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Has the DSM Failed?

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Editorial

It was originally hailed as the psychiatric profession's systematic break from the clutches of psychoanalytic thinking in order to lend proper credence to psychiatric diagnoses. Based upon seminal work [1,2], the DSM III-R was launched as the manual that would improve inter-rater reliability (as well as validity) of all psychiatric diagnoses, whether they were made in New York, London or anywhere else in the world [3]. Later iterations followed, including DSM IV, DSM IV-TR and most recently the DSM-5 in 2013 [4].

What has been gleaned in the decades that have followed? This is an obviously broad question, and depends much upon which country and which systems the DSM is pertinent to.

For example, in the United States, a whole billing and coding infrastructure has grown up around this iconic manual [5], that relies upon it (though not exclusively, as the ICD has remained the bedrock of diagnostic coding in the United States [6]). Hence, insurance companies, physician's offices and hospitals would not likely earn revenue, were it not for the existence of the DSM.

Teaching curricula of residents and medical students, as well as most psychiatric textbooks have included the DSM as the backbone of their content. Then there is the pharmaceutical industry, which has geared much of its efforts toward FDA approval of psychotropic drugs, based upon 'established' diagnoses such as bipolar depression even if some these indications were statistically questionable [7]. Not surprisingly, academic institutions in the United States have relied almost exclusively upon the DSM to focus their efforts on furthering knowledge about various psychiatric disorders as well as treatments.

Lastly (and despite its disclaimers) the DSM right has been brought right into the courtroom, in order to help address important legal questions such as insanity, civil commitment and competence to stand trial [8]. Thus, the importance of the DSM (at least in the United States) cannot be overstated. Then why would one ask if it is has 'failed'? This is a controversial question, given its near ubiquitous use.

The answer may lie more in the day to day clinical realities of clinical practice, than with the institutions referred to above. For it is here that diagnoses are regularly made. As has been learned over decades, the various disorders in the DSM are not as clearly distinguishable as they may appear [9]. Given that the criteria have been revised over this same time frame by repeated consensus and collaboration, this may not be a surprising finding.

However, of growing concern has been the use of the "Not Otherwise Specified" category that was noted to occur with almost alarming frequency in the years following the publication of the DSM-IV [10]. What does this signify? It is perhaps a genuine reflection of the limitations of the categorical classification of psychopathology with respect to real life clinical practice.

Studies have also revealed that the DSM's categorical classification of psychopathology, with its arbitrary rules for establishing diagnoses from various criteria, is not how clinicians actually arrive at diagnoses [11]. Not surprisingly, and in complete contrast to how DSM diagnoses are arrived at, most medical school teaching still teaches deductive reasoning and pattern recognition of a constellation of symptoms, more commonly termed a 'syndrome' [12,13].

Medical school also tends to emphasize etiological factors at the root of such symptoms, thereby making them more intelligible to those wanting to learn more about such psychopathology. An example would be anxiety-provoking cues (of emotional salience) triggering behavioral inhibition and leading to avoidance behaviors in anxiety disorders (with corresponding neurobiological pathways that would correlate with such reactions and behaviors).

Yet, the DSM has never made adequate use of such cumulative knowledge, somehow 'expecting' clinicians to adapt to a more algorithmic/iterative way of arriving at a diagnosis. Hence the much

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famed "256" ways to arrive at a diagnosis of Borderline Personality Disorder [14]. What was therefore originally carved out of diagnosis as an aberration (etiology), arguably 'hollowed out' the clinical 'essence' of these disorders for practicing clinicians [15].

The overlapping, "co morbid" disorders are similarly important in this context. This is because the anxiety disorders are not only etiologically, but also phenomenologically linked. Thus, the ruminations and avoidance behaviors of social anxiety disorder are also commonly found in combination with many symptoms of a "co-morbid" generalized anxiety disorder [16].

Similar phenomenology has been found in Post-Traumatic Stress Disorder and Obsessive Compulsive Disorder. However, they have now been curiously 'decoupled' from the anxiety disorders in DSM-5 [4,17]. This again speaks to the rather arbitrary and unwarranted delineation of these disorders, based upon 'splitting' of shared phenomenology.

Then there is the problem of 'lumping' of certain subtypes of disorders. With respect to Schizophrenia, subtypes in DSM IV were eliminated in DSM-5 as lacking reliability as well as prognostic significance [18]. Yet, for many practicing clinicians, paranoid schizophrenia remains very obviously distinguishable from other subtypes of Schizophrenia, with several (albeit older) studies indicating its better clinical prognosis [19,20].

Similarly, with respect to Autistic Disorder and Asperger's Disorder, the obvious clinical distinctions between these two have been 'lumped' together into the all encompassing 'Autism Spectrum Disorder' [15]. Unfortunately, service eligibility considerations and alarm at the rising incidence of autism disorder rather than strict clinical considerations appeared to be behind this particular change [21].

