

The DSM-5 Has Arrived

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The much anticipated fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) has been released.

Although the number of disorders remains basically unchanged from those of the DSM-IV-TR, the number of categories now totals 22. The DSM-5 is structured to mirror more closely the *International Classification of Diseases* (ICD) and contains both the currently used ICD, Ninth Revision, Clinical Modification (ICD-9-CM) codes as well as ICD-10-CM (codes in parentheses), which is slated to be published in late 2014 (American Psychiatric Association [APA], 2013a, p. 12). In addition, chapters are organized from a life span or developmental perspective with disorders more often diagnosed in childhood (for example, neurodevelopmental disorders) occurring earlier and those of older adulthood (for example, neurocognitive disorders) appearing later in the manual (APA, 2013a).

Although the DSM-5 is still a categorical classification of separate disorders, an effort has been made to incorporate a dimensional approach to symptom severity because many disorders are now understood to have overlapping symptoms and varying degrees of severity (APA, 2013a). This can be seen when looking at changes to schizophrenia—now schizophrenia spectrum disorder—where subtypes were removed and, instead, the severity of core symptoms is now measured through the use of a clinician-rated severity scale (for example, the Clinician-Rated Dimensions of Psychosis Symptom Severity Scale; APA, 2013a). Similarly, the previously separate disorders of autism (for example, Asperger's, childhood disintegrative disorder) were replaced by a broader category "autism spectrum disorder" (ASD) with instruction to differentiate symptom severity on a continuum with specifiers. Severity corresponds to the level of support needed for each of the two domains: social communication and restricted/repetitive behaviors (APA, 2013a).

But this new release is not without critique or debate. Since the debut of the DSM-5, hotly debated issues have surfaced in both scholarly publications and the mass media. Many critics wanted more transparency in the review process and an independent scientific review of the DSM-5 before publication. Furthermore, social workers, who, according to government sources and NASW, provide most of the country's mental health services, had minimal input in the review process with only one social worker out of over 160 professionals appointed to the DSM-5 Task Force (APA, 2013b).

One of the more controversial aspects of this updated version (the first since 1994) has to do with the claim by many critics that the changes made to consolidate some of the diagnoses (for example, elimination of Asperger's disorder from Autism) will result in the denial of much needed services (Lai, Lombardo, Chakrabarti, & Baron-Cohen, 2013). Another criticism is that the DSM-5 definition for ASD is too vague and lacks clinical utility (Frances, 2013); whereas others believe that this will allow for less accurate diagnoses and greater stigma (Lutz, 2013). For instance, a diagnosis of ASD for children who were previously diagnosed with Asperger's disorder may be more stigmatizing.

Just as concerning is the fear that lower diagnostic thresholds, inflated diagnostic criteria, and some new diagnoses in the DSM-5 pathologize normal behavior and may lead to misdiagnosis and reliance on drug therapies, which come with their own risks. For example, the elimination of the bereavement exclusion from the Depressive Disorder section, many fear, will make the natural grieving process a mental disorder (Friedman, 2012). This change was made because many felt that grieving patients with severe symptoms were being excluded from treatment (Kendler, 2010). However, the bereavement exclusion in the DSM-IV-TR already allowed the diagnosis for individuals with severe symptoms.

Another example is the creation of disruptive mood dysregulation disorder under depressive disorders, in an effort to prevent the overdiagnosis of bipolar disorder in children. Many professionals believe this change may lead to temper tantrums being labeled a mental illness (Frances, 2012). However, others believe the creation of this less stigmatizing disorder will decrease the use of drug therapies for children under the age of 18 years (Q&A with Dr. William Narrow, 2012).

Another debate revolves around the recent decision by the National Institute of Mental Health (NIMH) to no longer use DSM-based diagnostic categories in its research projects. A recent statement on the NIMH Web site posted by Director Thomas Insel (2013) called the DSM reliable but said that its diagnostic categories, which are based on clusters of clinical symptoms and not laboratory measurements, lack scientific validity. He later clarified his statement to say that the DSM, along with the ICD, represents "the best information currently available for clinical diagnosis of mental disorders." In addition, he said, "Yet, what may be realistically feasible today for practitioners is no longer sufficient for researchers." He went on to reiterate NIMH's plan to create a future replacement diagnostic system that more directly reflects biology and modern brain science via their Research Domain Criteria project (NIMH, 2013).

Another, perhaps less controversial, change that affects social work practitioners is the elimination of Axis IV on the multiaxial system. Although the authors of the DSM-5 state that "this axis provided helpful information, even if it was not used as frequently as intended" (p. 17), the axis was replaced with an unrequired notation of psychosocial issues by using the ICD-9-CM V codes and the Z codes in the ICD-10 (APA, 2013a). Since social workers constitute the majority of mental health professionals in the United States and given that they intervene with clients from a psychosocial and person-in-environment perspective, the importance of psychosocial factors that affect the mental health of our clients should not be overshadowed or underestimated. Although the DSM-5 Task Force asserted that there was no need for the DSM-5 to contain a separate nosology for psychosocial factors, they appear to have taken a backseat to the primary diagnosis of the mental disorder.

