

Development of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V): A Psychiatrist's Perspective

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The American Psychiatric Association (APA) will publish the much awaited Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-V) in 2013. The first of this series of manuals, called DSM-I was published in 1952 [1] and included personality disorders like paranoid, schizoid, and passive aggressive, but did not include borderline and or narcissistic personality disorders. In 1968 when the second edition or DSM-II came out, it discarded the earlier view that individuals with personality disorders did not experience emotional distress. For the first time in 1980 with DSM-III, the multi-axial system was introduced, and borderline personality disorder and narcissistic personality disorders were added. DSM-IV in 1994 had minimal revisions and dropped passive aggressive personality. Since psychiatry has changed a lot in the last few decades and there hasn't been much addition and revision in the manual, DSM-V has to carry the burden of revamping the way psychiatric diagnoses are made. There has been a lot of interest both publicly and professionally in its development right from the very beginning. For one, a website called dsmV.org has been developed to get feedback from both the public and from professionals [2]. Large field trials for major diagnosis have been started, mostly in renowned academic institutions, along with a few in the private sector. These methods, like the website and field trials are new for any DSM, and result in increased public and patient participation.

Public reaction has, thus far, not been favorable to DSM-V. Critics say that we are lowering the diagnostic thresholds in existing criteria, moving to more of a checklist form, and thus will decrease real patient contact time. Most do not like the radical overhaul of entire sections, like personality disorders, and some have expressed open criticism to that. The American Psychological Association, the British Psychological Society [3], and the American

Counseling Association have expressed their opposition publicly.

An online petition from the Society for Humanistic Psychology (part of the APA) has collected nearly 9,000 signatures in fewer than 60 days (<http://www.ipetitions.com/petition/dsm5/>). Physicians worry that with all the check lists signed by the patients, despite the physician's disagreement, the checklists will have legal implications with a potential to be used for claiming disability and other financial gains by the patient.

While critics [4, 5] predict that the newly devised DSM will have a tendency to over-diagnose mental illnesses, we have to accept that it is extremely difficult, if possible, to formulate a comprehensive, scientifically valid catalog of all mental illnesses. When we are talking about conditions that have both biological and socio-cultural origins, it seems clear that a diagnostic manual will never capture the full spectrum of psychiatric disorders. In the end, mental illness will always depend primarily upon the patient's subjective experience, and the history obtained from the patient and caregivers. It is common knowledge that DSM-V may not diagnose disorders like Asperger's Syndrome [6], and may even change some personality disorders, along with deleting histrionic personality disorder diagnosis.

Thus, the DSM-V, like all DSM's before it, will be, almost by definition, incomplete or deficient. All the previous DSM's are marred with controversy and from the looks of it, so will the latest edition [7]. It is supposed to be a descriptive tool, a guidebook, featuring the authors' best guess as to what might constitute a treatable condition. That is why the authors will have information from the field trials, and from the feedback gathered from the website. We should not be treating diagnoses, but symptoms, as there is so much perceptual difference in making the diagnosis, and they change so

Conflicting Interest:
None declared

This article has been peer reviewed.

Article Submitted on: 14th January 2012

Article Accepted on: 2nd February 2012

Funding Sources:
None declared

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periodically that symptom-treatment appears better than diagnosis-treatment.

Just to give an example, the same patient may have a diagnosis of bipolar disorder, then schizoaffective disorder and at times, eventually schizophrenia, but the treatment could be the same.

Calling it one name as opposed to another is more for billing purposes, otherwise the spectrum of disorders is what we see. Focusing on labels and diagnoses is what we all were told in training to stay away from, and treating the patient as a whole is the best choice for us. People worry that the new diagnoses will be overused and people may be “drugged up” more once the DSM-V comes into use. This argument was common with the diagnosis of ADHD and still is in some places. It is our job as clinicians not to overuse these diagnoses and not to over drug patients. Again, a good clinician will be looking at the patient as a whole as opposed to the checklist. But if so, the spotlight should be turned on those who do the over drugging, not on the document that simply describes the symptoms.

We are currently using ICD-9 in the US [4], although ICD-10 was completed in 1990 and came in to use by WHO Member States in 1994. The APA developed an international version of DSM-IV with “F-codes” for ICD-10. However, though ICD-10-CM was prepared by the US National Center for Health Statistics in the early 1990s, the US never adopted ICD-10 mostly due to a variety of delays related to insurance company battles. At the end of the Bush administration, the US Congress agreed that ICD-10-CM will go into effect on October 1, 2013—only 23 years after WHO approval. In the meantime, the WHO is now developing ICD-11, which will be published in 2015. Negotiations are in progress to “harmonize” DSM-V with ICD-11 and to “retro-fit” these codes into ICD-10-CM. Furthermore ICD-10-CM codes were “frozen” on October 1, 2011, to allow insurance companies to reprogram and to train professionals to use new codes. DSM-V publication is scheduled for 2013, but it needs to include ICD-10-CM “F-codes” in order to process all insurance claims that were made from and after October 1, 2011.

In reality, DSM-5 simply reflects our understanding of mental illness at this point in time. Whether it is flawed, dangerous, or incomplete, it is up to us to decide. As they say, “beauty lies in the eyes of the beholder”. In the

end, it’s just a book manual. What really matters is how we use it and how we change our practices based on this and other manuals.

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