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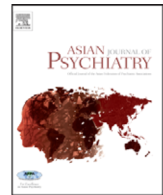

Letter to the Editor

Crisis and opportunity—The DSM-V and its neurology quandary

To the Editor

The set ways that Western medicine, and especially psychiatric medicine has followed for the past decades have increasingly come under critical scrutiny (Brennan et al., 2006; Preter and Kahn, 2008; Cosgrove et al., 2009). For those of us interested in the borderland between the mind and the brain, the ongoing revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM) offers a welcome opportunity for a more developed discussion of neurological–psychiatric overlap conditions. Neuropsychiatric conditions are prevalent, ranging from chronic pain (e.g., back pain, migraine, tension-type headaches) to Parkinson depression and ictal psychopathology. According to a recently released CDC 19-State survey on epilepsy, "about one out of 100 adults have active epilepsy, and more than one-third are not getting sufficient treatment [. . .]. The study found that nearly half (44 percent) of adults with active epilepsy reported having recent seizures" (CDC, 2008).

However, one cannot formulate a differential diagnosis as to what extent, e.g., complex partial epilepsy might be contributing to a mood, thought, or personality disorder presentation, unless one is trained and experienced to do so. Unfortunately DSM-IV based training leaves too many a trainee unprepared for clinical practice where patients present with complex neuropsychiatric spectrum conditions which do not fall neatly into one or another psychiatric or neurological subspecialty.

Patients with neuropsychiatric conditions need psychiatrists prepared to establish a differential diagnosis and to create a therapeutic alliance with a suffering and alienated patient. A DSM empty of descriptions of common neuropsychiatric conditions is as much a handicap as is training which not infrequently deemphasizes the ability to communicate and empathize with an often frightened, perhaps alienated patient in pain. Neither the neuropsychiatrically bereft DSM-IV nor such training (as is reflected in a recent initiative to use Virtual Reality in the American Board of Psychiatry and Neurology Part 2 oral examination in lieu of live patients) is likely to prepare psychiatrists for the impending neuropsychiatric era where methods as different as empathic imagining and neuro-imaging each can contribute to the diagnosis and treatment of an individual patient (Bursztajn et al., 1990). Eventually, a more extensive discussion of neurological–psychiatric overlap conditions will also require changes in current psychiatry and neurology training, and perhaps one day, lead to a serious reconsideration of the artificial, counterproductive split between psychiatry and neurology (Martin, 2002).

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Maurice Preter is a psychiatrist, neurologist, and forensic neuropsychiatrist in practice in New York City; Assistant Professor of Clinical Psychiatry, Columbia University, and Adj. Associate Professor of Neurology, State University of New York, Downstate Medical Center.

Harold J. Bursztajn is associate clinical professor of Psychiatry; co-founder, Program in Psychiatry and the Law @BIDMC Psychiatry of Harvard Medical School.

Maurice Preter*
1160 Fifth Avenue, 112, New York, NY 10029, USA
http://www.psychiatryneurology.com

Harold J. Bursztajn
Cambridge, MA, USA
http://www.forensic-psych.com

*Corresponding author. Tel.: +1 212 713 5336;
fax: +1 212 713 5336
E-mail address: mp2285@columbia.edu
(M. Preter)

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