

ANXIETY AND DEPRESSIVE DISORDERS: CONTEMPORARY DIAGNOSIS IN LIGHT OF THE DSM-5 AND THE STRUCTURING ROLE OF THE MULTIPROFESSIONAL MENTAL HEALTH TEAM

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Abstract

This article aims to discuss contemporary diagnostic aspects of anxiety and depressive disorders with reference to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), while relating this discussion to the pressing need to recognize and strengthen the multiprofessional mental health team. It is premised on the understanding that although psychiatric diagnosis is structured around operational criteria, it cannot dispense with comprehensive clinical listening, an understanding of individuals within their historical, social, and subjective contexts, or the coordinated efforts of different professional disciplines. Through a narrative literature review, the study traces the development of classification systems, discusses current diagnostic criteria for the principal anxiety and depressive disorders, identifies the challenges associated with differential diagnosis and comorbidities, and critically examines the hegemony of the biomedical model centered exclusively on physicians, which has historically underestimated and undervalued the contributions of psychologists, social workers,

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occupational therapists, nurses, and other professionals who comprise mental health teams. It concludes that overcoming the fragmentation of care depends on consolidating interdisciplinary practices, investing in continuing education, and restoring the symbolic, technical, and financial value of nonmedical professionals in order to ensure more accurate diagnoses and comprehensive, humanized, and effective care for users of mental health services.

Keywords: Anxiety disorders, Depressive disorders, DSM-5, Mental health, Multiprofessional team, Psychiatric diagnosis.

INTRODUCTION

For decades, anxiety and depressive disorders have ranked among the psychiatric conditions with the highest prevalence and greatest functional impact worldwide and have been recognized by international organizations as major causes of disability, work absenteeism, subjective distress, and strain on healthcare systems (World Health Organization, 2022).

The situation in Brazil is no different: recent epidemiological surveys indicate a marked increase in the prevalence of anxiety and depressive symptoms in the general population. This phenomenon has been exacerbated by the social, economic, and public health transformations of recent decades, particularly the psychosocial impact of the COVID-19 pandemic, which has brought lasting changes to contemporary patterns of psychological illness (Barros; Salles, 2021).

Against this backdrop, the careful and technically sound diagnosis of these disorders plays a central role, since it makes it possible to plan effective therapeutic interventions while avoiding both underreporting and undertreatment and the excessive medicalization of legitimate emotional experiences, such as grief, frustration, or insecurity in the face of stressful events in everyday life.

This is a delicate clinical distinction: not all sadness constitutes a depressive episode, just as not all restlessness constitutes an anxiety disorder. It is the intensity and persistence of symptoms and, above

all, functional impairment that warrant a diagnostic hypothesis of a mental disorder in the strict sense (Dalgallarrondo, 2019).

Historically, the principal classification systems used by mental health professionals have been the successive revisions of the International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Over time, these systems underwent significant revisions reflecting paradigmatic shifts in the understanding of psychological distress. The publication of the DSM-5 in 2013, followed by its translation and dissemination in Brazil beginning in 2014, represented an important milestone: it substantially reorganized diagnostic categories, abandoned the multiaxial system used in previous editions, and incorporated dimensional and developmental perspectives into the understanding of mental disorders (American Psychiatric Association, 2014).

At the same time, the World Health Organization published the eleventh revision of the International Classification of Diseases (ICD-11), seeking closer conceptual alignment with the US manual while retaining certain distinctive features (World Health Organization, 2019).

It is essential to recognize, however, that no classification system, regardless of its sophistication, can by itself capture the entirety of a patient's subjective experience. Critics of contemporary psychiatry have warned of the risks of reducing clinical practice to the mere checking of operational criteria, devoid of careful listening and an understanding of the individual's life history (Dunker, 2015; Caponi, 2014).

A technically correct diagnosis that lacks clinical meaning and comprehensive listening risks producing ineffective or even iatrogenic interventions. This is where one of the central arguments of this article lies: diagnosis in mental healthcare is inherently an interdisciplinary process, one that is enriched and improved when it incorporates the different perspectives and bodies of knowledge represented within the multiprofessional team.

