

On the Origin of the Specious: The Evolution of the *DSM-5*

A Review of

Diagnostic and Statistical Manual of Mental Disorders: DSM-5 (5th ed.)

by American Psychiatric Association.

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The Pocket Guide to the DSM-5 Diagnostic Exam

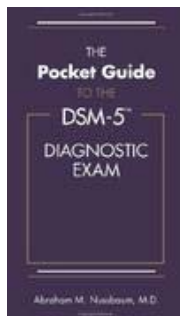
by Abraham M. Nussbaum

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Over the course of its six decades of evolution, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) has spawned an increasing biodiversity of mental disorders, even as it has seen the extinction of a wide range of disorders as well. The most recent edition of the *DSM* contains a fossil record that attests to the manual's ongoing evolution, even as it contributes to that evolution in substantial, and arguably accelerated, ways.

Long gone is the manual's original psychoanalytic endoskeleton, seen in its first and second editions, but the enduring "atheoretical interim" that followed it in subsequent editions is now gone as well. The manual's newest backbone is a biological one, where the origins of mental disorders are to be found squarely in brain dysfunction and the line between mental illness and what Freud (1896/1957) once referred to as normal human unhappiness is intentionally blurred in a quest for more dimensionalized diagnosis.

Whether this newly minted epistemic commitment will turn out to be sufficiently load bearing remains to be seen. What is clear is that it must bear an increasingly ponderous weight, given that the manual has grown from its 130-page origin (with 106 disorders) to a weighty tome of now nearly 1,000 pages and well over three times as many disorders. The manual's growing girth signals its ongoing appetite for pathologizing normality and its unmistakable optimism regarding its future evolutionary trajectory. But there is a fine line between optimism and audacity, between hopefulness and hubris, and it is not always clear which side of the line the fifth edition of the *DSM* (*DSM-5*) is on.

A Critique of Poor Reasons

Few would argue with the fact that something had to give with the *DSM*, anchored as it was in a categorical and presumably "naturalistic" system that ostensibly cut nature at its joints, identifying "real" disorders that, not unlike diabetes or heart disease or any of their physical brethren, actually existed in the outside world, beyond the taxonomic scaffold that described them. In fairness to its predecessors, antecedent editions of the *DSM* did include disclaimers about reification, urging users not to take its disorders too seriously. The *DSM-IV* (American Psychiatric Association, 1994) acknowledged, for example, that, "There is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder" (p. xxxi).

But these fleeting disclaimers were always followed by an authoritative accounting of hundreds of carefully detailed disorders, each replete with an avalanche of epidemiological information and scientific research that acted as flying buttresses to support the presumed reality of the disorders. In the context of such a definitive detailing, the disclaimer that the categorization of the disorders should not be taken too seriously was either eclipsed altogether or ran the risk of being perceived as disingenuous, like the head-shop proprietor who slides some rolling papers across the counter to his adolescent customer with a knowing wink, reminding him that “this product is not to be used with any illegal substances.”

To its credit, the *DSM-5* is now refreshingly candid about its categorizations of disorders serving only as fictive placeholders until such time as they can (selectively) be validated through largely biological markers of one sort or another. This seems like a prudent move, all in all, given the legion of difficulties associated with a categorical diagnostic system predicated on little more than descriptive accounts of overt behaviors.

Among the longstanding challenges that have vexed the *DSM*'s categorical taxonomy have been the excessive comorbidity that it invites (more the rule than the exception), its poor scientific standing, its high use of “Not Otherwise Specified” (NOS) diagnoses (as much as 50 percent of diagnoses in the Personality Disorders section and 60 percent or higher in the Eating Disorders section), and its inadequate coverage (after all, even with the tripling of the number of recognized disorders in the *DSM* over its evolutionary course, who can doubt that there will more likely be an increase, rather than a decrease, in future editions?). And, of course, there are all of the challenges that a polythetic categorical system invites. This includes the use of a fixed (and arbitrary) number of symptoms to determine whether a disorder exists, to say nothing of the related problem of interindividual heterogeneity, which results in a situation in which two individuals may share the same diagnosis but few, if any, of its symptoms.

