Diagnostic and statistical manual of mental disorders 5: A quick glance

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Dr. Dilip Jeste, the then President of the American Psychiatric Association, released the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5)[1] on May 18, 2013 at the 166th Annual Meeting of the APA at San Francisco. This was a landmark achievement for the APA. Indian psychiatrists should take additional pride in the fact that Dr. Dilip V. Jeste is actually one of us. He used to be an Overseas Member of the Indian Psychiatric Society (IPS).

HISTORY OF THE DSM

Earliest documented efforts to gather epidemiological data on mental illness commenced in the USA in the year 1840. Mental illnesses were then classified under a single category of idiocy/insanity. Inaccurately defined categories of mental illness like mania, melancholia, monomania, general paralysis of the insane, dementia, and dipsomania were included in the US Census of 1880. In 1918, the American Medico-Psychological Association published a manual of classification of mental illnesses that listed 22 categories. The manual was designed for the use of Institutions for the Insane. The American Medico-Psychological Association was later renamed APA in 1921. During World War II, the US army prepared a manual of medical illnesses called the '*Medical 203*'. The US Navy revised the Medical 203 to formulate the "Standard Classified Nomenclature of Disease" or the "Standard". Office of the US Surgeon General adopted the *Standard* to classify illnesses on the battle grounds and among veterans returning from the war. The Veterans Administration adopted the *Standard* with few modifications. After the war, psychiatrist with experience of using the Standard during the Second World War continued to use it in civilian practice. The World Health Organization (WHO) included a chapter on Mental Disorders in its International classification of Diseases (ICD) 6 (1949). It resembled the *Standard*. In the year 1950, the APA set up a committee on nomenclature and statistics. This committee published the first DSM in the year 1952.[2-6]

The first edition of DSM (1952) was titled 'Diagnostic and Statistical Manual of Mental Disorders'. It did not carry any number attached to its title. Authors of the manual had perhaps not envisaged that the manual would be revised periodically. The second edition (1968) was titled Diagnostic and Statistical Manual of Mental Disorders, Second Edition. The trend of fixing a roman suffix to the newer editions of the DSM commenced with the third edition which was titled DSM III (1980). DSM III also pioneered the multiaxial system of evaluation and classification of mental disorders. A revised version was christened DSM III R (1987). The trend continued while publishing the DSM IV (1994) and its text revised edition the DSM IV TR (2000).[2-6]

The most recent edition of the DSM was initially labeled DSM V. As the process of developing the manual progressed, the Roman numerical 'V' was replaced by the alpha numerical '5'. This would facilitate subsequent revisions being numbered as 5.1, 5.2 and so forth. While facilitating the numbering, it is also a tacit acceptance that the DSM 5 is not the ultimate manual of classification of mental disorders. It is a document that reflects current consensus of the leading academicians, clinicians, and researchers in the field of mental health.[5-7]

METHODOLOGY

By the year 1999, even as the DSM IV TR was being published, clinicians and researchers had noticed several flaws in the DSM IV. The DSM IV TR (2000) did not propose any substantial modifications to the doctrine of DSM IV (1994). The diagnostic criteria continued to result in rather frequent diagnosis of comorbidity. Heterogeneity within the diagnostic groups was unacceptable to the researchers and it contaminated treatment outcome. The erratic thresholds

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How to cite this article: Vahia VN. Diagnostic and statistical manual of mental disorders 5: A quick glance. Indian J Psychiatry 2013;55:220-3.

