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COMMENTARY

Opening Pandoras Box: The 19 Worst Suggestions For DSM5

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I have previously criticized the DSM5 processfor its unnecessary secretiveness, its risky ambitions, its disorganized methods, and its unrealistic deadlines.[1-6] Now, it is finally time to evaluate the first draft of the recently posted DSM5 product (at www.DSM5.org).

Poor and inconsistent writing
Perhaps it should occasion no surprise that a flawed process should yield a flawed product. The most fundamental problem is the poor and inconsistent writing. Admittedly, early Work Group drafts are often written imprecisely and with varying quality, but it is surprising that the DSM5 leadership has failed to edit for clarity and consistency. It would be a waste of effort, time, and money to conduct field trials before the new criteria sets receive extensive revision. The poor writing is also a bad prognostic sign, suggesting that the DSM5 text sections for the various disorders may eventually be equally inconsistent, variable in quality, and sometimes incoherent.

Higher rates of mental disorder
In terms of content, most concerning are the many suggestions for DSM5 that would dramatically raise the rates of mental disorder. These come in 2 forms:

1. New diagnoses that would be extremely common in the general population (especially after marketing by an ever alert pharmaceutical industry)

2. Lowered diagnostic thresholds for many of the existing disorders.

DSM5 would create tens of millions of newly misidentified false positive “patients,” thus greatly exacerbating the problems caused already by an overly inclusive DSM4.[7] There would be massive overtreatment with medications that are unnecessary, expensive, and often quite harmful. DSM5 appears to be promoting what we have most feared--the inclusion of many normal variants under the rubric of mental illness, with the result that the core concept of "mental disorder" is greatly undermined.

Unforeseen consequences
A third pervasive weakness in the DSM5 options is their insensitivity to possible misuse in forensic settings. Work Group members cannot be expected to anticipate the many ways lawyers will try to twist their good intentions, but it is incumbent on the DSM5 leadership to establish a thorough ongoing

forensic review that would identify the many likely instances of proposals with important forensic implications (for example, the expansion of pedophilia to include attraction to adolescents).

Space constraints (as well as my own blind spots and limitations in expertise) make this a limited survey, both in the numbers of issues discussed and the depth of discussion possible on each. I would encourage the field to identify the additional problems that will require correction.

PROBLEMATIC NEW DIAGNOSES

The **Psychosis Risk Syndrome** is certainly the most worrisome of all the suggestions made for DSM5. The false positive rate would be alarming70% to 75% in the most careful studies and likely to be much higher once the diagnosis is official, in general use, and becomes a target for drug companies.[8] Hundreds of thousands of teenagers and young adults (especially, it turns out, those on Medicaid) would receive the unnecessary prescription of atypical antipsychotic drugs.[9] There is no proof that the atypical antipsychotics prevent psychotic episodes, but they do most certainly cause large and rapid weight gains (see the recent FDA warning) and are associated with reduced life expectancyto say nothing about their high cost, other side effects, and stigma.

This suggestion could lead to a public health catastrophe and no field trial could possibly justify its inclusion as an official diagnosis. The attempt at early identification and treatment of at risk individuals is well meaning, but dangerously premature. We must wait until there is a specific diagnostic test and a safe treatment.

Mixed Anxiety Depressive Disorder taps nonspecific symptoms that are widely distributed in the general population and would therefore immediately become one of the most common of all the mental disorders in DSM5. Naturally, its rapid rise to epidemic proportions would be ably assisted by pharmaceutical marketing. It is likely that medication would not be much more effective than placebo because of the high placebo response rates in milder disorders.[10]

Minor Neurocognitive Disorder is defined by nonspecific symptoms of reduced cognitive performance that are very common (perhaps almost ubiquitous) in people over fifty. To protect against false positives, there is a criterion that requires objective cognitive assessment to confirm that the individual has decreased cognitive performance, but getting a meaningful reference point is impossible in most instances and the threshold has been set to include a whopping 13.5% of the population (ie, the percent of population within the first and second standard deviation). Moreover, the suggestion for objective testing will probably be widely ignored in the primary care settings where the bulk of diagnosing will be done.

