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Editorial

On the Publication of the *Diagnostic and Statistical Manual of Mental Disorders:* Fourth Edition (DSM–IV)

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The postman who delivered the copy of DSM–IV (American Psychiatric Association, 1994) provided for this review also brought a recent issue of the *American Journal of Psychiatry* containing a paper entitled *Measuring diagnostic accuracy in the absence of a 'gold standard'*. This has as its second reference a 1988 publication headed *Why are we rushing to publish DSM–IV?*. Faced with all this, the psychiatric tiro could be forgiven for a moment of puzzlement, assuming innocently that DSM–IV is a sort of gold standard whose necessity could hardly be in question. But it seems that even in the United States there may be some ambivalence about DSM–IV, so those of us in other countries need to evaluate it with special care.

The first thing to be said about DSM–IV is that there should be no hesitation in acknowledging the several years of hard work and efficient organisation that have been necessary for its production; the very large number of mainly American psychiatrists and psychologists who have been involved deserve to be congratulated. Over the last few years the chairmen of the 13 Work Groups and the indefatigable trio of final arbiters, Drs Francis, First and Pincus, must have dedicated a large part of their waking hours (and no doubt some of their dreams) to DSM–IV. Even if one cannot agree with the publisher's advertisement that it is "the mental health field's most important book", its publication must be viewed as a major event for psychiatry. Copies of the full version should be in every psychiatric and medical library, since it represents the consensus view of a great many eminent and carefully selected teachers and researchers from the United States. Individual psychiatrists and psychologists will perhaps purchase the cheaper and shorter desk versions, but the use of these must not be regarded as a substitute for careful study of the main volume.

One of the main reasons for the publication of DSM–IV now is so that it coincides approximately with that of the new international classification produced by the World Health Organization. The *Clinical Descriptions and Diagnostic Guidelines of the ICD–10 Classification of Mental and Behavioural Disorders* (CDDG) were published in 1991, the *Diagnostic Criteria for Research* (DCR–10) in 1993, and other versions will follow shortly. This commentary is not the place for detailed discussion of the ICD–10 classification, but the relationships between ICD–10 and DSM–IV will be examined later, together with comments upon their main similarities and differences.

DSM–IV is big, because it is intended to be both comprehensive and detailed; the full version has 912 pages, of which 650 are required for the descriptions and the diagnostic criteria of the disorders in the classification. This means that there are well over 200 pages devoted to an introduction, instructions for users, comments on multi-axial use, and ten appendices. The comprehensiveness of this volume is well illustrated by the titles of the ten appendices; these include decision trees for differential diagnosis, criteria sets for further study, a glossary of technical terms, a list of changes between DSM–III–R and DSM–IV, DSM–IV categories with equivalent ICD–10 codes, and an outline for cultural formulation with a glossary of culture-bound syndromes.

Read about it first

The introduction and the instructions for users are essential preliminary reading for anybody interested in DSM–IV; they give a clear and concise account of both the advantages and problems of using a psychiatric classification. It is a pity that DSM–IV cannot be presented in a cover that will only allow access to the rest of the contents after the reader has demonstrated familiarity with these first sections (and the same goes for the ICD–10 volumes). Many of the misuses of both these classifications arise because the user plunges straight into the list of

categories without bothering first to learn about potential hazards.

DSM–IV and ICD–10 share another problem that passes in both without comment. They are both presented as classifications of disorders rather than diagnostic concepts, but yet they provide for each disorder a set of 'diagnostic' criteria. This is not just a quibble about terms, since there is an important difference between describing a disorder and making a diagnosis, and unfortunately we have rather more disorders than diagnoses. 'Disorder' is defined in the same way in both the systems, to indicate a clinically recognisable set of symptoms or behaviour associated with distress or disability. Diagnosis is left undefined in both; presumably it is intended to have its usual meaning – a diagnosis implies the identification of a process underlying the immediately obvious symptoms and behaviour, and so carries (according to current knowledge) implications about possible causes. Thus all diagnoses are manifest by means of disorders, but in the present state of psychiatric knowledge not all disorders have an underlying diagnosis. With hindsight it might have been preferable for both these major systems to have separate sections (or different textual identifiers) for diagnoses and disorders. The disorders could then have been provided with 'identifying features'.