Access this article online

Website: www.indianjpsychiatry.org

DOI: 10.4103/0019-5545.117131

Quick Response Code

for inclusion and exclusion could not differentiate the normal from abnormal or syndromal from subsyndromal disorders. Clinicians would then resort to the not otherwise specified (NOS) diagnoses. The DSM IV did not consider emerging clinical conditions like addiction to the internet or the so called nocturnal refrigerator raids. Some authors had noticed that the number of psychiatric classification had "swollen to kaleidoscope of putative disorders".[2,3,8-12]

These are some of the salient features that prompted leaders in the field led by Dr. Steven M. Mirin, the then Medical Director of the APA; Dr. Steven Hyman the then Director of National Institute of Mental Health (NIMH); and Dr. David Kupfer, the then Chairman of the APA's Committee on Psychiatric Diagnosis and Assessment, to take cognizance of the scope for the APA and NIMH to work together and explore scientific basis for diagnosis and classification of mental disorders. It reflects the need for urgency and prominence of mental disorders. An important component of mental disorders is that unlike physical illnesses that incorporate a socially acceptable sick role, mental disorders could stigmatize personal sense of identity.[12,13]

The first DSM 5 Research Planning Conference of 1999 was attended by invited participants. The planning conference included experts in family and twin studies, molecular genetics, basic and clinical neurosciences, cognitive and behavioral sciences, and covered issues in development throughout the lifespan and disability. The conference focused on issues like lacunae in the DSM IV system of classification, disability and impairment, newer insights from the research in neuroscience, need for improved nomenclature, and the impact of cross cultural issues. The thrust at the planning stage itself was to look beyond the DSM IV. Participants closely involved in the process of developing DSM IV were not invited to participate in the process of developing the DSM 5. By the year 2008, Dr. Darrel A. Reiger then the Executive Director of the American Psychiatric Institute for Research and Education (APIRE), leaders from the WHO and the World Psychiatric Association (WPA) and 397 participants nearly half of them from outside of the US, were involved in the process of developing the DSM 5. All the working group members were reviewed for potential conflict of interest and approved by the APA Board of Trustees.[13,14]

DSM 5 is essentially a joint effort of APA, the National Institutes of Health USA viz the NIMH, National Institute of Drug Abuse, and the National Institute of Alcoholism and Alcohol abuse; the WHO and the WPA. Dr. David Kupfer, MD and Dr. Darrel A. Reiger led the team of more than 397 participants working in 13 work groups, six study groups, and a task force of advocates, clinicians, and researchers since the year 2008. Each committee had co-chairs from both the US and another country. The entire process maintained transparency by publishing minutes of every meeting and monographs of their proceedings on the APA website, presentations at scientific conferences with question-and-answer opportunity at countless national and international conferences, they held grand rounds at leading university medical center, and presented posters as well as papers at the annual meetings of the APA.[13,14]

The years of relentless efforts include evidence based planning; field trials; revising; seeking; and incorporating feedback, suggestions, and objections from the stake holders, public, patient, and other interested groups worldwide; revising again; and obtaining approval of the Board of Trustees of the APA. The process finally concluded with the publication of DSM 5 on the morning of May 18, 2013 at the 166th Annual Meeting of the APA at San Francisco.

THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 5

DSM 5 does not claim to be the ultimate or the final word in classification of mental disorders. It is a manual that reflects current state of knowledge and consensus among leaders in the field.[15] It is a 947 page manual, divided into three sections and an appendix. Section I is the basics which includes introduction, instruction on how to use the manual, and a chapter on cautionary statement for forensic use of DSM 5. Section II of the manual lists diagnostic criteria and codes of 22 diagnostic categories. DSM 5 has a single axis format and considers the relevance of age, gender, and culture. The manual lists ICD 9 Clinical Modification (CM) and ICD 10 CM codes for each diagnostic category. The APA is scheduled to switch over to ICD 10 CM codes from October 01, 2014. Section III is on the emerging measures and models. It covers self-rated cross-cutting symptom measures for adults, children, and adolescents between age 6 and 17 years; WHO Disability Assessment Schedule 2, an alternative DSM 5 model for personality disorders; and a list of conditions for further study. Cultural Formulation Interview with guide for the interviewer.[1]

Dr. Dilip Jeste[15] had clearly stated at the release of the DSM 5 that goal of DSM 5 is to help clinicians make more accurate diagnoses and improve patient outcomes. When viewed in totality, DSM 5 is not very much different from DSM IV. All major categories of mental disorders in Section II of the DSM 5 have listed specifiers and precise instructions about coding the severity of the disorder on a five point scale, where applicable. The new approach combines the former axes I, II, and III into a single axis. Psychosocial and contextual factors (formerly axis IV) and disability (formerly axis V) have to be rated separately. The DSM 5 specifies that psychosocial and contextual factors be rated on the Z code of ICD 10 CM or V codes of ICD 9 CM.