With respect to the clinically critical delineation of ADHD from Anxiety Disorders (a conundrum which outpatient psychiatrists are presented with regularly) there again appears to be inadequate diagnostic guidance by the DSM. Thus, being 'keyed up' and being 'on the go' can look phenomenologically identical, as can forgetfulness due to inattention.

Perhaps of greater utility (for clinicians) would be the more intense subjective distress and discomfort experienced with anxiety than with prototypical ADHD, or the predisposition to subjective misinterpretation of everyday events because of the degree of hypervigilance and relative distractibility attributable to hyperarousal with anxiety.

This is because the 'neo-Kraeplinian' model (from which DSM was spawned) emphasizes empirical concepts such as course, and prognosis, rather than symptom complexes per se [22]. This is in contrast to the Jasperian model which, coming from an existentialist tradition, was more geared towards elucidating a patient's subjective experience of psychopathology [23].

Guidance by the DSM in distinguishing disorders has therefore been distinctly lacking, particularly in the area of psychopathology. Thus, the distinct "whatness" of a disorder is now absent from its current nomenclature [24]. In so doing, the DSM could have also helped clinicians fashion differing pharmacological approaches, by relating now-established knowledge about known neurobiological pathways [25].

For patients, the unintended consequence has been a plethora of labels added as codes to a "bill". This may paradoxically worsen stigmatization of psychiatric disorders. This is not to detract from the subjective distress and dysfunction experienced by the patient (something the DSM was right to emphasize). However, as a result of such dry 'lists' of symptoms/disorders being ubiquitously available on the internet, and without any corresponding discussion of etiology, patients are oftentimes left more overwhelmed with disjointed facts than actually educated.

Perhaps the greatest confusion lies in the various subtypes of Bipolar Disorder. Here, the mixed bipolar category appears to resemble more of an agitated depression than a separate subtype at all. It is now clear that Bipolar Disorder is one of the least well described disorders [26], especially in the pediatric age group [27]. Yet its overdiagnosis and misdiagnosis has been well described [28,29].

From extensive post-DSM IV publication research, the Schizoaffective Disorder diagnosis similarly appears to be on rather shaky phenomenological ground [30]. Yet, it too has been diagnosed with alarming frequency, perhaps because it inadvertently 'lumps' psychotic and mood symptoms so successfully together.

With respect to the personality disorders, DSM-5 appears to have stymied a timely opportunity to facilitate a radical paradigm shift from the trait and criteria-based model to a more dimensional model of personality functioning.

Despite over two decades worth of data validating the utility of personality dimensions, including work on various temperamental as well as cognitive aspects of personality [31-33] we now have to wait yet longer for the next iteration of DSM to see if such dimensional descriptions can be shifted over to the mainstream personality disorder section. Meanwhile existing (and flawed) categories become even more entrenched [34].

Then there is the relational context. By aligning itself so narrowly to an exclusively medical model of mental disorders, DSM successfully marginalized psychological or relational aspects of psychopathology, confining these to various appendix sections ("Other conditions that may be a focus of clinical attention") [35]. A good example of this would be Intermittent Explosive Disorder, where neither the DSM IV nor DSM-5 considered the relational context, implying that this was merely derangement of impulse control ('behavioral outbursts'), and arbitrarily assigning the frequency to twice a month [36].

DSM IV did at least devote an entire Axis (IV) to such 'psychosocial stressors', but this has now been eliminated in DSM-5, as has the degree of decompensation (Axis V) that used to be reflected in the GAF score. This would appear unhelpful for both clinicians and patients, because it eliminates focus on the impact of psychiatric morbidity as well as ongoing stressors as they pertain to daily psychosocial functioning.

Defensive functioning was also retained in recognition of a psychodynamic, yet clinically applicable paradigm for the DSM. Yet, in reality, its use was rare by clinicians and not even recognized by insurance companies. As a result of insurance-driven incentives, clinicians were only encouraged to record Axis I entities that were more likely to be reimbursed (something that defensive functioning, relational problems and other clinically relevant codes such as 'Non Compliance with Treatment' were not) [5,26]. This would similarly explain the underutilization of the Borderline Personality Disorder

diagnosis, in favor of the 'billable' Axis I Bipolar Disorder, over the course of the last decade [21].

The remaining serious criticism (including from a former DSM taskforce chairman) has been an unwarranted expansion of mental disorders that has arguably pathologized various behaviors within the spectrum of normal mental health [37-39].