Despite decades of progress in public mental health policies and the consolidation of legal frameworks providing for teamwork, such as the Brazilian Psychiatric Reform and the establishment of

the Psychosocial Care Network (Rede de Atenção Psicossocial - RAPS), the day-to-day operation of services continues to be marked by the persistent hegemony of medical and psychiatric knowledge. This results in the symbolic, technical, and financial devaluation of the other professionals who make up these teams, including psychologists, social workers, occupational therapists, nurses, nursing technicians, and others (Peduzzi, 2001; Saupe et al., 2005).

This devaluation manifests itself in precarious employment arrangements, excessive workloads, low pay, limited participation in clinical decision-making, and, not infrequently, the invisibility of these professionals' diagnostic and therapeutic contributions in the face of the prominence afforded to medical diagnosis and prescribing (Amarante, 2007; Onocko-Campos, 2019). This configuration, which remains deeply rooted in a hospital-centered biomedical model, runs counter to the founding principles of the Psychiatric Reform and compromises the quality of care provided by fragmenting a process that, by definition, should be collective, dialogical, and based on shared responsibility.

In view of this situation, this article seeks to connect two dimensions that, although frequently addressed separately in the literature, are intrinsically interdependent: on the one hand, an updated technical discussion of contemporary DSM-5 diagnostic criteria for anxiety and depressive disorders; on the other, a critical examination of the structuring, yet still insufficiently recognized, role played by the multiprofessional team in developing diagnoses that are more accurate, contextualized, and ethically committed to comprehensive mental healthcare.

OBJECTIVES

GENERAL OBJECTIVE

To discuss contemporary diagnostic criteria for anxiety and depressive disorders as established by the DSM-5, relating this discussion to the need to strengthen and recognize the multiprofessional mental health team as a structuring element of the diagnostic and therapeutic process.

SPECIFIC OBJECTIVES

- To describe the historical development of psychiatric classification systems, with an emphasis on the changes introduced by the DSM-5 in relation to previous editions;
- To present the principal current diagnostic criteria for anxiety disorders, namely generalized anxiety disorder, panic disorder, social phobia, and agoraphobia, and for depressive disorders, namely major depressive disorder, persistent depressive disorder, and disruptive mood dysregulation disorder;
- To discuss the challenges inherent in differential diagnosis and in identifying comorbidities between anxiety and depressive conditions;
- To critically examine the hegemony of the physician-centered biomedical model in the mental health diagnostic process;
- To reflect on the role of psychologists, social workers, occupational therapists, nurses, and other professionals in developing comprehensive diagnoses and providing comprehensive mental healthcare.

METHODOLOGY

This is a qualitative, exploratory-descriptive narrative literature review. A narrative review was selected because it allows for a broad, critical, and reflective analysis of the proposed topic without the methodological rigidity of systematic reviews. It thus makes it possible to connect technical data from classification manuals with broader theoretical discussions from the fields of public health, psychology, and the social sciences applied to health.

The Scientific Electronic Library Online (SciELO), Latin American and Caribbean Health Sciences Literature (Literatura Latino-Americana e do Caribe em Ciências da Saúde - LILACS), PubMed, and Google Scholar databases were searched using the descriptors “anxiety disorders,” “depressive

disorders,” “DSM-5,” “psychiatric diagnosis,” “multiprofessional team,” and “mental health,” both separately and in combination using the Boolean operator “AND.”

Priority was given to publications in Portuguese, English, and Spanish from the preceding fifteen years, without precluding the inclusion of classic works of recognized theoretical relevance to the historical understanding of the topic. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the eleventh revision of the International Classification of Diseases (ICD-11) were used as primary normative sources.

