

First in a series

Getting ready for DSM-5: Part 1

The process, challenges, and status of constructing the next diagnostic manual

Work on the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)—scheduled to be published in May 2013—has been ongoing for more than a decade. Momentous advances in genetics and brain imaging since publication of DSM-IV in 1994 have generated optimism that an improved understanding of the neurobiologic underpinnings of psychiatric disorders might lead to a paradigm shift from the current descriptive classification system to a more scientific etiopathophysiological system similar to that used by other medical specialties.¹

Some fear that any changes to our current classification system may be premature and could make an already complex system even more unwieldy.² Scores of articles about the content and process of DSM-5 and several critiques and commentaries on the topic have been published. The American Psychiatric Association (APA) has made the DSM-5 process transparent by posting frequent updates to the DSM-5 Development Web site (www.dsm5.org), seeking feedback from the psychiatric community and the public, and presenting progress reports by members of the DSM-5 Task Force at scientific meetings.

There have been few discussions on the implications of DSM-5 from the practicing clinician's vantage point, which I seek to present in this series of articles, the remainder of which will be published at *CurrentPsychiatry.com*. In this article, I:

- provide a brief history of psychiatric classification, focusing on the origins and evolution of the DSM system

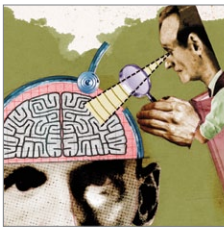


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continued



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Clinical Point

Some fear that any change to our current classification system could make an already complex system even more unwieldy



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Table 1

Conceptual development of DSM-I to DSM-IV-TR

Version	Comments
DSM-I (1952) ³	Presumed etiology. 106 diagnoses
DSM-II (1968) ⁵	Glossary definitions. 185 diagnoses
DSM-III (1980) ⁶	Paradigm shift. Explicit criteria. Emphasis on reliability. 265 diagnoses
DSM-III-R (1987) ⁷	Modest changes. Blunted hierarchies. Clarifications. 292 diagnoses
DSM-IV (1994) ⁸	Modest changes. More blunted hierarchies. 361 diagnoses
DSM-IV-TR (2000) ⁹	Only text revision. 361 diagnostic conditions

- summarize the limitations of DSM-IV
- note the challenges and tensions in the construction of DSM-5
- review the DSM-5 process
- outline its current status
- discuss the organization and content of future articles in this series.

Although I am a member of the DSM-5 Psychotic Disorders Work Group, I am solely responsible for the content and any opinions that I offer in this article and series. All details of DSM-5 that I discuss are publicly available at www.dsm5.org. I've been a clinician and clinical researcher for >25 years, and my opinions are colored by the need for clarity, rigor, clinical relevance, and a disdain for overly speculative thinking.

Evolution of DSM

A nosological system (system of classification of disease) enables clinicians to provide specific treatments for medical causes of human disease and/or disability with precise and predictable effects and guide patients and families about the likely course and outcome. Such classification systems also are used by:

- researchers, to learn more about the nature of the conditions being classified and develop better treatments for them
- health care systems, to provide optimal health care and track its appropriate provision
- insurance companies, to provide appropriate reimbursement for health care
- health product developers, including pharmaceutical companies, to develop health care products and promote their appropriate utilization

- government agencies, to determine health priorities and apportionment of health care resources

- public health agencies, to track the distribution of health and disease in communities around the world.

An ideal classification system would meet all constituents' needs while perfectly mapping natural disease entities with distinct etiology and pathophysiology (validity), consistently allow all users to reach the same diagnosis (reliability), and provide clinicians with clear guidance about treatment and likely course for each of the entities (utility), with the list of entities being mutually exclusive and collectively exhaustive (coverage).

The current nosological system for psychiatric disorders originated in the late 19th and early 20th centuries and culminated in the first edition of the Diagnostic and Statistical Manual of Mental Disorders³ released in 1952 and a section related to mental disorders (section V) in the sixth revision of the International Classification of Disease (ICD).⁴ Whereas DSM focuses exclusively on mental disorders, the ICD is a general medical classification system that began covering mental disorders with its sixth revision in 1949. In subsequent revisions (ICD-7 through -10 and DSM-II through -IV), substantial changes in diagnostic criteria have been made, although the systems' basic structure has been retained. *Table 1* describes major changes from DSM-I through DSM-IV-TR.^{3,5-9} DSM and ICD both are being revised; DSM-5 is scheduled to be released in 2013 and ICD-11 is to be finalized by 2016.

What do clinicians need?

Similar to ICD-10, DSM-IV is marked by considerable complexity, variable validity, limited clinical and research utility, and problems of burgeoning comorbidity.¹⁰ Efforts to revise DSM seek to address these limitations. From a clinician's perspective, the most challenging aspects of DSM-IV derive from its complexity—which makes clinical application difficult—and its limited clinical utility, which is exemplified by artificial comorbidity,¹¹ frequent use of “not otherwise specified” (NOS), and relative treatment nonspecificity with reference to diagnosis.

As clinicians, we want a nosological system that is easy to use, can guide treatment decisions, provides useful information about likely disease course and outcomes, and allows us to easily communicate about disease nature with patients, families, payers, and health care administrators. Additionally, although good validity and reliability are desirable for clinicians, adequate coverage of psychiatric disease—the listed conditions should be collectively exhaustive and mutually exclusive—is particularly valued. Finally, we want a diagnostic system that allows us to explain the reasoning behind psychiatric diagnoses and related treatment in lay terms to patients and their families.

