Evolving psychiatric diagnosis and the DSM: hasten slowly

As the publication date draws closer, concerns grow over the proposed format of the DSM-5

Paul B Fitzgerald
MB BS, PhD, FRANZCP,
Deputy Director and
Professor of Psychiatry

Monash Alfred Psychiatry
Research Centre, Monash
University Central Clinical
School and Alfred Health,
Melbourne, VIC.

p.fitzgerald@alfred.org.au

doi: 10.5694/mja12.10578

The American Psychiatric Association is currently undertaking a major revision of the *Diagnostic and statistical manual of mental disorders*, and the 5th edition (DSM-5) is due to be published in May 2013. The process of the revision of this publication has been mired in controversy. As we approach its proposed date of publication, the controversy has only grown, with considerable spread of debate into the broader community. Concern about the process of revision of the DSM initially highlighted a number of procedural issues, especially with regard to the manner in which members of the DSM-5 taskforce were committed to secrecy by a confidentiality agreement.[1] Concerns have also been voiced about the degree to which members of the taskforce have substantive ongoing or past relationships with the pharmaceutical industry and whether these are adequately mitigated by the current conflict of interest policy.[2]

These concerns have now been mostly superseded by content-related debates about the degree to which substantial changes to diagnostic processes are justified and about the potential impacts of broadened diagnositic categories. With regard to the former, it was proposed by the DSM-5 task force that the DSM-5 would introduce something of a paradigm shift in diagnosis by moving towards dimensional diagnoses,[3] such as the inclusion of rating scales of symptom severity, and possibly having an aetiological framework.[4,5] Objections to this proposal were based on a perceived lack of sufficient evidence to justify radical change.[5] It now appears more likely that the DSM-5 will introduce a less dramatic restructure of diagnostic processes, with the inclusion of some measures that use dimensional rating scales alongside pre-existing categories — but this may still be problematic.[6]

It is now mostly in the area of the potential broadening of diagnositic categories that the debate continues. A variety of modifications have been proposed that could substantially increase the number of individuals who would meet formal criteria for a psychiatric disorder. For example, a new "risk syndrome for first psychosis" has been proposed to allow the formal diagnosis of individuals presenting with attenuated or subthreshold psychotic symptoms.[7] Criteria have been developed over recent years that may be used to define a risk group where the chance of progression to psychotic disorder over the subsequent 2 years is relatively high (up to 50% in some but not all studies).[7] The inclusion of this category would clearly better allow the delineation and treatment of this group of individuals. However, this could result in many who were not destined to develop psychosis being exposed to treatments with inevitable side effects and costs. It is also likely to be stigmatising, and there are concerns about resultant relationship- and insurance-related discrimination.[8] This could be justified, however, if all treated individuals were actually suffering and seeking help[9] but would be potentially more problematic if screening approaches were applied to the general population with a broader preventive intent.

Another proposed change attracting considerable attention is the potential removal of a bereavement exclusion from the diagnostic criteria for major depressive disorder. This would allow access to treatment for individuals who are suffering significant distress following a loss and is based on the proposal that depression following loss does not differ from depression experienced at other times.[10] This proposal is not necessarily supported by data,[10] however, and has been widely criticised for its potential to allow the medicalisation of normal human experience. Fears of the creation of other "epidemics" of illness have been raised in relation to other proposed changes, especially those perceived to be at the boundary between normal

and abnormal behaviour (for example, behavioural addictions and distressed or disruptive childhood behaviour).

It can be argued that no matter what the actual make-up of the manual is, the onus falls on clinicians to ensure that diagnoses are applied in a sensible and balanced fashion. However, the DSM is not just used by psychiatrists: it is used by non-psychiatric clinicians, by insurance companies, and by the legal and compensation systems, and to allocate resources for care. In this context, its impact is far greater than in just guiding clinical practice or in defining diagnositic categories for research. Field trials used to assess changes do not take into account these indirect applications. Therefore, reasons for major changes should be debated and analysed openly and in a manner that engages the medical and non-medical communities. This might delay publication, but in the apparent absence of a strong case that change is required with urgency, premature publication may well do more harm than good.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed.

1 Carey B. Psychiatrists revise the book of human troubles. *New York Times* 2008; 17 Dec: A1. http://www.nytimes.com/2008/12/18/health/18psych.html?pagewanted=all (accessed Apr 2012).
2 Cosgrove L, Krimsky S. A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: a pernicious problem persists. *PLoS Med* 2012; 9: e1001190. doi: 10.1371/journal.pmed.1001190.
3 Helzer JE, Kraemer HC, Krueger RF, et al, editors. Dimensional approaches in diagnostic classification: refining the research agenda for DSM–V. American Psychiatric Publishing, 2008.
4 Luyten P, Blatt SJ. Looking back towards the future: is it time to change the DSM approach to psychiatric disorders? The case of depression. *Psychiatry* 2007; 70: 85-99.
5 Frances A. Whither DSM-V? *Br J Psychiatry* 2009; 195: 391-392.
6 Pilkonis PA, Hallquist MN, Morse JQ, Stepp SD. Striking the (im)proper balance between scientific advances and clinical utility: commentary on the DSM-5 proposal for personality disorders. *Personal Disord* 2011; 2: 68-82.
7 Woods SW, Walsh BC, Saksa JR, McGlashan TH. The case for including Attenuated Psychotic Symptoms Syndrome in DSM-5 as a psychosis risk syndrome. *Schizophr Res* 2010; 123: 199-207.
8 Yang LH, Wonpat-Borja AJ, Opler MG, Corcoran CM. Potential stigma associated with inclusion of the psychosis risk syndrome in the DSM-V: an empirical question. *Schizophr Res* 2010; 120: 42-48.
9 Ruhrmann S, Schultze-Lutter F, Klosterkötter J. Probably at-risk, but certainly ill — advocating the introduction of a psychosis spectrum disorder in DSM-V. *Schizophr Res* 2010; 120: 23-37.
10 Wakefield JC, First MB. Validity of the bereavement exclusion to major depression: does the empirical evidence support the proposal to eliminate the exclusion in DSM-5? *World Psychiatry* 2012; 11: 3-10. ❑