DEVELOPMENT

FROM CLASSICAL NOSOGRAPHY TO THE DSM-5: THE DEVELOPMENT OF CLASSIFICATION SYSTEMS

The development of psychiatric classification systems has historically accompanied the epistemological transformations of the field itself. The first systematic attempts to categorize mental disorders can be traced to the work of Emil Kraepelin in the late nineteenth century, who sought to differentiate conditions based on their clinical course and prognosis. Throughout the twentieth century, successive editions of the DSM, first published in 1952, reflected different theoretical orientations, ranging from psychoanalytic influences in the earliest versions to the neo-Kraepelinian shift consolidated with the DSM-III in 1980. The latter established explicit operational criteria, symptom lists, and quantitative thresholds with the aim of improving interrater diagnostic reliability (Dalgarrondo, 2019; Pereira, 2013).

The DSM-5, published in 2013 by the American Psychiatric Association, represented a significant departure from the multi-axial model adopted in the DSM-III-R and retained in the DSM-IV-TR. The elimination of the five assessment axes, which separated, for example, clinical disorders on Axis I from personality disorders and intellectual disabilities on Axis II, gave way to a single, nonhierarchical list of diagnoses. This was accompanied by a recommendation for supplementary assessment using cross-

cutting and disorder-specific dimensional scales capable of capturing severity and continuous variation in symptoms rather than merely their categorical presence or absence (American Psychiatric Association, 2014).

This change sought to address longstanding criticism of the excessive categorical rigidity of previous manuals, which tended to create artificial boundaries between clinical conditions that, in practice, exhibit substantial symptomatic overlap, as is notably the case with anxiety and depression (American Psychiatric Association, 2014).

The DSM-5 also reorganized entire chapters. Anxiety disorders, which had previously been grouped into a single broad chapter that also encompassed obsessive-compulsive disorder and posttraumatic stress disorder, were divided among three distinct chapters: Anxiety Disorders; Obsessive-Compulsive and Related Disorders; and Trauma- and Stressor-Related Disorders. This reorganization recognized the pathophysiological and clinical distinctions among these conditions (American Psychiatric Association, 2014).

At the same time, the World Health Organization published the eleventh revision of the International Classification of Diseases in 2019, which officially came into effect in 2022. It sought greater structural compatibility with the DSM-5 while maintaining relevant differences, particularly regarding symptom-duration thresholds and the relatively greater emphasis placed by the ICD on distress and functional impairment rather than on extensive symptom lists (World Health Organization, 2019; Fonseca; Andrade, 2020).

This partial convergence between the two principal classification systems reflects an international effort to harmonize diagnosis without, however, eliminating the epistemological tensions underlying the very act of classifying psychological distress.

ANXIETY DISORDERS: CONTEMPORARY DIAGNOSTIC CRITERIA

Under the chapter on Anxiety Disorders, the DSM-5 groups a set of conditions characterized by excessive fear or anxiety accompanied by related behavioral disturbances. These conditions are distinguished from one another primarily by the type of object or situation that triggers the anxiety response and by the associated cognition (American Psychiatric Association, 2014).

Generalized Anxiety Disorder (GAD) is defined by the presence of excessive anxiety and worry occurring on most days for at least six months, involving a number of events or activities, and which the individual finds difficult to control. At least three of the following associated symptoms must be present: restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and sleep disturbance. Only one of these symptoms is required in children (American Psychiatric Association, 2014).

The condition must cause clinically significant distress or functional impairment and cannot be better explained by the effects of a substance, a general medical condition, or another mental disorder (American Psychiatric Association, 2014).

Panic Disorder is characterized by recurrent, unexpected panic attacks, defined as abrupt surges of intense fear or discomfort that reach a peak within minutes and are accompanied by physical and cognitive symptoms such as palpitations, sweating, trembling, shortness of breath, chest pain, nausea, dizziness, depersonalization or derealization, fear of losing control, and fear of dying. For the disorder to be diagnosed, at least one of the attacks must have been followed by one month or more of persistent concern about additional attacks or a maladaptive behavioral change related to them, such as avoiding certain places or activities (American Psychiatric Association, 2014).

Social Anxiety Disorder (Social Phobia) involves marked fear or anxiety about social situations in which the individual may be negatively evaluated by others, accompanied by concern about behaving in a humiliating manner or displaying anxiety symptoms that may be negatively perceived. The social

situation is almost always avoided or endured with intense distress, and the condition typically persists for six months or more (American Psychiatric Association, 2014).