DSM-5 development to date

DSM-5 development has been a collaborative effort led by the APA and involves the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the World Health Organization (WHO). Between 1999 and 2002, 3 work conferences resulted in a series of white papers that identified gaps and research needs.¹ Between 2003 and 2008, the American Psychiatric Institute for Research and Education, the National Institute of Health, and the WHO organized 13 international conferences to review a wide range of nosologic issues; the proceedings have been compiled into 13 monographs (11 published and 2 in press) and >125 scientific articles that serve as key reference sources for the

Table 2

DSM-5 Work Groups

Attention-deficit/hyperactivity disorder and disruptive behaviors
Anxiety, obsessive-compulsive, posttraumatic, and dissociative disorders
Disorders in childhood and adolescence
Eating disorders
Mood disorders
Neurocognitive disorders
Neurodevelopmental disorders
Personality and personality disorders
Psychotic disorders
Sexual and gender identity disorders
Sleep-wake disorders
Somatic distress disorders
Substance-related disorders

DSM-5 process. For a continually updated list of these publications, see www.dsm5.org/Research.

In 2006, DSM-5 Task Force Chair David J. Kupfer, MD and Vice Chair Darrel A. Regier, MD, MPH were appointed and began selecting members of the DSM-5 Task Force, a process that was completed in 2007. Members of the 13 diagnostic area Work Groups (Table 2) were selected and the Work Groups were constituted in 2008. All 168 Task Force and Work Group members were vetted to ensure that they met standards of minimum conflict of interest and broad representation. Membership includes diverse professional representation from academia and mental health; 75% of members are from the United States. Six cross-cutting study groups have deliberated on a range of common issues, including:

- spectrum disorders
- lifespan and development
- gender and cross-cultural
- psychiatric/general medicine interface
- impairment and disability assessment
- diagnostic measurement and assessment.

Additionally, >300 external advisors with special expertise have participated in the process. Since 2008, each of the Work Groups has conducted extensive literature reviews of all assigned disorders, evaluated what

Clinical Point

For DSM-5, although good validity and reliability are desirable, adequate cover of psychiatric disease is particularly valued



Getting ready for DSM-5

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Hopes that DSM-5 could represent a paradigm shift have been tempered by limitations of our understanding of psychiatric disorders

Related Resources

- American Psychiatric Association. DSM-5 Development. www.dsm5.org.
- Black DW, Zimmerman M. Redefining personality disorders: Proposed revisions for DSM-5. *Current Psychiatry*. 2011;10(9):26-38.

Disclosure

Dr. Tandon is a member of the DSM-5 Psychotic Disorders Work Group. He reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

works and what doesn't work in DSM-IV-TR, assessed new research developments and clinical issues that have arisen since publication of DSM-IV-TR in 1994, and developed research plans to investigate critical issues utilizing systematic reviews and secondary data analyses. Based on these analyses, each Work Group proposed draft diagnostic criteria for its disorders, using a strict protocol for criteria revisions such as addition or deletion of disorders and changes to existing diagnostic criteria. These draft diagnostic criteria were first presented on www.dsm5.org in late 2009 through early 2010. Based on input from other Work Groups, the Task Force, several external groups, and the public, the Work Groups revised these criteria and prioritized necessary field trials to evaluate key recommendations. Phase I of the field trials began in 2010.¹² Results of these field trials are being compiled and analyzed.

The DSM-5 Work Groups have met via teleconference 1 to 2 times a month and in-person twice a year, with significant communication between meetings. Work Group chairs are members of the Task Force, which has equally frequent meetings. Reports of DSM-5 deliberations have been presented at hundreds of professional

meetings and described in >200 scientific publications. Comprehensive information and ongoing updates on DSM-5 and a list of publications and meetings are provided at www.dsm5.org.

Public input has been sought and the Work Groups have received and processed >10,000 comments. In 2010, the APA Board of Trustees appointed a Scientific Review Committee to evaluate the scientific merit and clinical impact of the Work Group recommendations and comment on the strength of the evidence advanced in support of each proposed revision. In 2011, the Board of Trustees appointed a Clinical and Public Health Committee to evaluate the clinical utility and public health significance of the proposed revisions. The APA and WHO have shared information and assessments in an effort to harmonize diagnostic criteria between DSM-5 and ICD-11.

Initial hopes that DSM-5 could represent a paradigm shift toward an etiopathophysiological classification of psychiatric disorders have been tempered by recognition of the limitations of our current neurobiologic understanding of psychiatric disorders. Therefore, the focus for DSM-5 has shifted from validity enhancements to improved clinical utility while building a framework that better lends itself to a future etiopathophysiological nosology.¹³⁻¹⁸ Whereas dimensional assessments are likely to be added across various diagnostic categories, a primarily categorical nosology will be retained and the proposed criterion changes are relatively modest. The results of our enhanced knowledge about the neurobiologic underpinnings of psychiatric disorders will not be reflected in diagnostic criteria, but in the significant revisions to the DSM text.

Bottom Line

Scheduled to be published in May 2013, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) will retain a primarily categorical nosology, although dimensional assessments are likely to be added. Other articles in this series will review specific proposed changes in 13 groups of disorders.

Our DSM-5 series

Subsequent articles in this series—which will be published at CurrentPsychiatry.com—will discuss specific proposed DSM-5 changes in 13 groups of disorders (*Table 2, page 35*) and their clinical implications. These articles also will address the relationship of DSM to ICD, issues with dimensional classification, and the importance of and challenges in precise diagnostic measurement.

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Dimensional assessments are likely to be added across various diagnostic categories in DSM-5

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