Epidemiology and Psychiatric Sciences (2015), **24**, 185–187.
doi:10.1017/S2045796015000256

DSM-5 two years later: facts, myths and some key open issues

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In May 2013, the American Psychiatric Association (APA) published the fifth edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The process that led to the release of the DSM-5 took nearly two decades, with working groups of experts asked to propose revisions based on the most recent research findings. Originally, the APA hoped to introduce a 'paradigm shift', in which psychiatric diagnosis would be in greater harmony with neuroscience (Regier *et al.* 2009). When it became clear the data supporting these changes were too fragmentary for radical changes, the APA backed off from major revisions (Paris & Phillips, 2013). In fact, to date, there is no knowledge on whether most conditions listed in the manual are true diseases. In the meantime, while waiting for genetics and neuroscience to elucidate the causes (and guide the treatment) of psychiatric disorders, we should simply acknowledge, 'our classification of mental disorders is no more than a collection of fallible and limited constructs that seek, but never find, an elusive truth. Nevertheless, this is our best current way of defining and communicating about mental disorders' (Frances & Widiger, 2012).

The main and most consistent criticism of the DSM-5 (actually it was criticised both before and after it was formally published) is that it included a number of new and untested psychiatric disorders without sufficient data on prevalence, reliability, validity, treatment response and risk/benefit ratio (Frances, 2010, 2013). According to critics, all of the proposed new diagnoses, together with lowered thresholds for some existing diagnostic categories, would expand psychiatric diagnosis at its fuzzy and hard-to-define border with normality, leading to overdiagnosis, i.e., attributing diagnostic labels to responses to life situations that should be considered to be within normal variation. This is both a major clinical and an ethical issue (Wakefield, 2010, 2013*a*). Such overdiagnosis could discredit psychiatry by claiming that there is no essential difference between mental disorder and normality, and by forcing clinicians to treat normally functioning people with medications that they do not necessarily need (Paris & Phillips, 2013). Psychiatry has long been criticised for medicalising and pathologising normal variations and overdiagnosis means overtreatment, with all the existing side effects of psychopharmacological interventions.

However, as critics themselves acknowledge, 'despite all its epistemological, scientific and even clinical failings, the DSM incorporates a great deal of practical knowledge in a convenient and useful format; it does its job reasonably well when it is applied properly and when its limitations are understood. One must strike a proper balance' (Frances & Widiger, 2012). At its core, the DSM-5 should be simply regarded 'as a guidebook to help clinicians describe and diagnose behaviours and symptoms of their patients; it provides clinicians with a common language to deliver the best patient care possible' and aims to encourage future directions in research (Kupfer, 2013).

Two years after its publication, it is time to carefully weigh the pros and cons of the new diagnostic system and to explore the facts and the myths surrounding the DSM-5. For this purpose, we invited to comment in the 'Editorial in this Issue' of *Epidemiology and Psychiatric Sciences,* two eminent scholars who have leading roles in the DSM-5 debate taking place in the scientific literature, Jerome Wakefield (see e.g., Wakefield, 2010, 2013*a*, *b*) and Mario Maj (see e.g., Maj, 2012, 2013, 2014).

Wakefield (2015) highlights a number of critical issues with the DSM-5, considering this new diagnostic system flawed in process, goals and outcome. The revision process itself suffered from lack of adequate public record of the rationale for the changes, thus misleading the future scholarship. In fact, for scholars trying to understand and evaluate the validity of the DSM-5 task force's decisions, the most important problem with the revision process was its secrecy and lack of adequate documentation. Moreover, the declared goals of the revision process, such as dimensionalising diagnosis, incorporating biomarkers and separating impairment from diagnosis (Regier *et al.* 2009), were ill-considered and were eventually mostly abandoned. In Wakefield's view, the major drawback of the DSM-5 is the worsening of the false-positive problem. This is a major problem: the DSM-5 has missed the opportunity