Medicalizing the expectable cognitive impairments of aging will result in much unnecessary treatment with ineffective prescription drugs and quack folk remedies. These will undoubtedly attain great popularity since there will likely be a very high placebo response rate.

Binge Eating Disorder will have a rate in the general population (estimated at 6%) and this will probably become much higher when the diagnosis becomes popular and is made in primary care settings. The tens of millions of people who binge eat once a week for 3 months would suddenly have a “mental disorder” subjecting them to stigma and medications with unproven efficacy.

Temper Dysfunctional Disorder with Dysphoria is one of the most dangerous and poorly conceived suggestions for DSM5a misguided medicalization of temper outbursts. The “diagnosis” would be very common at every age in the general population and would promote a large expansion in the use of antipsychotic medications, with all of the serious attendant risks described above. Apparently, the Work Group was trying to correct excessive diagnosis of childhood bipolar disorderbut its suggestion is so

poorly written that it could not possibly accomplish this goal and instead would it would create a new monster.

The misapplication of this diagnosis would provide a blanket excuse for reduced personal responsibility and will lead to forensic nightmares. It is a nonstarter.

Paraphilic Coercive Disorder would expand the pool of sex offenders who are eligible for indefinite civil commitment because they have a "mental disorder" to include cases of sexual coercion. Paraphilic Coercive Disorder was initially considered for inclusion in DSM-III-R (under the name Paraphilic Rapism) but was rejected because it was impossible to reliably and validly differentiate those rapists whose actions are the result of a paraphilia from the large majority of rapists who are motivated by other factors (such as power). Given the facts (acknowledged in the rationale section) that most rapists are savvy enough to deny sexual fantasies and the unreliability (and unavailability) of laboratory testing, the diagnosis will inevitably be based only on the person's behavior, leading to a potentially alarming rate of false positives with consequent wrongful indefinite commitment.[11]

Hypersexuality Disorder would be a gift to false positive excuse seekers and potential forensic disaster. Another clear nonstarter.

A **Behavioral Addictions** category would be included with the substance addictions section and would start life with one disorder, Pathological Gambling (transferred from Impulse Disorders section). Next in line might be a new category for Internet Addiction. This could provide a slippery slope leading to the back door inclusion of a variety of silly and potentially harmful diagnoses (ie, "addictions" to shopping, sex, work, credit card debt, videogames etc, etc, etc) under the broad rubric of "behavioral addictions not otherwise specified." The construct "Behavioral Addictions" represents a medicalization of life choices, provides a ready excuse for off loading personal responsibility, and would likely be misused in forensic settings.

LOWERED THRESHOLDS

The greatest general impact would come from the suggestion to eliminate the "clinical significance" criterion required in DSM4 for each disorder that has a fuzzy boundary with normality (about two-thirds of them). These were included to ensure the presence of clinically significant distress or impairment when the symptoms of the disorder in mild form might be compatible with normality. Removing this requirement would reduce the role of clinical judgment as a gatekeeper in determining the presence or absence of mental disorders and thus would increase the already swollen rates of psychiatric diagnosis.

Attention Deficit/Hyperactivity Disorder. The DSM4 wording changes (along with extremely active drug company marketing) contributed to escalating rates of ADD - accompanied by the widespread misuse of stimulant medications for performance enhancement and the emergence of a large secondary illegal market.12 There are 4 suggestions for DSM5 that would make this existing overdiagnosis much worse.

•The first change is to raise the required age of onset from 7 to 12.[13]
•The second is to allow the diagnosis based only on the presence of symptoms, not requiring

impairment.
•The third is to reduce by half the number of symptoms required for adults.

