benefit or be lost, once again, in Big Brother's agenda to fit in with the ICD crowd? Parental Alienation Syndrome (PAS) is a good example of a syndrome trying to sneak in while everyone's attention is diverted elsewhere. Obviously you sense my bias - but there is serious lobbying going on to include it in DSM-5. The pros - its akin to something like PTSD, it causes real suffering and it will help courts recognize and hence make better custody decisions when post-divorce family dynamics go awry. The cons - it is medicalizing an essentially legal process, it's an artifact of the legal adversarial process and it's designation under the syndrome or disorder moniker puts it at the same level as, for example, autism. That is not to belittle the people, children, mothers and fathers caught up in this nasty dynamic that has real consequences. But not everything that causes psychological distress has to become a psychiatric syndrome or a disorder. I simply don't buy the analogy argument - ie PAS is a relational disorder akin to DSM V codes.

The overreach of PAS speaks to the multiple levels involved in constructing child psychiatric syndromes in this particular culture at this place in time. It speaks of the political power-play involved in getting a disorder commissioned or decommissioned in DSM. Which brings me to Dr. Bergeron's Commentary and the feature article by Biskin et al. in this issue. Under the threat of subspecialty status, Dr. Bergeron asks us to look at ourselves and start the debate about who we are and what we do, critical identity questions. Dr. Biskin and colleagues take old familiar categories (Axis II disorders) and examine their variability and hence validity in a developmental context - the bread and butter of child psychiatry I would argue. In this rich field of ours, we can most certainly evolve beyond being simple lumpers or splitters; but right now I gotta split to catch the Canucks game.

Normand Carrey MD, Editor-in-Chief

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