Agoraphobia, which has been separated from panic disorder and recognized as an independent diagnosis since the DSM-5, refers to marked fear or anxiety concerning two or more of the following situations: using public transportation, being in open spaces, being in enclosed places, standing in line or being in a crowd, or being outside the home alone. This fear is motivated by the concern that escape might be difficult or help unavailable in the event of panic-like symptoms (American Psychiatric Association, 2014).

Separation Anxiety Disorder also warrants attention. Its inclusion among the anxiety disorders, rather than exclusively among childhood disorders, acknowledges that the condition may also emerge or persist in adulthood. It is characterized by excessive fear or anxiety that is developmentally inappropriate and related to separation from attachment figures (American Psychiatric Association, 2014).

Across all these conditions, the DSM-5 emphasizes the need to rule out organic causes and substance use, as well as the importance of carefully assessing functional impairment, which is indispensable for distinguishing pathological anxiety from emotional reactions that are expected in response to stressful circumstances in everyday life (Dalgarrondo, 2019).

DEPRESSIVE DISORDERS: CONTEMPORARY DIAGNOSTIC CRITERIA

The chapter on Depressive Disorders, which was also reorganized in the DSM-5, now includes two new categories in addition to the well-established Major Depressive Disorder and Persistent Depressive Disorder, formerly known as dysthymia: Disruptive Mood Dysregulation Disorder and Premenstrual Dysphoric Disorder. These categories seek to capture specific clinical presentations that were previously poorly classified or subject to excessive diagnoses of bipolar disorder in children (American Psychiatric Association, 2014).

Major Depressive Disorder requires the presence of at least five out of nine symptoms over a minimum period of two weeks, representing a change from previous functioning. Either depressed mood or loss of interest or pleasure, known as anhedonia, must be present. The remaining symptoms include significant changes in weight or appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, impaired concentration or indecisiveness, and recurrent thoughts of death or suicidal ideation. The symptoms must cause clinically significant distress or functional impairment, cannot be attributable to the physiological effects of a substance or medical condition, and cannot be better explained by schizophrenia spectrum disorders or other psychotic disorders (American Psychiatric Association, 2014).

A significant change introduced by the DSM-5 was the elimination of the so-called “bereavement exclusion,” which was present in the DSM-IV-TR and precluded the diagnosis of a major depressive episode during the first weeks following the death of a loved one. Although the removal of this exclusion was technically justified by the recognition that bereavement may, in some cases, precipitate or coexist with a genuine major depressive condition, it generated intense debate within the scientific community. Critics identified it as a paradigmatic example of the risk of pathologizing emotional processes that are expected and culturally meaningful (Frances, 2013; Caponi, 2014).

In response to this controversy, the manual itself included a footnote instructing clinicians to differentiate normal grief from a major depressive episode through careful clinical judgment, taking into account factors such as the predominant nature of the affect, the preservation of self-esteem, and the temporal variation of distress.

In the DSM-5, Persistent Depressive Disorder (Dysthymia) merges the former categories of dysthymic disorder and chronic major depressive disorder. It is characterized by depressed mood for most of the day, on most days, for at least two years in adults and one year in children and adolescents, accompanied by at least two additional symptoms, such as changes in appetite, sleep disturbances, low

energy, low self-esteem, difficulty concentrating, or feelings of hopelessness (American Psychiatric Association, 2014).

Disruptive Mood Dysregulation Disorder, which applies to children between six and eighteen years of age, was introduced to reduce the excessive diagnosis of pediatric bipolar disorder. It is characterized by severe, recurrent temper outbursts that are disproportionate to the situation and are associated with persistent irritability or anger between episodes (American Psychiatric Association, 2014).

DIFFERENTIAL DIAGNOSIS AND COMORBIDITIES: A TERRITORY OF BLURRED BOUNDARIES

The high level of comorbidity between anxiety and depressive disorders represents one of the greatest diagnostic challenges in contemporary clinical practice. Epidemiological studies indicate that between 50% and 60% of individuals diagnosed with major depressive disorder also experience an anxiety disorder during their lifetime, a phenomenon that raises questions about the validity of a strict categorical separation between these conditions (Kessler et al., 2015; Ballone, 2018).