Perhaps the most problematic feature from the standpoint of the creators of the *DSM*, however, is the fact that few of its neo-Kraepelinian categories actually have robust or isomorphic relationships to independent biological markers of any sort, such as genetic indicators, distinctive neuroimaging patterns, or hormonal fluctuations. Dimensional measures of various traits or symptoms, by contrast, seem to perform better, as demonstrated by the chair and vice-chair of the *DSM-5* Task Force (Kupfer & Regier, 2011). So, perhaps the incremental movement toward a more dimensionalized nosological system grounded in a biological substrate represents a more promising and prescient position.

On the other hand, predicating the utility of the diagnostic system on biological bases that are not yet available could place the *DSM-5* somewhere between “A Bridge Too Far” and a “Bridge to Nowhere,” depending on whether one believes that bridge is likely to lead to the Promised Land. In the meantime, in an extended discussion of the issue of validity, the *DSM-5* makes some substantial concessions: “In *DSM-5*, we recognize that the current diagnostic criteria for any single disorder will not necessarily identify a homogeneous group of patients who can be characterized reliably” (p. 20). In the statement that follows, the *DSM-5* lays bare its assumptive structure in a passage that is as likely to thrill some constituents as to chill others, depending on their predilection for biological reductionism: “Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the *DSM-5* disorder criteria will be their clinical utility” (p. 20). Having established a biological reductionism as its desired destination and conceding the role of the current disorders as fictive, interim placeholders, the *DSM-5* frees itself to allow “clinical utility” to reign supreme, and much of the volume celebrates this liberation.

Why 5?

Changes to the *DSM-5* are legion, signaled at the outset by the move away from the use of Roman numerals to Arabic ones. The reason for the move has conjured all sorts of conjecture, but the basis for it is quite simple. A software program labeled 2.0 can enjoy rapid revision with a 2.1 edition, and the *DSM-5* is hoping to do likewise. No one knows how frequently it is likely to be updated, but the clear expectation is that rapid advances (especially in the neurosciences) might be incorporated more expeditiously into a manual that did not have to wait for the development of the massive task force and work group structure that now seems to unfold in geological time. And without the conversion to an Arabic system, the titling of any microrevisions in Roman numerals would be potentially problematic. Imagine a *DSM-V.I*, which, from a distance, would surely resemble *DSM-VI* and only become more confusing still in subsequent revisions, where the reader would confront such perplexing enumerations as *DSM-VI.VI* or *DSM-IX.IX*.

The name change, however, is among the least significant changes in the newest edition of the manual. Gone is the entire multi-axial system (with its venerable 33-year history), largely as a concession to making the volume have the “look and feel” of a more medical diagnostic system (where there are no multiple axes to consider) and, relatedly, to better harmonize it with the International Classification of Diseases (ICD).

The addition of a range of new disorders is now an expectable outcome of any *DSM* revision, and the *DSM-5* does not disappoint in this regard. Binge-eating disorder works its way up from the Appendix to official recognition, as does premenstrual dysphoric disorder and mild neurocognitive disorder (perhaps difficult to distinguish from normal aging).

These are joined by the newly minted disruptive mood dysregulation disorder (DMDD), arguably among the most contentious additions to the manual. The controversy over DMDD pivots around its *raison d'être*, which was avowedly an effort to reduce the (over)diagnosis of childhood bipolar disorder with its attendant (and potentially lifelong) pharmacological treatment. On the surface, this would seem to be a good thing, given the long-term effects of the chronic dosing of antipsychotics and anticonvulsants that commonly follow from this diagnosis. These can include obesity, diabetes, and tardive dyskinesia, reducing life expectancy by an average of nearly 12 years. This, of course, is in an adult population; virtually nothing is known about the effects of long-term dosing of preadolescent children.

The flip side of the story is that this diagnosis, first dubbed “temper dysregulation disorder” (until someone realized that temper tantrums were at risk for being diagnosed as a mental illness), was not fashioned in the crucible of science. Indeed, it was delivered through the gates of the *DSM-5* without having been worked through the time-honored mechanism of its Appendix, where disorders under consideration presumably reside in a kind of limbo state as the “subject of further research” before their fate is finally adjudicated and followed either by an ascent into official recognition or a descent into eternal ignominy, depending on the weight of the evidence. In this case, that evidential weighing was bypassed in favor of a prompt inclusion on an expressly nonscientific basis: to prevent the overprescription of medications to this subgroup of children initially culled from the ranks of those diagnosed with attention-deficit/hyperactivity disorder (ADHD). In this and many other instances, the *DSM-5* makes a definitive shift away from being an empirically driven manual to an ideologically driven one (Greenberg, 2013; Paris, 2012).