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to increase the conceptual validity of psychiatric diagnosis by aggressively addressing false-positive issues; in squandering this opportunity, the DSM-5 placed the hard-won integrity of psychiatry as a medical discipline at risk. According to Wakefield (2015), the worsening of the false positive problem specifically applies to: (1) substance use disorder (increasing the symptom options while decreasing the diagnostic threshold will pathologise mild conditions), (2) major depression (the elimination of the bereavement exclusion implies that bereaved individuals who manifest five general distress symptoms for 2 weeks after a loss will now be classified as having a Major Depressive Disorder), (3) intermittent explosive disorder (allowing verbal arguments among diagnostic criteria will artificially inflate its prevalence rate) and (4) attention deficit hyperactivity disorder (expanding diagnosis to adults before addressing its manifest false positive problems in children will perpetuate the same high false positive rate by encompassing normal variations within the umbrella of the disorder). On the other hand, Wakefield (2015) also acknowledges that the DSM-5 has made some progress in addressing the false positive problem, such as the addition of a more stringent criterion for insomnia disorder, the exclusion of defiant behaviour directed only at a sibling for the diagnosis of oppositional defiant disorder, and the exclusion criterion of severe relationship distress for diagnosing sexual dysfunction. Moreover, the DSM-5 changes are likely to prevent some false positives, e.g., excluding 'irritable mood' from manic episode criteria (only 'abnormally and persistently increased activity or energy' is now required) will probably reduce misdiagnoses of bipolar disorders.

Maj (2015) challenges some recurring critical comments in the media that have preceded and followed the publication of the DSM-5. These include statements such as (1) the DSM is 'the bible of psychiatry' (e.g., Horgan, 2013), (2) the DSM pathologises conditions that are in the range of normality (e.g., Cassels, 2013), (3) the unavailability of biological tests invalidates psychiatric diagnoses (e.g., Insel, 2013), and (4) the Research Domain Criteria (RDoC) project recently launched by the NIMH in the USA (Cuthbert, 2014) is going to transform psychiatric diagnosis by replacing descriptive psychopathology with behavioural and neurobiological measures (e.g., Insel, 2013). Maj challenges these statements by applying rigorous reasoning and providing compelling evidence drawn from the scientific literature. Regarding the first issue, literature shows that only a minority of psychiatrists around the world use formal diagnostic systems in their ordinary practice and, when a diagnostics system is used, only one tenth of clinicians use the DSM. It therefore seems that the wide gap exists between current diagnostic systems and ordinary diagnostic practice; the scientific community keeps revising diagnostic systems, but the impact of these revisions on clinical practice is much lower than expected. With regard to the second statement, after having acknowledged that some conditions included in the DSM-5 may not qualify as psychiatric disorders and that the threshold for the diagnosis of some conditions that do qualify may be too low. Maj argues that a pragmatic set of inclusion and exclusion criteria needs to be developed in order to apply them explicitly and consistently when the introduction of a new condition in the diagnostic system is proposed (and if a balance between possible benefits of the inclusion and possible risks is involved in the decision, this should be made explicit). Moreover, non-validated thresholds should not be used in the name of reliability or to avoid changing current assessment instruments; alternative thresholds should be formally studied, especially with respect to their clinical utility. As far as the third issue is concerned, Maj points out that the crucial element is not whether the threshold for the diagnosis of a disorder is based on a biological test or a set of clinical variables, but rather whether the threshold has sufficient predictive validity (therefore, in the absence of biological tests, an active search for clinical thresholds that are predictively valid should be performed). Finally, the notion that the RDoC approach will transform psychiatric diagnosis in the foreseeable future is also challenged; based on the current available research evidence, the RDoC project is more likely to develop neurobiological measures that may help in subtyping rather than replacing current diagnostic categories, with the aim of improving the predictions of outcomes and treatment responses.

In summary, a number of problems do exist in our current diagnostic systems (and the DSM-5 has probably even worsened the situation), and many limitations still affect the diagnostic process in psychiatry. However, trashing current diagnostic practices may be harmful for psychiatry's image and, more importantly, for our patients. Throwing out the baby with the bathwater, so to speak, is always dangerous.

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https://doi.org/10.1017/S2045796015000256 Published online by Cambridge University Press

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https://doi.org/10.1017/S2045796015000256 Published online by Cambridge University Press