Symptoms such as irritability, muscle tension, sleep disturbances, and difficulty concentrating are shared by both conditions. This requires the clinician, and ideally the multiprofessional team as a whole, to conduct a careful longitudinal assessment focusing on the chronology of symptom onset, precipitating factors, and patterns of response to treatment (Kessler et al., 2015; Ballone, 2018).

In addition, these conditions must be differentiated from general medical conditions that frequently mimic anxiety and depressive symptoms, including thyroid dysfunction, anemia, nutritional deficiencies, psychoactive substance use and withdrawal, and medication side effects. The DSM-5 explicitly recommends ruling out these organic causes before confirming any primary psychiatric diagnosis. This once again underscores the importance of a multidisciplinary clinical assessment capable

of integrating a general medical evaluation, a detailed mental status examination, a psychosocial investigation, and, where indicated, supplementary tests (Dalgarrondo, 2019).

The sociocultural dimension of diagnosis also warrants attention. Factors such as precarious living conditions, domestic violence, unemployment, structural racism, and gender inequalities directly affect the manifestation and intensity of anxiety and depressive symptoms. The diagnostic process must therefore extend beyond the checking of operational criteria and incorporate a comprehensive understanding of the context in which the individual lives, a task for which the contributions of social workers and psychologists are indispensable (Amarante, 2007; Vasconcelos, 2010).

THE HEGEMONY AND LIMITATIONS OF THE BIOMEDICAL MODEL

Historically, the mental health field in Brazil and much of the Western world has been structured around a model strongly centered on the psychiatrist as the sole holder of diagnostic and prescribing authority. As the product of an asylum-based and organicist tradition, this model tends to reduce psychological distress to a neurochemical dysfunction to be corrected pharmacologically, relegating the subjective, relational, social, and existential dimensions of illness to a secondary position (Amarante, 2007; Basaglia, 1985).

Although the Brazilian Psychiatric Reform, legally consolidated through Law No. 10,216/2001, promoted significant advances toward a territorial, community-based, and multiprofessional model of care embodied in the Psychosocial Care Network (RAPS) and services such as the Psychosocial Care Centers (Centros de Atenção Psicossocial - CAPS), the day-to-day operation of services continues to reveal an institutional culture that reproduces symbolic hierarchies among professional disciplines (Peduzzi, 2001; Onocko-Campos, 2019).

Even when formally resulting from team discussions, a diagnosis tends to be “ratified” or “validated” by a physician’s signature. Other professional categories are consequently relegated to a role

perceived as auxiliary or complementary rather than constitutive of the diagnostic process itself (Peduzzi, 2001; Onocko-Campos, 2019).

This hierarchy has concrete consequences: excessive workloads for physicians; underuse of the clinical potential of psychologists and occupational therapists in developing diagnostic hypotheses; the invisibility of the fundamental role played by nurses and nursing technicians in the longitudinal observation of patients; and disregard for the socioeconomic and family assessments performed by social workers, which are often decisive for a comprehensive understanding of the clinical condition and for therapeutic success itself (Saupe et al., 2005; Federal Council of Psychology, 2019).

Moreover, this hierarchy is reflected in substantial pay disparities, reduced participation by nonmedical professionals in institutional decision-making, and barriers to the full exercise of their roles, as illustrated by recurrent professional disputes over formal diagnostic authority (Saupe et al., 2005; Federal Council of Psychology, 2019).

THE STRUCTURING ROLE OF THE MULTIPROFESSIONAL TEAM IN THE DIAGNOSTIC PROCESS

In contrast to this hegemonic approach, a growing number of authors have advocated viewing mental health diagnosis as an essentially collective and interdisciplinary process in which each professional discipline contributes a distinctive, indispensable perspective that complements those of the others (Peduzzi, 2001; Merhy, 2002).

