

DSM-5: THE MORE IT CHANGES THE MORE IT IS THE SAME

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At the annual meeting of the American Psychiatric Association that took place in San Francisco in May 2013, after a year-long delay the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released. It is the result of the assiduous work of 400 clinicians who for about ten years endeavoured to articulate a new edition of the Manual. The last edition (DSM-IV-TR) appeared 13 years ago.

Did anything substantially new occur in psychiatry in the meantime that could justify the creation of a new edition? No, it did not. Did the imperfections of the previous editions starting from the third one (DSM-III, 1980; DSM-III-R, 1987; DSM-IV, 1994; DSM-IV-TR, 2010) build up to a point where a new version that would correct them was badly needed? Indeed, the downsides of the preceding revisions of the Manual proved serious and numerous. Has DSM-5 managed to redress them?

Whence comes the need for DSM-5?

Here is how David J. Kupfer, the DSM-5 Task Force chairman, et al. (2013) expound what motivated them to produce DSM-5: "Conceptually development of DSM-5 sprang from a need to reduce clinicians' reliance on the 'not otherwise specified' category of many disorders, which is vague and contributes little to treatment planning; to develop more accurate criteria that improve diagnostic reliability; and to integrate dimensional aspects of psychiatric disorders with the current categorical approach, so that the classification system more accurately represents how symptoms manifest and present clinically."

The architects of the DSM-5 present their product as a "living document" which means that they want to update it as evidence comes in. That is why they use the digit "5" instead of "V". Thus, this edition of the DSM-5 is actually "DSM-5.0". Hopefully, there will be "DSM-5.1", "DSM-5.2" etc. if biological markers of mental disorders are identified in years to come. It appears that those in charge of DSM-5 wanted to prevent the need for DSM-6 any time soon, or, were keen on conveying that their work is the final product of the DSM series unless, of course, something revolutionary in psychiatry happens in the meantime that will initiate the creation of DSM-6.

It is worth reminding that DSM-III was a reaction to psychoanalytical fanciful interpretations, to a reliability crisis in psychiatry, to a lack of structural validity, and

to antipsychiatry's questioning the basics of psychiatry. The idea was to re-medicalize psychiatry because it significantly moved away from medicine in the sixties and seventies. DSM-III was welcomed by health insurance agencies. They recognized it as an instrument that will enable them to more accurately assess whether someone is mentally ill, and if yes, from which kind of mental disorder they suffer, on which kind of treatment they are entitled, and for how long. The legal institutions also found DSM-III helpful in dealing with insanity pleas, and compensation claims. Researchers joined the group of those who greeted DSM-III. Now, they said, we are more confident than before that, whilst researching the causes of a mental disorder, we are looking for the underlying of just this particular and not of some other mental illness.

The fact that DSM-III for the first time in the history of psychiatry introduced operational diagnoses in diagnostics and classifications of mental disorders sufficed to label it as revolutionary. Soon after the publication it became the psychiatrists' bible. When carrying out empirical research, the experimental group had to be formed according to the DSM-criteria. Residents, primarily in the United States, were learning psychiatry from DSM-III. The Court asked psychiatrists to define mental disorders in tune with the DSM-III terminology.

You could not have been mentally disordered if your symptoms did not fit in some of the DSM-III diagnostic categories. You could not claim compensation unless your mental difficulties that appeared secondary to some traumatic experience did not correspond to a diagnostic entity as defined in DSM-III. The financial effect of such widespread use of DSM-III was quite expected. It counted in millions of dollars. The coffins of the American Psychiatric Association were overflowing with money.

The same happened with DSM-IV which followed in the footsteps of its predecessor.

Threshold lowering and its consequences

And, now, we have DSM-5. Does the fifth edition keep the promise of its authors that it would be revolutionary in the sense in which the third version was so at the time? Does it provide a diagnostic paradigm shift as advertised? Does it provide a correlation between biological facts and the mental epiphenomena? No, it does not.