DSM–IV is intended for use "in clinical, educational, and research settings". In other words, it is an all-purpose document with no allowances made for different levels of knowledge and expertise in its users. Problems inherent in this policy are well-recognised in the introduction, which contains clear and wise guidance about the over-riding importance of clinical judgement and experience when deciding how to apply detailed criteria to an individual instance. The educational and research aspects of the major efforts put into its production are manifest in the DSM–IV Source Book, the first volume of which is available. The set of five volumes is based upon the extensive literature reviews prepared by the Work Groups, together with reports on data analyses and field trials that guided many of the decisions about changes.

The full version of DSM–IV bears a superficial resemblance to a textbook, but the authors are careful to point out that no such equivalence is intended, since treatment and references are not included. There is nevertheless an impressive array of information provided about most of the disorders, under headings such as Diagnostic Features; Associated Features and Disorders; Specific Culture, Age and Gender Features; Prevalence; Course; Familial Pattern; and Differential Diagnosis.

What's new?

Irrespective of the exact nature of the content, the first and probably rather anxious question of most clinicians will be about differences between DSM–IV and DSM–III–R. The answer here depends upon who is asking the question. Those outside psychiatry and clinical psychology might find it difficult to see many changes. Even those in the mental health field will have to look closely to find much that is new, but they will be helped by Appendix D, which lists and comments briefly upon the main changes. The great majority of these are adjustments to the wording and numbers of the criteria, with a few changes in terms. Most clinicians are likely to accept these with little reaction, and it will be left to the dedicated experts to develop a head of steam about any changes to the details of their favourite sets of criteria. A wise overall policy was adopted of making the threshold for change higher than that between DSM–III and DSM–III–R. The work groups had to justify their suggestions for change by reference to literature or to new empirical evidence, rather than simply give their opinion.

Changes in overall presentation and arrangement are few, but two deserve special comment. First, the major heading "Organic Mental Disorders" has been eliminated from DSM–IV "because it implies that the other disorders in the manual do not have an organic component". In DSM–III–R the dementias, delirium, psychoactive substance-induced organic mental disorders and organic mental disorders associated with physical disorders were the subdivisions of the 'organic' heading. The term 'cognitive' is now preferred to organic for dementias and delirium, and organic is omitted from the others. This change should stimulate a fruitful discussion about the many shades of meaning of both 'organic component' and 'cognitive'. To prefer cognitive is a reasonable option, but its use may be seen by some to under-value the frequent behavioural component in many cognitive (or organic) disorders (Henderson *et al*, 1994). A useful spin-off from this change is that all types of substance use disorders can be brought together in one group.

Second, a change in the terms used to cover the anxiety disorders results in an extraordinary omission that is passed over without mention elsewhere; the DSM–III–R headings "Anxiety Disorders (or Anxiety and Phobic Neuroses)" and "Dissociative Disorders (or Hysterical Neuroses, dissociative type)" are now replaced by the simpler "Anxiety Disorders" and "Dissociative Disorder" respectively. Viewed in isolation, this change seems innocent and reasonable. But the result is that nowhere in this major publication

can the words 'neurosis', 'neurotic', 'hysteria' or 'hysterical' be found, and so some of the most hallowed terms in psychiatry are left out in the cold. Whatever has happened to American psychiatry? It seems a pity that the authors of the introduction could not bring themselves to give at least a backward glance to history by, for instance, referring the reader to the discussion of this issue in the introduction to DSM–III. To deplore this omission is not to defend the concepts, for there are serious problems associated with their use in a basically descriptive classification. They deserve a mention simply because many psychiatrists and other mental health workers in the USA (and in many other countries) still find them useful, and will want to know how they are related to the categories in the new classification. The authors of DSM–IV should remember the warning given by the late Sir Aubrey Lewis about the tendency of some psychiatric terms to outlive their obituarists (Lewis, 1975).