Through in-depth clinical interviews, standardized psychological tests, and symptom-rating scales, psychologists make a decisive contribution to the qualitative characterization of psychological distress, the investigation of factors that precipitate and perpetuate symptoms, and the differentiation between conditions that arise in response to life events and those with a more endogenous or structural basis. Their extended listening, often more extensive than that available during a traditional medical consultation, enables them to identify biographical nuances, relationship patterns, and defense mechanisms that rarely

emerge in one-time, objective assessments, thereby substantially enriching the final diagnostic formulation (Federal Council of Psychology, 2019; Dunker, 2015).

Social workers, in turn, play an indispensable role in assessing the concrete conditions of a service user's life, including family relationships, housing circumstances, participation in the labor market, access to social rights, and exposure to violence and vulnerability. Anxiety and depressive symptoms frequently originate in or are significantly exacerbated by social determinants that fall beyond the scope of strictly individual clinical care. Ignoring this dimension compromises not only diagnostic accuracy but also the appropriateness of the proposed interventions (Vasconcelos, 2010; Iamamoto, 2015).

It is often the social worker who recognizes that a case of “generalized anxiety” is, in fact, an understandable response to food insecurity, domestic violence, or chronic unemployment, circumstances that require psychosocial intervention and intersectoral coordination rather than psychopharmacological treatment alone (Vasconcelos, 2010; Iamamoto, 2015).

Occupational therapists contribute through detailed functional assessments, observing the concrete impact of symptoms on an individual's occupational performance, including the ability to work, study, care for oneself and others, maintain routines, and sustain social relationships. This assessment is particularly relevant to distinguishing subclinical distress from conditions that effectively result in significant functional impairment, one of the central and sometimes neglected criteria in diagnostic manuals (American Psychiatric Association, 2014; Bartalotti, 2006).

Through longitudinal follow-up, observation of sleep, appetite, and behavioral patterns, and the day-to-day relationships established particularly in inpatient settings or during intensive follow-up at CAPS, nurses and nursing teams provide valuable clinical information, often gathered at times and in contexts to which physicians do not have direct access (Kantorski et al., 2009).

Likewise, physical education professionals, art therapists, music therapists, and other members of extended mental health teams contribute complementary perspectives on the bodily, creative, and

symbolic expression of psychological distress, dimensions that are often inaccessible through exclusively verbal and anamnesis-based approaches.

Rather than fragmenting the diagnostic process, the integration of these multiple perspectives tends to improve it and make it more faithful to the genuine complexity of the human experience of illness. Well-established experiences at CAPS in different regions of Brazil demonstrate that team-based case discussions, with the active and horizontal participation of all professional disciplines rather than psychiatrists alone, result in more consistent diagnostic formulations, individualized therapeutic plans that are more closely aligned with service users' circumstances, and a lower incidence of diagnostic errors, particularly in cases involving atypical presentations or strong influences from social determinants (Onocko-Campos, 2019; Kantorski et al., 2009).

PATHWAYS TOWARD RECOGNIZING THE MULTIPROFESSIONAL TEAM

Overcoming the fragmentation and hierarchy historically entrenched in mental health services requires investment on multiple fronts, extending far beyond the formal rhetoric of “teamwork,” which is frequently devoid of practical effectiveness. First, there is a need for continuing health education capable of providing all professional disciplines with technical training in the updated diagnostic criteria of the DSM-5 and ICD-11, while also sensitizing them to the importance of genuine interdisciplinary work. This entails moving beyond the mere juxtaposition of different bodies of knowledge toward the effective shared construction of care (Ceccim; Feuerwerker, 2004).

Second, institutional workflows and clinical protocols must be reviewed to formalize and recognize the diagnostic contribution of each professional category, thereby moving beyond models in which nonmedical assessments serve merely as “supporting information” to be endorsed by medical authority. Regular team meetings, structured clinical case discussions, the joint development of Singular Therapeutic Projects (Projetos Terapêuticos Singulares - PTS), and shared medical records are concrete

mechanisms through which this cultural change can be implemented (Onocko-Campos, 2019; Merhy, 2002).