It has replaced the GAF with the World Health Organization's Disability Assessment Schedule 2 (WHODAS 2). Section

III DSM 5 has 36 item self-administered version of the WHODAS 2. A set of flash cards to administer the WHODAS 2 may be downloaded online from www.who.int/classifications/icf/whodasii/en.[16] There is a provision in DSM 5 to obtain better understanding of the patient's perception of the dynamics of the mental disorder with the help of prompt driven Cultural Formulation Interview (CFI) included in Section III of the DSM 5.[1,16]

DIMENSIONS OF MENTAL DISORDERS

Clinicians frequently encounter depressed patients experiencing panic or patients of schizophrenia with varying degrees of impairment or a patient exhibiting symptoms of anxiety that could not be clearly labeled as abnormal. DSM IV did not provide clear guidelines to categorize such cases. Panic attacks in a patient of depression invited two comorbid diagnoses. The longitudinal course specifiers of schizophrenia in DSM IV or DSM IV TR did not clearly differentiate symptom free patient of schizophrenia from a patient experiencing florid symptoms. An anxious adolescent was often a diagnostic dilemma. The dimensional approach of DSM 5 rates magnitude of individual symptoms. The dimensional model helps to grade and chart the course of the disorder. It thus differentiates normal from the abnormal. It can be used as an apparatus to screen for mental disorders in general population or be used as an instrument to conduct study of prevalence of mental disorders in a given community.[16]

Many of the procedures that were adopted while developing the DSM 5 are improvised versions of those of the previous editions of DSM.[1] Yet the DSM 5 is a indeed a unique manual. It includes published American and global information on mental disorders. Where needed, the DSM committees planned and conducted specifically designed studies in academic institutions and in clinical practice. The new knowledge thus gained during the planning of the manual from clinical practice within and outside the US was integrated in the text of the DSM 5. It also amalgamates manuals like the ICD and the Disability Assessment Schedules, while providing an avenue for the individual clinician to study cultural components of mental illness, worldwide.

Critics of the DSM 5 feel that the state of current knowledge does not justify a new classification. They doubt whether the current understanding of psychopathology or the phenomenology augment clinician's competence to make a clinical diagnoses by objective parameters or measurable criteria. Dr. Thomas Insel voiced that Research Domain Criteria (RDoC) would be a better diagnostic tool. Later, the then APA President elect Dr. Jeffrey Liebermann, and Dr. Thomas Insel issued a joint statement as they noted that criteria that are important for clinical practice may not be sufficient for researchers. In a joint statement they said "…Looking forward, laying the groundwork for a future diagnostic system that more directly reflects modern brain science will require openness to rethinking traditional categories. It is increasingly evident that mental illness will be best understood as disorders of brain structure and function that implicate specific domains of cognition, emotion, and behavior".[17]

CONCLUSION

DSM 5 indeed is a manual of the state of knowledge of the mental disorders, by experts in the field of mental health and related professions, for the betterment of those involved with mental disorders including patients, clinicians, researchers, administrators, insurance companies, and other stakeholders. It has retained the categorical model of DSM IV in large proportion. Some clinical conditions have been recategorized. Dimensions of individual clinical condition are added. We will have to understand and apply them in our clinical practice ahead of meaningful debates on their relevance. At this moment, one would readily concur with Dr. Jeffrey Liebermann and Dr. Thomas Insel that "….along with the International Classification of Diseases, the DSM (5) represents the best information currently available for clinical diagnosis of mental disorders" and that the two publications "remain the contemporary consensus standard to how mental disorders are diagnosed and treated".[17]

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