Only a few of the changes in content can be selected for comment here. In the section on "Disorders usually first diagnosed in infancy, childhood and adolescence" there has been a significant narrowing of the concept of autistic disorder, with Rett's Disorder, Childhood Disintegrative Disorder and Asperger's Disorder now recognized as separate but related categories. In contrast, there has been a bringing together into one overall category of the previously separate Attention Deficit Hyperactivity Disorder and Undifferentiated Attention Deficit Disorder (without hyperactivity).

Schizophrenia criteria

There are some changes to the criteria for schizophrenia that are difficult to evaluate at this stage. The wording of criterion A which gives those symptoms that are typical of schizophrenia has been 'simplified', and also more emphasis is given to negative symptoms by the addition of alogia and avolition (previously only flat affect was mentioned). The six month duration is retained but the mixtures of symptoms that are allowed within this overall period are different; the minimum of one week of 'active-phase' symptoms has been increased to one month "or less if successfully treated". As before, the remainder of the six months may include periods of prodromal or residual symptoms, but "the definition of prodromal and residual phases has been simplified by eliminating the lists of specific symptoms". In fact, the brief lists of prodromal and residual symptoms previously in the diagnostic criteria have been replaced by several paragraphs in the narrative description of schizophrenia and its associated features; these paragraphs are well written, but there could be a problem in that they will be read only by those who consult the main DSM–IV volume.

Only practical experience will show whether these changes will meet with general approval, and what effect they will have upon agreement between clinicians. The change in the composition of the six months will have very little effect upon the diagnostic practice of those who work in rehabilitation services or with long-established patients; it is important only for the diagnosis of patients seen early during illnesses of fairly acute onset (it does, however, have an important effect on studies of incidence). In criterion C the social consequences of the illness are retained as an optional part of what is supposed to be a diagnostic criterion; this is questionable logic, but a custom dating back to DSM–III. There is also a significant change in the way the acute brief psychoses are defined, which many will see as an improvement; the unjustified assumption that these are atypical unless there is a precipitating stress has been removed.

Affective disorders

All psychiatric classifications are at their weakest when trying to cope with affective disorders, mainly because we have no externally valid methods of identifying boundaries between the current concepts of the various affective syndromes. Noting the number and severity of symptoms is all that we can do for the moment, and it is not the fault of DSM–IV that many boundary problems remain. Many psychiatrists will be pleased to see that Hypomania can now be specified as separate from Mania, which also facilitates the inclusion of Bipolar II Disorder (Recurrent Major Depressive Episodes with Hypomanic Episodes).

Anxiety disorders

Changes in those disorders that others may wish to call neurotic are eminently sensible, but except for the addition of the important new Acute Stress Disorder they are cosmetic rather than conceptual. Liaison psychiatrists will be relieved to see that the permutation for Somatization Disorder (any 13 symptoms from a list of 35) has been simplified; the requirement is now eight symptoms, some coming from each of four groups. These groups are open-ended lists of examples and the user is not limited to the list provided, as in DSM–III–R. This substitution of a list of examples for a specified limited list is a good example of a similar and welcome change in several other places. It implies

a realistic recognition of the need to guide rather than direct in clinical work, in view of the inherent fuzziness of many concepts in contemporary psychiatry.

There are comparatively large changes in the section covering Sleep Disorders, in that the arrangement is now based on presumed aetiology, and the content is enlarged.

To summarise all the changes in terms of simple quantity, DSM–IV contains only five categories more than DSM–III–R; 13 categories have been added and eight deleted.

Compatibility of DSM–IV and ICD–10

The relationship between DSM–IV and the ICD–10 classification is mentioned in several places in the introduction and the appendices. That DSM–IV and ICD–10 are closely compatible as classifications, and for many categories virtually identical, is largely due to a series of meetings held between 1988 and 1992 as part of the Joint Project between the World Health Organization and the Alcohol, Drug Abuse and Mental Health Administration of the USA (ADAMHA). At these meetings, the Chairpersons of the DSM–IV working groups were able to discuss with a selection of WHO advisers both the content and the style of the emerging classifications. As far as possible, congruence was increased and differences were minimised, and many of the changes listed in Appendix D are a result of these meetings.