So, did the DSM succeed at all? In 'dethroning' the prevailing unscientific and speculative ideology of psychoanalytic theory, and in conjunction with subsequent biological advances in the field, the DSM did appear to transform psychiatry into a more credible 'medical' specialty. And though it promoted an almost exclusively biological model of psychiatric disorders, this was nonetheless helpful in enriching understanding of disorders such as Schizophrenia and Bipolar Disorder, for which their biological basis is now indisputable.

More recently, DSM-5 was astute to add a developmental perspective, proceeding pragmatically through disorders relevant to appropriate stages of the human lifespan. Certain disorders have also received appropriate revisions. For example, Post-Traumatic Stress Disorder has criteria have now been more parsed out to include explosive anger as well as dissociation (including the complex PTSD subtype) [40].

The DSM is now firmly embedded in the healthcare landscape, and looks likely to stay, albeit with iterative changes in subsequent editions. In its lifespan, it appears to have gone on to serve four major stakeholders: academia, big pharma, insurance corporations and finally clinicians. Of these, it is the last category that is arguably the least well served. Sadly, it is also the group that advocates the least well for itself by virtue of its being so diverse, so mired in day to day patient care, and by its not being as politically 'galvanized' as the other stakeholders above [41].

By its very association with corporate, government and academic entities, DSM has gone on to achieve almost 'monolithic' power [42]. Yet, paradoxically, from clinicians' vantage point, it may have also become its own barrier to effective mental health care. This is because the prevailing emphasis on 'co-morbidities' inevitably leads to unintended, 'downstream' consequences, such as polypharmacy as well diagnostic confusion for both clinicians and patients alike.

The notion of reliable diagnoses and good inter-clinician communication was always a laudable one. But, as research has shown, this almost exclusive focus by the DSM has actually led to poor emphasis on the validity of psychiatric diagnoses [43,44] as well as the progressive erosion of clinical psychopathology [45].

Hence, a long overdue appeal 'from the clinical trenches' is being made: Let us make our diagnoses, our descriptions and our distinctions mean something once more. Let us also put our patient's concerns in proper context, thereby utilizing the biopsychosocial approach that we have given so many platitudes to heretofore. The plea is thus: Psychiatry (and by extension, its professional 'arm' known as the DSM) should not unwittingly end up complicating the very disorders that it is trying so hard to treat.

References

1. Feighner JP, Robins E, Guze SB, Woodruff RA, Winokur G, Munoz R. Diagnostic criteria for use in psychiatric research. Arch Gen Psychiatry. 1972;26(1):57-63.
2. Spitzer RL, Endicott J, Robins E. Research diagnostic criteria: rationale and reliability. Arch Gen Psychiatry. 1978;35(6):773-82.
3. Kendell RE, Cooper JE, Gourlay AJ, Copeland JR, Sharpe L, Gurland BJ. Diagnostic criteria of American and British psychiatrists. Arch Gen Psychiatry. 1971;25(2):123-30.
4. Diagnostic and statistical manual of mental disorders (DSM-5®). Virginia: American Psychiatric Association; 2013.
5. Anand S, Malhi GS. From manual to bible: the questionable hegemony of DSM IV. Aust N Z J Psychiatry. 2011;45(5):348-50.
6. Reed GM. Toward ICD-11: Improving the clinical utility of WHO's International Classification of mental disorders. Prof Psychol Res Pr. 2010;41(6):457-64.
7. Nathan PE, Gorman JM. A guide to treatments that work. Oxford: Oxford University Press; 2015. p. 253.
8. Slovenko R. The DSM in litigation and legislation. J Am Acad Psychiatry Law. 2011;39(1):6-11.
9. Brown TA, Barlow DH. Comorbidity among anxiety disorders: Implications for treatment and DSM-IV. J Consult Clin Psychol. 1992;60(6):835-44.
10. Wakefield JC. DSM-5: An overview of changes and controversies. Clin Soc Work J. 2013;41(2):139-54.
11. Kim NS, Ahn WK. Clinical Psychologists' Theory-Based Representations of Mental Disorders Predict Their Diagnostic Reasoning and Memory. J Exp Psychol Gen. 2002;131(4):451-76.
12. Coderre S, Mandin H, Harasym PH, Fick GH. Diagnostic reasoning strategies and diagnostic success. Med Educ. 2003;37(8):695-703.
13. Norman G. Research in clinical reasoning: past history and current trends. Med Educ. 2005;39(4):418-27.
14. Trull TJ, Distel MA, Carpenter RW. DSM-5 borderline personality disorder: At the border between a dimensional and a categorical view. Curr Psychiatry Rep. 2011;13(1):43-9.
15. Wing L, Gould J, Gillberg C. Autism spectrum disorders in the DSM-V: better or worse than the DSM-IV? Res Dev Disabil. 2011;32(2):768-73.
16. Widiger TA, Clark LA. Toward DSM-V and the classification of psychopathology. Psychol Bull. 2000;126(6):946-63.
17. Zoellner LA, Rothbaum BO, Feeny NC. PTSD not an anxiety disorder? DSM committee proposal turns back the hands of time. Depress Anxiety. 2011;28(10):853-56.
18. Tandon R, Gaebel W, Barch DM, Bustillo J, Gur RE, Heckers S, et al. Definition and description of schizophrenia in the DSM-5. Schizophr Res. 2013;150(1):3-10.
19. Tsuang MT, Winokur G. Criteria for subtyping schizophrenia: Clinical differentiation of hebephrenic and paranoid schizophrenia. Arch Gen Psychiatry. 1974;31(1):43-7.
20. Kendler KS, Gruenberg AM, Tsuang MT. Outcome of schizophrenic subtypes defined by four diagnostic systems. Arch Gen Psychiatry. 1984;41(2):149-54.
21. Halfon N, Kuo AA. What DSM-5 could mean to children with autism and their families. JAMA Pediatr. 2013;167(7):608-13.
22. Blashfield R. The classification of psychopathology: Neo-Kraeplinian and quantitative approaches. Berlin: Springer Science & Business Media; 1984.
23. Halling S, Nill JD. A brief history of existential-phenomenological psychiatry and psychotherapy. J Phenomenol Psychol. 1995;26(1):1-45.
24. Parnas J. A disappearing heritage: the clinical core of schizophrenia. Schizophr Bull. 2011;37(6):1121-30.
25. Hyman SE. Can neuroscience be integrated into the DSM-V? Nat Rev Neurosci. 2007;8(9):725-32.
26. Malhi GS, Berk M. Diagnosing bipolar disorder: Defining thresholds and