In DSM-5, a number of disorders have been reclassified: shifted from one diagnostic group to another. Some diagnostic entities were split, some lumped. As is the case with DSM-III and DSM-IV, the categorical approach has been applied in diagnosing and classifying all mental disorders. A portion of mental disorders have been additionally described by making use of the dimensional principle. The combination of these two ways of diagnosing mental disorders does not seem user friendly; moreover, it is likely to breed numerous deliberations and misunderstandings.

I would like to draw the reader's attention to a few changes from DSM-IV to DSM-5 that in all likelihood would be considered controversial, to say the very least.

In DSM-IV, individuals meeting the criteria for a major depressive episode were excluded from a diagnosis of major depressive disorder if symptoms occurred within 2 months of the death of a loved one. In DSM-5, the bereavement exclusion has been eliminated from major depressive disorder. Thus, now, grief as a normal reaction to the loss of a significant person might be diagnosed as major depressive disorder. The danger of the pathologization of normal life stresses and strains is more than obvious in this case.

Also, in DSM-5, the category of mild neurocognitive disorder has been introduced. It will be a big challenge to make a clear distinction between incipient dementia and the level of cognitive impairment that goes with ageing. The introduction of this category also carries the risk of pathologizing normal processes.

The same holds for the reduction in the number of criteria necessary for the diagnosis of Attention Deficit Disorder. The inflation of this diagnosis was noted after the publication of DSM-IV. DSM-5 will not reduce the inflation; quite the reverse, it will most likely lead to a hyperinflation of this diagnosis.

The reduction in symptomatic duration and the number of necessary criteria for the diagnosis of Generalized Anxiety Disorder will probably have the same effect.

The overall impression is that, in a good number of cases, diagnostic thresholds have been lowered. So much so that, as someone commented, it will be difficult to be normal after the publication of DSM-5. Consequently, a rise in work- and motor vehicle accident-related mental health claims is feared. The broadening of diagnoses might precipitate an increase in unnecessary treatment and a mislabelling of people, not to mention the risk of the depletion of insurers' funds. The legal institutions and law-enforcing agencies should also be concerned. If psychiatrists stick to the DSM-5 to the letter, they will have, on the grounds of mental disturbance, to acquit more people who came into conflict with the law than they had to do before the publication of the newest diagnostic and classificatory system.

I do not agree with Nassir Ghaemi (2013) who maintains that there should not be any fuss about having

half or even more than half of population diagnosed as mentally disturbed. "Why should people, nosologists included," asks Ghaemi, "despise the fact that much of the population might experience psychiatric problems, even illness?" The point that this psychiatric scholar wants to make is that there is not much difference between having mental and having physical disorders, especially those which are brief and transient. The argument runs as follows: Why should having many people mentally disturbed be disquieting, and at the same time we are not concerned about the fact that minor physical disorders are common. In my view, the major difference between these two kinds of disorders is that all mental disorders are associated with stigma, whereas the greatest majority of physical disorders are not. Moreover, the social repercussions of being diagnosed as mentally disturbed are more numerous, more serious and far more reaching than being diagnosed as physically ill.

Where is the whole picture of a mentally ill person gone?

What is of greatest concern to me is the fact that the philosophy of DSM-5 has not changed a bit in relation to the philosophy of DSM-III and DSM-IV. "The DSM framework does very little to enlighten the clinician regarding the 'inner world' of the suffering patient" (Pies 2012). DSM-5 fails – the same as DSM-III and DSM-IV failed – to assist the clinician in better understanding the illness from the patient's perspective. "Most psychiatrists have been steeped in the culture of symptom check-list – not in the sorrows of the soul." (Pies 2011) In DSM-5, there is, as in DSM-III and DSM-IV, a listing of symptoms and signs which are mutually independent entities. The specific experience of each patient, the way in which they experience mental difficulties and relate to them, themselves and the world as well as the Gestalt of a particular disorder is missing. Furthermore, except for a few disorders, e.g., Acute Stress Disorder, Adjustment Disorder, and Post Traumatic Stress Disorder, the diagnostic entities remain decontextualized. There is not much mention of the context in which a particular disorder appears, and of the disorder-maintaining circumstances.