Since the two classifications are so similar, many psychiatrists now ask why both are needed. From the viewpoint of the WHO, the answer is quite simple – there is a statutory obligation to the member states of the United Nations Organization to update the ICD at regular intervals (until now, at ten-year intervals) and a psychiatric Chapter V is an essential part of the whole. From the viewpoint of the APA the answer is perhaps more complicated, but it would be likely to include the points that national classifications are able to reflect national traditions and usage, and that national pride dictates that there should be a worthy successor to DSM–III and DSM–III–R. For the WHO, Stengel's principle of conservation still applies, particularly in these times of rapid change and pressure to be fashionable (Stengel, 1960).

It is, therefore, inevitable and appropriate that some differences of content and emphasis remain, largely because ICD–10 has to serve as a common language for a diverse and international set of users. Three examples can be used to illustrate briefly some of the results of the different origins and purposes of the two classifications. First, the definition of schizophrenia in ICD–10 is simpler, in that for the important common varieties it depends upon the presence of typical symptoms for a period of one month. Prodromal and residual states are not included in this period, and there is no requirement for an overall duration of six months. This sets the clinician an easier diagnostic task, appropriate for very different and often difficult settings. The typical symptoms specified in the two systems are virtually the same, so the differences noted have no effect upon the diagnosis of patients who have been ill for more than six months (which is very often the case).

As a second example, there is a difference in emphasis with respect to what is called Dissociative Identity Disorder in DSM–IV, and Multiple Personality Disorder in ICD–10. This was omitted from early drafts of ICD–10, since some advisers had pointed out that in many parts of the world it is a diagnosis that is never made; if it has any status at all, it should be regarded as a dyadic culture-specific disorder largely limited to parts of the USA and other locations where certain types of psychotherapy are practised. But as a result of the widespread consultations that were a vital part of the development process, it was finally included, albeit as a subdivision of another category. Third, Neurasthenia is absent from DSM–IV, but present in ICD–10. It is a diagnosis used by a few psychiatrists in several European countries, but more importantly it is one of the most common diagnoses in China; there is some information available about its approximate equivalents in both European and American terms so it must be present in an international classification, defined as simply as possible whatever the difficulties.

The relationships between the individual categories of the two classifications are shown in DSM–IV by the inclusion of the equivalent ICD code alongside the DSM–IV headings. In the present version these are from ICD–9 because the USA government will continue to use ICD–9 for the publication of its official statistics for several more years (but Appendix H gives the equivalent ICD–10 codes for those who want them).

The most obvious differences between the two classifications are not in the categories, but in the method of presentation; the WHO chose a policy of "different versions for different purposes" rather than the production of one all-purpose document, mainly because of the need to provide for users with widely different responsibilities and levels of training.

The final point that must be addressed is to do with the next versions – will DSM–V and ICD–11 appear in a few years, to serve, stimulate or torment the next generation of mental health workers, depending on their viewpoint? There seems to

be a distinct feeling at large that we all need a period of classificatory rest and calm, during which experience can be gained and evaluations carried out. It is likely that this feeling will be respected since the compilers and the expert advisers (many of whom advised on both the classifications) need a rest just as much as the users. Collectors of national and international medical statistics are also joining in the call for a long period of stability. At least one source of pressure on the APA for further revisions will be diminished in the future, since the WHO has decided to abandon the policy of a regular ten-yearly revision of the whole ICD. Instead, individual chapters or parts of chapters will be revised as changing knowledge justifies the work required. With luck, it is likely that many more than ten years will pass before the next major revisions are attempted. In the meantime there is plenty of work to be done, even within the present confines of reliance upon largely descriptive information. Some progress should be possible in the improvement of descriptive and correlative techniques, and in the sorting out of the mixed bag of items of information at present called diagnostic criteria. But we cannot expect much progress towards new and more satisfying types of classifications until we have developed some new ideas – for instance, ideas about the different levels of the brain and mind at which symptoms are formed, and how these are related to the diverse influences that are assumed to be contributory causes.

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