The DSM-5 does contain a cultural formulation interview instrument that highlights the importance

of cultural influences on mental health diagnoses. In addition, three key concepts have been included that stress the importance of culture and its impact on the individual and social group. "Cultural syndrome," "cultural idiom of distress," and "cultural explanation or perceived cause" are newly added terms to the DSM-5 that describe cultural syndromes, cultural expressions of emotional suffering, and culturally bound perceived causes for mental health issues (APA, 2013a). The contrast between the prominence of these additions and the lack of foci on psychosocial issues warrants further examination.

A dimensional approach was incorporated into the DSM to provide greater detail to the clinician and to allow the differentiation of symptoms by measuring number/count, duration, and intensity beyond just the absence or presence of a symptom (see APA, 2013a). New cross-cutting symptom measures (adult/child versions), which come in two levels (level 1 is a brief survey and level 2 is more in-depth), were developed to rate and track symptom severity and response to treatment over time (APA, 2013a). The DSM definition for a *cross-cutting symptom measure* is a "measure that assesses mental health domains that are important across psychiatric diagnoses" (APA, 2013a, p. 734). The use of such instruments (both self and clinician rated) will allow for the tracking of symptoms that are not necessarily part of the diagnosis but, nevertheless, are important to the therapeutic relationship and quality of life for the patient (for example, suicide ideation, sleep problems). A separate clinician-rated dimensional scale that measures the symptoms of psychosis, including hallucinations, delusions, and cognitive impairment was also included (see APA, 2013a). Information on impairment type/disability can be garnered from the World Health Organization Disability Assessment Schedule (see APA, 2013a) and the cultural context as discussed earlier from the Cultural Formulation Interview (see APA, 2013a). All measures are included in section III (APA, 2013a).

However, the shift to include dimensional measures, including cultural assessment, at the same time that Axis IV is being truncated and psychosocial/environmental factors and their impact on mental illness are being downplayed, is puzzling. In the ongoing effort to aid clinical judgment and more accurately define mental illness, there was a realization that many disorders have overlapping

symptoms. The boundaries between different disorder categories often blur, and severity levels wax and wane. Many disorders reflect symptoms in the same dimension, which is why comorbidity is ever present. The same can be said of the causation and contributors to mental health or mental illness—and a psychosocial framework can help clinicians conduct a more comprehensive assessment.

In an effort to lend support to the clinical utility of the new diagnostic constructs, APA field-tested many of the new diagnoses in both large academic medical settings and private practice. Unfortunately, a test of the validity of these diagnoses was not scheduled to occur until after publication. The results showed that 14 out of 23 DSM-5 diagnoses tested (including ASD and attention deficit/hyperactivity disorder in children and posttraumatic stress disorder and binge-eating disorder in adults) had “very good” to “good” reliability. In addition, the newly added cross-cutting symptom and severity measures were also tested and found to have good to excellent reliability. Six diagnoses had acceptable to low reliability scores, including major depressive disorder and generalized anxiety disorder, two of the most common psychiatric diagnoses (APA, 2012). Whether these new diagnoses and dimensional tools are valid and offer clinical utility will need to be time tested in clinical practice.

In the end, what will matter most to social workers is whether the changes made to the DSM improve clinical care. Are the new diagnoses and dimensional measures value-added tools when making an assessment or building a treatment plan? Furthermore, the current manual’s biomedical focus does not necessitate the elimination of a client-centered approach, one that builds on clients’ strengths and resources. Psychosocial issues can still be coded if they are the focus of clinical attention or otherwise affect diagnosis, prognosis, or treatment. However, many feel that this change undermines the psychosocial framework. The primary focus on a biomedical approach to mental illness with the implication that mental health is simply an amalgam of symptoms and biology, while marginalizing the social and environmental factors that can lead to disease development or treatment, is shortsighted.

As social workers, we are familiar with working from a strengths perspective with our clients, and this approach enhances our understanding of the DSM-5. The strength of the DSM has been in establishing a common language by which to

classify presenting symptoms and mental disorders. However, there is clearly a role for the assessment of psychosocial, cultural, and social factors in diagnosis and treatment of psychopathology. Therefore, until proven otherwise, when making therapeutic decisions, a holistic approach to diagnosis, one that incorporates psychosocial and biological factors, is crucial. Clinical judgment cannot be replaced by a laboratory test. Leaving aside the criticism, insurance coverage, school services, disability benefits, even prison sentences are currently tied to the DSM. Our client-centered approach to clinical care depends on a biopsychosocial-spiritual understanding of our clients and their lived experiences. We need to meet our clients where they are, and the same can be said of the DSM. To date, the promises of the biomedical model have been elusive in that biology, neuroscience, and genetics have not yet been able to find a valid scientific explanation for mental disorders. Nonetheless, our clients continue to come to us for help, with presenting symptoms, and it is from a person-in-environment perspective that we must move forward. **SW**

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Advance Access Publication July 3, 2013

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