Even before it was published DSM-5 drew wide criticism. The most vociferous critic was, and still is, Allen Frances (2012), the DSM-IV Task Force chairman. Yet, having in mind that the National Institute of Mental Health funds most psychiatric research projects in the United States, the blow that Thomas Insel (2013), director of this organization, dealt to DSM-5 seems to be the most serious one, so far. Insel argues that it is wise to discard DSM-5 because it actually involves "mostly modest alterations of the previous edition", and because far from being a Bible for the field "it is, at best, a dictionary, creating a set of labels and defining each."

Insel does not criticize DSM's paying lip service to the way in which patients experience the disorder and to how they elaborate their experience; rather, he argues for the launch of the Research Domain Criteria (RDoC) project "to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classificatory system". In Insel's view, "the diagnostic system has to be based on emerging research data, not on the current symptom-based categories", and, one might add, on a consensus about clusters of clinical symptoms.

The revisers of DSM-s since 1968, the authors of the newest one including, all claimed that each revision is much more scientific. It is doubtful, however, whether any revision was justified by particular major scientific advances unless you consider the application of instruments that are meant to increase the reliability of diagnosis – criteria-based diagnostic categories and operational definitions of such criteria - as a token of the scientific status of psychiatry. It is a big question whether RDoC will bring any substantial change in that regard.

On the other hand, we are witnessing the revival of interest in phenomena of inner experience and sensations against observable symptoms (Fulford et al. 2003). It would appear that there is an emerging remake of the old clash in psychiatry: the clash between observation and empathy, general causal laws and diverse meaningful accounts, explaining and understanding. The biggest challenge psychiatry has been facing up to over the last 200 years is how to negotiate the need to increase reliability of psychiatric diagnosis and establish its validity, and the need to fully appreciate the subjectivity of people with mental disorder. DSM-5 did not, because it could not, address this challenge of all challenges.

In the past, a single general conception so often had the upper hand. Hopefully, this will not be the case in the future of psychiatry.

The good news is that a growing number of psychiatrists, especially the private ones, do not stick to DSM in their day-to-day clinical practice because they do not believe that any operationalized diagnostic system (structured diagnostic interviews and checklists) can enable them to grasp the whole picture of the patient's illness. My guess is that the practice of turning back to DSM's diagnostic recipes will expand.

One thing is for sure in the aftermath of the publication of DSM-5. A diagnostic and classificatory system that would square with the specificity of mental disorders, and accordingly be widely agreed-upon, is a long way off.

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References

1. *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, fifth edition.* American Psychiatric Association, Washington, DC, 2013.
2. Frances AJ & Widiger T: *Psychiatric diagnosis: lessons from the DSM-IV past and caution for DSM-5 future.* *Ann Rev Clin Psychol* 2012; 8:21-28.
3. Fulford B, Morris K, Sadler J, Stanghellini G: *Nature and Narrative. An Introduction to the New Philosophy of Psychiatry.* Oxford University Press, New York, 2003.
4. Ghaemi SN: *Against 'pragmatism' in DSM/ICD: A commentary on prodromal psychosis.* *Acta Psychiatr Scand* 2013; 127:253.
5. Insel T: *Transforming diagnosis.* Director's blog.<http://nimh.nih.gov/about/direct>, Accessed 3 June 2013.
6. Kupfer DJ, Kuhl EA, Wulsin L: *Psychiatry's integration with medicine: The role of DSM-5.* *Ann Rev Med* 2013; 64:385-92.
7. Pies R: *Why psychiatry needs to scrap DSM system: An immodest proposal.* <http://psychcentral.com/blog/archiv>, January, accessed 3 June 2013.

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