These 3 changes greatly reduce the specificity of the ADD diagnosis in adolescents and adults and will result in a further flood of false positives and of resulting stimulus misuse for performance enhancement.[14]

•The fourth change is to allow the diagnosis of ADD in the presence of autism. This might create the interaction of 2 false epidemics, encouraging increased stimulant use in an especially vulnerable population.

Addiction Disorder. DSM5 proposes to eliminate the distinction between substance abuse and substance dependence, lowering the threshold for diagnosing the new unified category “addiction”that would be introduced to replace them both. This confounding of episodic binge use with continuous compulsive use loses valuable clinical information about their very different treatment and prognostic implications. It also seems unnecessarily stigmatizing and misleading to label with the loaded word addiction those whose problem is restricted to intermittent substance use.

Autism Spectrum Disorder. Asperger’s disorder would be collapsed into this new unified category. Although this consolidation appeals to some experts, it remains controversial and presents serious problems. Those with Asperger’s (which is much less impairing) will be stigmatized by the association with classic autistic disorder. Moreover, in the average everyday practice conducted by non-experts, the spectrum concept will likely further fuel the “epidemic” of loosely defined autism that was already been triggered by the introduction of Asperger's in DSM4.[15]

Medicalizing Normal Grief. DSM5 would reverse 30 years of diagnostic practice and allow the diagnosis of Major Depression to be made for individuals whose grief reaction symptomatically resembles a Major Depressive episode (eg, 2 weeks of depressed mood, loss of interest in activities, insomnia, loss of appetite, and trouble concentrating immediately following the loss of a spouse would be a mental disorder. This is radical and astounding change that may be helpful for some individuals, but will cause a huge false positive problemespecially since there is so much individual and cultural variability in bereavement. Of course, grief would become an extremely inviting target for the drug companies.

Pedohebephilia is one of the most poorly written and unworkable of the suggested criteria sets. Expanding the definition of pedophilia to include pubescent teenagers would medicalize criminal behavior and further the previously described misuse of psychiatry by the legal system. Certainly, sex with under-age victims should be discouraged as an important matter of public policy, but this should be accomplished by legal statute and appropriate sentencing, not by mental disorder fiat.

Deleting the Multiaxial System. This would result in the loss of much valuable clinical information. Multi-axial diagnosis provides a disciplined approach to distinguishing between state and trait (Axis I versus Axis II) and to determining the contributions of medical conditions (Axis I II) and of stressors (Axis IV) to the diagnosis and treatment of psychiatric disorders. The GAF score (Axis V) provides the most convenient and familiar rating of overall functioning. No compelling rationale is offered for making so radical a change.

Various Small Changes. There are numerous small editorial changes meant to help clarify the existing criteria sets. Some of these appear to be improvements, many are trivial, and some are worse than their DSM4 counterparts. Any possible gain from wording changes has to be weighed against the risks that the new version will create its own set of unanticipated consequences. The old, tried and true criteria sets have withstood the test of time -in some instances for 30 years-without creating forensic problems. Moreover, even small changes can have a dramatic impact on the definition of caseness and resulting rates of disorder[16] needlessly compromising the interpretation of all the clinical and epidemiological research that was done before versus that done after DSM5.

Dimensional Assessments

Three dimensional assessments (for severity, co-morbid symptoms, and personality traits) are suggested for DSM5. Dimensions are most appropriate in describing continuously distributed phenomena that can be reduced to numbers. It has been widely accepted for several decades that adding dimensions would help to solve the categorical system's problem with fuzzy boundaries- thus improving the accuracy and precision of psychiatric diagnosis.[17] Unfortunately, however, the field has never achieved consensus on which dimensions to choose and how best to measure them. Moreover, and most crucial, clinicians find dimensional ratings far too unfamilar and cumbersome for use in everyday practice and all efforts to include even a few simple dimensional ratings into previous DSM's have been met by clinician resistance and neglect. The DSM5 dimensional proposals are especially problematicad hoc, unworkably complex, vague, untested, and premature. If anything, the poorly executed introduction of unwieldy dimensions into DSM5 is likely to give them a bad name and poison the well for their future necessary acceptance. It is also possible that the use of dimensions may create problematic unintended consequences in insurance, disability, and forensic determinations. The possible introduction of dimensions by DSM5 has been greatly oversold as a “paradigm shift.” With a few exceptions, it would probably be advisable to include the suggested dimensional ratings in the DSM5 appendix or in a separate volume for diagnostic instruments.