setting boundaries. Aust N Z J Psychiatry. 2014;48(6):500-4.

27. Cahill C, Hanstock T, Jairam R, Hazell P, Walter G, Malhi GS. Comparison of diagnostic guidelines for juvenile bipolar disorder. Aust N Z J Psychiatry. 2007;41(6):479-84.

28. Mitchell PB. Bipolar disorder: the shift to overdiagnosis. Can J Psychiatry. 2012;57(11):659-65.

29. Blader JC, Carlson GA. Increased rates of bipolar disorder diagnoses among US child, adolescent, and adult inpatients, 1996–2004. Biol Psychiatry.2007;62(2):107-14.

30. Malhi GS. Making up schizoaffective disorder: Cosmetic changes to a sad creation? Aust N Z J Psychiatry. 2013;47(10):891-4.

31. Costa Jr PT, Widiger TA. Personality disorders and the five-factor model of personality. Virginia: American Psychological Association; 1994.

32. Morey LC, Skodol AE, Oldham JM. Clinician judgments of clinical utility: A comparison of DSM-IV-TR personality disorders and the alternative model for DSM-5 personality disorders. J Abnorm Psychol. 2014;123(2):398-405.

33. Widiger TA, Mullins-Sweatt SN. Clinical utility of a dimensional model of personality disorder. Prof Psychol Res Pr. 2010;41(6):488-94.

34. Hyman SE. The diagnosis of mental disorders: the problem of reification. Annu Rev Clin Psychol. 2010;6:155-79.

35. Whooley O. Nosological Reflections. Soc Mental Health. 2014;4(2):92-110.

36. Anand S. Intermittent explosive disorder and DSM-5: A flawed conceptualization of pathological anger. Aust N Z J Psychiatry. 2013;47(6):578-9.

37. Frances A. DSM-5 is a guide, not a bible: Simply ignore its 10 worst changes. 2013.

38. Horwitz AV, Wakefield JC. The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder. New York: Oxford University Press; 2007.

39. Horwitz AV, Wakefield JC. All we have to fear: Psychiatry's transformation of natural anxieties into mental disorders. New York: Oxford University Press; 2012.

40. Friedman MJ. Finalizing PTSD in DSM-5: Getting here from there and where to go next. J Trauma Stress. 2013;26(5):548-56.

41. Carroll BJ. Lessons for ICD-11 coming after DSM-5. Aust N Z J Psychiatry. 2014;48(1):90-1.

42. Angell M. Drug companies & doctors: A story of corruption. New York Rev Books. 2009;56(1):8-12.

43. Beutler LW, Malik ML. Rethinking the DSM: A psychological perspective. Washington, DC: American Psychological Association; 2002.

44. Vieta E, Phillips ML. Deconstructing bipolar disorder: a critical review of its diagnostic validity and a proposal for DSM-V and ICD-11. Schizophr Bull. 2007;33(4):886-92.

45. Andreasen NC. DSM and the Death of Phenomenology in America: An Example of Unintended Consequences: Schizophr Bull. 2007;33(1):108-12.