This latter fact has further fueled the flames of controversy because, from an empirical perspective, the children diagnosed with DMDD would seem to have considerably more in common with those who have a conduct and impulse control disorder than with those who have a depressive disorder, the category in which DMDD resides (Geller, Tillman, Bolhofner, & Zimmerman, 2008). The decision to place DMDD within the category Depressive Disorders seems to be predicated on hopes of garnering greater sympathy for children with this diagnosis, in lieu of incurring the “taint” associated with disorders such as conduct disorder and oppositional defiant disorder, whose bearers so often run the risk of being identified as “bad kids” (Greenberg, 2013; Paris, 2012).

Regardless, it is not clear how the placement of DMDD within the Depressive Disorders category is likely to spare these children from pharmacological intervention. If a psychiatrist’s choice is to either dose such children with the customary mix of medications or prescribe nothing at all, it seems more probable that more psychiatrists would do the former than the latter. And it is not as if there are any alternative medications available that are unique to DMDD. Indeed, the history of the *DSM* suggests that pharmacology shadows the disorders, no matter how they are renamed or recategorized. For example, the medication regimen for manic-depressive psychosis neither morphed nor diminished when it was renamed *bipolar disorder* and moved from the Psychotic Disorders to the Mood Disorders category, so it is not clear why any different fate would await those transitioned from pediatric bipolar disorder to DMDD.

With “clinical utility” as the primary basis for the identification, inclusion, or organization of mental disorders, it is not surprising that the newest version of the manual re-sorts and realigns familiar disorders into all sorts of new groups. Adjustment disorders are now listed in the Trauma- and Stressor-Related Disorders category, and body dysmorphic disorders have been relocated from the newly renamed Somatic Symptom and Related Disorders category (which replaces the now-defunct Somatoform Disorders category) to Obsessive-Compulsive and Related Disorders, where they are joined by brethren pilgrims arriving from other distant diagnostic domains (e.g., trichotillomania) and newly identified disorders that make their debut in the manual for the first time (e.g., hoarding disorder, excoriation disorder). The substantial exodus of disorders from Somatic Symptom and Related Disorders—some through forcible relocation (like body dysmorphic disorder) and others through a vanishing act owing to ideological shifts in the *DSM-5* (like hypochondriasis, somatization disorder, etc.)—leaves this diagnostic domain looking like the manual’s Island of Misfit Toys.

In addition to these changes, many disorders that were previously embedded within larger diagnostic categories now enjoy pride of place in categories all their own. Gender Dysphoria (the disorder formerly known as gender identity disorder) now occupies a class unto itself. Other disorders rise up in clusters. The former category Anxiety Disorders, for example, suffers substantial attrition as Trauma- and Stressor-Related Disorders liberate themselves in their ascendancy to a category all their own, which is true of Obsessive-Compulsive and Related Disorders as well.

The reconfigured category of mood disorders, now called Depressive Disorders, has lost bipolar disorders, which migrate yet

again, this time to a category all their own (although adjacent to the category Schizophrenia Spectrum and Other Psychotic Disorders, from whence they came originally). The Depressive Disorders category, though, has gained DMDD and premenstrual dysphoric disorder in compensation for its loss.

The category Substance Related and Addictive Disorders has gained its first-ever behavioral addiction by poaching gambling disorder from the Other Disorders category of the *DSM-IV*, with yet another behavioral addiction now waiting in the wings (Internet gaming disorder, currently located in the Appendix for further study). These and many other changes amount to a diagnostic diaspora of epic proportions.

The Wild, Wild West

The scope and scale of the challenges faced within (and between) the 13 different work groups that revised the *DSM-5* are scarcely imaginable. Numerous disorders were brought into this game of diagnostic musical chairs; when the music stopped, participants must surely have looked around to see who had found a seat and where they were located. At least one disorder seems to have found itself in two chairs: Schizotypal personality disorder is now listed twice, once under the Personality Disorders and again under the category Schizophrenia Spectrum and Related Disorders. The irony of this latter designation is not lost on those who have cut their eyeteeth on earlier versions of the *DSM*, where schizotypal personality disorder was fashioned from the long-defunct diagnosis of borderline schizophrenia. Quizzically, it now returns again to its homeland, though its tandem location obligates it to live out its current dissociative life in a Tale of Two Cities.