Third, and perhaps most urgently, the pay disparities and precarious working conditions that disproportionately affect nonmedical mental health professionals must be addressed. Many of these professionals work under insecure contractual arrangements, endure exhausting schedules, and receive compensation incompatible with the technical complexity and emotional burden inherent in clinical mental health practice. Symbolic recognition of interdisciplinary work is necessary but insufficient unless accompanied by substantive material recognition. Otherwise, institutional contradictions between what is proclaimed and what is actually practiced will continue to be perpetuated (Saupe et al., 2005; Amarante, 2007).

Finally, the role of professional associations and participatory oversight bodies, such as professional councils, labor unions, and municipal and state health councils, must be emphasized in the political struggle to consolidate regulatory frameworks that guarantee equal participation in decision-making among the different professional disciplines within mental health services. This requires overcoming historically entrenched professional resistance and advancing toward the construction of a truly democratic, pluralistic, and effective model of care.

FINAL CONSIDERATIONS

This article sought to connect an updated technical discussion of contemporary diagnostic criteria for anxiety and depressive disorders in light of the DSM-5 with a critical examination of the structuring, yet historically underestimated, role played by the multiprofessional team in the mental health diagnostic and therapeutic process. The analysis supports the conclusion that although contemporary classification systems have made significant advances in the pursuit of greater diagnostic accuracy, reliability, and clinical sensitivity, no operational criterion, regardless of how carefully constructed, can replace the

richness of comprehensive listening, a contextualized understanding of the individual, or the collective and interdisciplinary construction of diagnostic perspectives.

The high prevalence of comorbidities between anxiety and depressive conditions, the decisive influence of social, economic, and cultural factors on the manifestation of psychological distress, and the concrete risks of both underdiagnosis and excessive medicalization reinforce the central argument of this study: mental health diagnosis is, by its nature and out of necessity, a collective process. Its quality and legitimacy increase when it genuinely and horizontally incorporates the contributions of psychologists, social workers, occupational therapists, nurses, and the other professionals who comprise mental health teams.

Nevertheless, a substantial gap persists between the formal discourse of teamwork, which is firmly established in the guidelines of the Psychiatric Reform and the Psychosocial Care Network, and the concrete reality of services, which remain marked by symbolic hierarchies, pay disparities, and the limited participation of nonmedical professionals in decision-making. Overcoming this contradiction requires coordinated investments in continuing education, the review of institutional workflows, efforts to address employment inequalities, and the strengthening of participatory oversight mechanisms.

It may therefore be concluded that improving contemporary psychiatric diagnosis and ensuring comprehensive, humanized, and effective care for users of mental health services necessarily depend on the substantive symbolic, technical, and financial recognition of the entire multiprofessional team. This is an indispensable condition for effectively overcoming the hegemonic biomedical model and consolidating a mental health practice genuinely committed to the complexity of human experience. Future studies should conduct empirical research in a range of Brazilian institutional contexts to investigate the concrete effects of genuinely interdisciplinary models on diagnostic accuracy and therapeutic outcomes in mental healthcare.