Severity ratings tailored for each disorder. In fact, this approach was tried for 8 categories in DSM3R, but was dropped in DSM4 because the anchors of the severity ratings were not validated and the system was too cumbersome for routine clinical use. The severity ratings suggested for DSM5 are bewilderingly inconsistent across sections in their format and quality and are largely ad hoc, extremely complicated and totally impractical for use in clinical settings.

Ratings on "crosscutting" symptoms that exist across a number of different diagnoses to supplement the primary categorical diagnosis. Such assessment might be useful in some settings, but is far too cumbersome for use in routine clinical practice.

Dimensional ratings for personality. These would, in theory, have clear advantages over the clumsy categorical approach to personality assessment. In practice, however, the multiple, complicated, confusing, and cumbersome systems suggested for DSM5 would be far too unfamiliar and time consuming to ever be used by clinicians. Another side effect would be deletion of five of the personality disorders (paranoid, narcissistic, histrionic, dependent, schizoid) from the manual.

CONCLUSIONS

It will likely be argued by the DSM5 leadership that I am unduly and prematurely alarmist, that they are still early in the DSM5 process, and that any problematic suggestions will eventually be weeded out in the field trials. This is putting the cart (ie field testing) before the horse (ie having usable criteria sets to test) and continues to miss the point that DSM5 has been and remains in serious trouble. I feel it is my responsibility to raise clear alarms now because the past performance of the DSM5 leadership does not inspire confidence in its future ability to avoid serious mistakes.

What leads me to this pessimistic conclusion? Every step in the development of DSM5 has been secretive and disorganized. The leadership has established a consistent track record of proposing unrealistic plans and impossible to meet timetableswith predictably erratic course changes and repeatedly missed deadlines. It was, for example, announced last May at the APA annual meeting (and in the press) that the DSM5 field trials were about to begin in the summer of 2009. Then, it turned out that none of the necessary preparatory steps had been accomplished and the field trials had to be postponed for at least a year. During the past 6 months, there have been several successive target dates for posting the DSM5 draftseach of which passed unmet causing unexplained postponements. Poor planning and execution have already forced a 1 year delay in the projected DSM5 publication date (to May 2013).

The DSM5 process is already nearly 3 years old. By now, a careful editing process should have resulted in refined proposals that were all plausible and all clearly and consistently written. Field trials are arduous and expensive and make sense only for testing the precise wording of criteria sets that have a real chance of making it into the manualnot for the many poorly written and far out suggestions that have just been posted. It seems prudent to identify and root out problems now lest they sneak through in what will likely be an eventual mad rush to complete DSM5. My fear remains that left to its own devices and without continued external pressure and assistance, the DSM5 process may never produce a quality product (even with the extended deadline of 2013).

There is, however, one criticism of the DSM5 process that demands a clear rebuttal. It has been alleged that those working on DSM5 have financial and/or professional conflicts of interest which bias them to

make decisions that increase the rates of psychiatric diagnoses (ie, to benefit drug companies, or to increase research funding, or to expand the practice opportunities of mental health workers. I know most of the people working on DSM5 and can assure you that this accusation is simply false. They have the highest integrity and are making (what I believe to be often mistaken and sometimes even dangerous) suggestions because they sincerely, but naively, believe that this is where the science is leading them not for any personal or professional gain.