Indeed, the sheer volume of resorting and realignment of disorders (in the interest of “clinical utility”) invites an image of a group of gunslingers sitting around a card table in the Old West. With the din of a barroom brawl in the background, they remain nonetheless focused on the poker game at hand. Six-shooters strapped to their thighs, they edgily eye the dealer. No matter who cuts the deck in support of fairness (and the *DSM-5* had two such cross-cutting committees, one for scientific affairs and one focusing on public health implications), the dealer is the one to watch. Radically reshuffled, the deck of disorders is dealt out as each work group assembles its hand, ever vigilant of being dealt a card from the bottom of the deck or finding one of its own fall to the floor. Of course, no one player was ever assured a “win,” and some work groups did, in fact, get dealt a very poor hand. After five years of hard labor (replete with work group recriminations and resignations), the group that was everyone’s odds-on favorite to effect the most substantial changes in its domain of disorders (the Personality Disorders Work Group) effectively folded. They didn’t so much fold, really, as discover that they had overplayed their hand.

In the end, the *DSM-5* Task Force called their bluff and rejected every one of their recommendations on the apparently reasonable rationale that extraordinary changes require extraordinary evidence (regarding the value and impact of those changes), which was largely lacking. Instead, a compromise was effected: The work group’s proposal for revision of the Personality Disorders category was printed in toto in the manual’s “unofficial” Section III: Emerging Methods and Models, also known as the “Elephant burial ground,” as Greenberg (2013, p. 191) referred to it in *The Book of Woe: The DSM and the Unmaking of Psychiatry* (also reviewed in *PsycCRITIQUES*; Nathan, 2013).

Mission Creep

Both of the previous *DSM* task force chairs, Robert Spitzer (*DSM-III* and *III-R*; American Psychiatric Association, 1980, 1987) and Allen Frances (*DSM-IV* and *IV-TR*; American Psychiatric Association, 1994, 2000), have serious concerns about the *DSM*’s latest incarnation, and rightly so. Whether couched in terms of “mission creep,” “diagnostic imperialism,” or downright “disease mongering,” the net effect of the *DSM-5* will surely be to support the labeling of many more people as mentally ill.

The removal of the bereavement exclusion alone, which prevented the diagnosis of major depression during the first two months of mourning, invites the consideration of this diagnosis for at least some portion of the eight-to-10 million Americans who suffer the loss of a significant loved one each year. With the addition of new diagnoses with potentially substantial prevalence rates (e.g., binge-eating disorder, hoarding disorder, skin-picking disorder, mild neurocognitive disorder, DMDD, premenstrual dysphoric disorder) and the lowering of the diagnostic threshold on a range of other disorders (e.g., ADHD, bulimia, posttraumatic stress disorder, generalized anxiety disorder), it is easy to see how the *DSM-5* might bank the fires of its detractors who have wryly noted that “Life is the problem for which psychiatry is the cure.”

Although it is true that the *DSM-5* held the line in relation to the potential inclusion of a wide range of additional proposals (e.g., hypersexual arousal disorder, relational disorders, hebephilia), it also positioned a phalanx of potentially high-prevalence disorders at the front of the line for future consideration in the section Conditions for Further Study. These include caffeine use

disorder, Internet gaming disorder, suicidal behavior disorder, nonsuicidal self-injury, and attenuated psychosis syndrome, among others. The last one, originally dubbed “risk psychosis,” raises the specter of diagnosing individuals who show subclinical symptomatology with unknown likelihoods of developing actual disorders.

Of course, this is a common and fully justified practice in medicine, where, for example, individuals who have significant risk factors, but no actual medical disorder, may be administered preventative treatment. A combination of high cholesterol, family history, obesity, and a diet high in saturated fats may fully warrant the prescription of cholesterol-lowering medications, but only because the probable risks incurred by not intervening would substantially outweigh the downsides associated with taking medications that themselves incur minimal risks. The same rationale undergirds the widespread practice of fluoridating city water, on the assumption that overall public health is improved through this practice by reducing dental decay (particularly among tooth-brushing “minimalists”) while incurring little or no collateral damage.