REFERENCES

- Amarante, P. *Saúde mental e atenção psicossocial* [Mental health and psychosocial care]. Rio de Janeiro: Editora Fiocruz, 2007.
- American Psychiatric Association. *DSM-5: Manual diagnóstico e estatístico de transtornos mentais* [DSM-5: Diagnostic and Statistical Manual of Mental Disorders]. 5th ed. Porto Alegre: Artmed, 2014.
- Ballone, G. J. Comorbidade entre ansiedade e depressão [Comorbidity between anxiety and depression]. *Revista Brasileira de Psiquiatria Clínica*, v. 45, n. 2, p. 34–41, 2018.
- Barros, M. B. A.; Salles, D. Impacto psicossocial da pandemia de COVID-19 na saúde mental da população brasileira [Psychosocial impact of the COVID-19 pandemic on the mental health of the Brazilian population]. *Ciência & Saúde Coletiva*, v. 26, n. 9, p. 4211–4224, 2021.
- Bartalotti, C. C. *Terapia ocupacional e saúde mental* [Occupational therapy and mental health]. São Paulo: Plexus, 2006.
- Basaglia, F. *A instituição negada* [The denied institution]. Rio de Janeiro: Graal, 1985.
- Caponi, S. *Loucos e degenerados: uma genealogia da psiquiatria ampliada* [The mad and the degenerate: A genealogy of expanded psychiatry]. Rio de Janeiro: Editora Fiocruz, 2014.
- Ceccim, R. B.; Feuerwerker, L. C. M. O quadrilátero da formação para a área da saúde [The quadrilateral of healthcare education]. *Physis: Revista de Saúde Coletiva*, v. 14, n. 1, p. 41–65, 2004.
- Conselho Federal De Psicologia. *Referências técnicas para atuação de psicólogos(os) no CAPS* [Technical guidelines for psychologists working in CAPS]. Brasília: CFP, 2019.
- Dalgalarrodo, P. *Psicopatologia e semiologia dos transtornos mentais* [Psychopathology and the semiology of mental disorders]. 3rd ed. Porto Alegre: Artmed, 2019.
- Dunker, C. I. L. *Mal-estar, sofrimento e sintoma: uma psicopatologia do Brasil entre muros* [Discontent, suffering, and symptom: A psychopathology of Brazil between walls]. São Paulo: Boitempo, 2015.

Fonseca, A. B.; Andrade, L. H. Comparação entre DSM-5 e CID-11: convergências e divergências

[Comparison between the DSM-5 and ICD-11: Convergences and divergences]. *Revista de Psiquiatria Clínica*, v. 47, n. 3, p. 112–120, 2020.

Frances, A. *Saving normal: an insider's revolt against out-of-control psychiatric diagnosis*. New York:

William Morrow, 2013.

Iamamoto, M. V. *Serviço social em tempo de capital fetiche* [Social work in an age of fetish capital]. 10th

ed. São Paulo: Cortez, 2015.

Kantorski, L. P. et al. A enfermagem e o cuidado em saúde mental [Nursing and mental healthcare].

Revista Gaúcha de Enfermagem, v. 30, n. 3, p. 526–532, 2009.

Kessler, R. C. et al. Comorbidade entre transtornos de ansiedade e depressão [Comorbidity between

anxiety and depressive disorders]. *World Psychiatry*, v. 14, n. 2, p. 154–162, 2015.

Merhy, E. E. *Saúde: a cartografia do trabalho vivo* [Health: The cartography of living labor]. São Paulo:

Hucitec, 2002.

Onocko-Campos, R. T. Saúde mental no Brasil: avanços, retrocessos e desafios [Mental health in Brazil:

Advances, setbacks, and challenges]. *Cadernos de Saúde Pública*, v. 35, n. 11, p. e00156119,

2019.

World Health Organization. *Relatório mundial de saúde mental: transformando a saúde mental para todos*

[World mental health report: Transforming mental health for all]. Geneva: WHO, 2022.

Peduzzi, M. Equipe multiprofissional de saúde: conceito e tipologia [Multiprofessional healthcare team:

Concept and typology]. *Revista de Saúde Pública*, v. 35, n. 1, p. 103–109, 2001.

Pereira, M. E. C. Do DSM-III ao DSM-5: trinta anos de nosografia psiquiátrica [From the DSM-III to the

DSM-5: Thirty years of psychiatric nosography]. *Revista Latinoamericana de Psicopatologia*

Fundamental, v. 16, n. 2, p. 195–208, 2013.

Saupe, R. et al. Competência dos profissionais da saúde para o trabalho interdisciplinar [Healthcare professionals' competence for interdisciplinary work]. *Interface — Comunicação, Saúde, Educação*, v. 9, n. 18, p. 521–536, 2005.

Vasconcelos, E. M. *Saúde mental e serviço social: o desafio da subjetividade e da interdisciplinaridade* [Mental health and social work: The challenge of subjectivity and interdisciplinarity]. 6th ed. São Paulo: Cortez, 2010.

World Health Organization. *ICD-11: International Classification of Diseases for Mortality and Morbidity Statistics*. 11th ed. Geneva: WHO, 2019.