How can such smart and scrupulous people make so many bad suggestions? It has been my consistent experience (gained working on the previous three DSM's) that each Work Group always has a strong (and seemingly irresistible) bias for expanding the boundaries of the disorders in its section. This expectable Work Group diagnostic imperialism must always be recognized and resisted. Experts understandably place a high value on reducing false negatives for their favorite disorders and in avoiding the need to resort to the label “not otherwise specified.” They hope in this way to identify patients early in their course and to institute treatments that will be effective in reducing the lifetime burden of illness.

Unfortunately, Work Group members usually have a correspondingly huge blind spotmissing the fact that every effort to reduce the rate of false negatives must inevitably raise the rate of false positives (often dramatically and with dire consequences). It is inherently difficult for experts, with their highly selected research and clinical experiences, to appreciate fully just how poorly their research findings may generalize to everyday practiceespecially as it is conducted by harried primary care clinicians in an environment heavily influenced by drug company marketing. They also consistently underestimate the costs and risks of medication treatment when it is given to those who don't really need it. If we are ever to realize the wished for gains of early case finding, we must first have both specific diagnostic tests and safe and effective treatments. In contrast, the DSM5 suggestions display the peculiarly dangerous combination of nonspecific and inaccurate diagnosis leading to unproven and potentially quite harmful treatments.

I wish to emphasize that the problems in this DSM5 draft are not at all the fault of the Work Group members who have labored hard under very unpromising conditions. The DSM5 options are poorly conceived and executed because of the interaction of 4 unfortunate decisions made by the DSM5 leadership:

1. Requiring unnecessary confidentiality agreements that insulated the Work Groups from the usual and necessary corrective interaction with the field

2. Tightly restricting Advisors to a small and highly selected group

3. Establishing the expectation that Work Groups be innovative rather than risk/benefit conscious

4. Providing the Work Groups with remarkably little guidance, consistency, and editorial assistance.

Because of the secretive and closed nature of the DSM5 process, the expectable enthusiasms of the experts who comprise the Work Groups have not been balanced, as they must always be, with real world practical clinical wisdom and a careful risk/benefit analysis of the possible unintended consequences of every suggestion.

It would be reckless now to rely on the complacent assumption that all these problems will eventually come out in the wash. By its previous actions and inactions, the DSM5 leadership has sacrificed any "benefit of the doubt" faith that their process will be self-correcting in a way that guarantees the eventual elimination all of the harmful options.

There is, however, some cause for measured optimism regarding the future of the DSM5 process based on the fact that it does respond, albeit reluctantly, to external pressure. There have been significant and encouraging improvements during the past several months. A DSM5 Oversight Committee was finally appointed and has played a very beneficial role in correcting the most egregious problems in the previous methods and deadlines. The ill conceived plan to conduct field trials before having a public review of criteria was dropped and the unrealistic field trial and publication deadlines were each extended by a year. The additional time provided by the extended deadlines, if used well, would be sufficient to produce a serviceable DSM5.

What needs to be done next? The responsibility (and opportunity) for rescuing DSM5 falls most heavily on the field at large and on the Oversight Committee. Now that the DSM5 drafts are finally open for wide review, it behooves the field to be active in identifying problems and providing the needed pressure to ensure they will be corrected. My recommendations for the Oversight Committee are:

1. Extend the period allotted for public review to 3 months.

2. Use this time to ensure the careful editing of each word of each item of every criteria set to provide the clarity and consistency that is now sorely lacking and is absolutely necessary before any meaningful field testing can begin.

3. Post field trial methods for public review.

4. Appoint 3 subcommittees reporting to the Oversight Committee (responsible, respectively, for monitoring forensic review, risk benefit analysis, and field trials.

5. Post the literature reviews and plans for ICD-11 harmonization.

Every future step in the preparation of DSM5 should involve active interaction with the field and with the Oversight Committee and its subcommittees. Unnecessary secrecy has caused the current problems and only full transparency and openness to outside input will solve them.

I have had the space and expertise to identify only the DSM5 trouble spots that are most obvious to me. The rest is up to you. Please take the time to review the DSM5 options (at least in your areas of interest) and supply your input. They can be found at www.dsm5.org.

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