However, risk diagnoses in the field of mental health may be a different kettle of fish. Available large-scale longitudinal research studies have found that only about one third of those diagnosed with an attenuated psychosis syndrome wind up “converting” into a psychotic disorder (Cannon et al., 2008), and there is no research to suggest that early psychotropic intervention in this population would actually prevent, delay, or diminish the onset of psychosis. The same trade-off between cost and benefit that invites us to embrace the fluoridation of our water source would give us pause regarding the introduction of antipsychotics and anticonvulsants into our drinking water on the dubious grounds that it could conceivably protect some subset of us from possibly developing subsequent psychotic symptoms.

Back to the Future With the *DSM-5*

In the 30-something years since the exorcism of (psychoanalytic) theory from the *DSM*, three principles have guided its development: It was expected to be (a) atheoretical, (b) empirically driven, and (c) all about diagnostics (rather than about presumed etiology, on the one hand, or intervention, on the other). The *DSM-5*, however, takes a decidedly different turn with respect to each of these long-standing canons. It is now overtly (and optimistically) theoretical (i.e., biological), wholly ideological (in hopes that evidence may one day support ideology), and all about presumed etiology (replete with implications for intervention). Under the guise of “clinical utility,” the *DSM-5* has reclaimed for its future many of the features it has specifically eschewed in its past. Although biological reductionism may share little with the metaphysics of psychoanalysis, it is nonetheless similarly freighted with epistemic implications that, unexamined, simultaneously enable and disable particular lines of inquiry. The belief that mental illness is fully reducible to brain disorders represents, as Paris (2012) noted, the “hope that mental illness can be translated into neuroscience” (p. 74) and, with it, psychiatry transformed into an applied clinical specialty of neurology. As one neurologist quipped to his psychiatric colleague, “We treat the axon and you treat the synapse” (Paris, 2012, p. 74).

But not everyone is pleased with this course of events. Thomas Insel, the director of the National Institute of Mental Health, the leading source of funding of behavioral research, has recently criticized the *DSM-5* for its lack of validity, indicating that the Institute will no longer accept grant proposals crafted specifically along the lines of *DSM* diagnoses (Insel, 2013). And the federal mandates for using *ICD-10* codes kick into place in October 2014, which would seem to undercut the value of the *DSM* in clinical contexts, as well, leaving many to wonder what unique value the *DSM* may have to offer that would even justify its continued use.

Still, there may be legacies left by the *DSM*'s introduction of a wide variety of novel elements in its most recent edition. The introduction of its Section III, Emerging Measures and Models, signals a courageous turn toward embracing novel conceptual, as well as empirical, developments, and it includes a range of methods and measures of considerable clinical utility. In the manual's avowed aim to “dimensionalize” diagnoses, for example, the inclusion of a range of “cross-cutting” measures in Section III clearly supports attendant efforts to create diagnostic spectra in Section II (e.g., autism spectrum disorder, schizophrenia spectrum disorder), developments that chip away at the silos of psychopathology that are otherwise endemic to a categorical system. And the manual itself is usefully supported both by its customary accompaniments, the *Desk Reference to the Diagnostic Criteria From DSM-5* and *The Pocket Guide to the DSM-5 Diagnostic Exam*, and by a whole range of exceptionally helpful assessment measures available online at the website of the American Psychiatric Association (www.psychiatry.org).

But in the ongoing evolutionary process of psychodiagnosis, who is to say which of the *DSM-5*'s mutations will be retained and which will perish in future generations? The *DSM-5* itself has, arguably for the first time, articulated a clear expectation for future variations and reshuffling within its nomenclature. Given that its taxonomy is now an expressly “nominalistic” (i.e., in name only) rather than a “naturalistic” one, the expectation is that the manual's current conceptualizations and categories will

continue to shift and change across time, first according to prevailing clinical custom and utility and, ultimately, according to the yet-to-be-discovered underlying biological nature of the variegated forms of mental illness.

In the meantime, perhaps the *DSM–5* says it best in its incisive acknowledgment at the outset: “The science of mental disorders continues to evolve” (p. 5). Whether the *DSM–5* represents an enduring contribution to this evolution or a distinct departure from it is a tale that can be told only in time.

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