

Deconstructing the DSM-5

By Jason H. King

The DSM-5 does not make diagnoses

In the May issue of *Counseling Today*, seven counselor educators and practitioners answered some pressing questions about the official release of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). In this initial column of what will be a monthly look at the topic of the DSM-5, I would like to follow up to offer a deeper level of understanding about the DSM-5.

Background and history

First, let me introduce myself. I served as a DSM-5 revision task force committee member for both the American Mental Health Counselors Association and the American Counseling Association. In these roles, I provided commentary and feedback on the proposed DSM-5 revisions and copresented with other task force members at the 2012 AMHCA and 2012 ACA conferences.

I will be presenting with my colleagues again at the 2013 AMHCA conference in July. In February, I completed a podcast interview, "DSM-5 Diagnosis Drill Down," with ACA's Rebecca Daniel-Burke, and I conducted a webinar with her in June on the new DSM-5 substance-related and addictive disorders category.

I also own and direct an outpatient mental health and substance abuse treatment clinic (lecutah.com) that collected data for the American Psychiatric Association's (APA) routine clinical practice field trials that informed the DSM-5 revision process. For the past eight years, I have taught DSM and clinical assessment-based classes at four universities in three mental health counseling programs.

OK, enough about me. Let's talk about the DSM-5.

The DSM-5 revision process began in 1999 (even before the DSM-IV-TR was published) with preplanning white papers that addressed a research agenda for the DSM-5, age and gender considerations in psychiatric diagnosis, and cultural and spiritual issues that can affect diagnosis (for the complete timeline, see dsm5.org/about/Pages/Timeline.aspx).

At that time, APA's DSM-5 task force and work groups began critical discussion and extensive consumption of the scientific literature on mental disorders. According to Dr. John Oldman, a former APA president, the members of the work groups were not APA employees, were not paid by APA and were not under contract with APA. Their participation was strictly voluntary and based upon their interest in advancing the field of psychiatry and better serving patients. The same is true for those, including me, who participated in the field trials. Talk about pro bono publico!

On April 16, 2010, Lynn Linde, then serving as president of ACA, sent a letter on behalf of ACA to her counterpart at APA. This letter addressed concerns about the applicability of the DSM-5 across all mental health professions; the need to integrate gender and cultural issues across disorders and criteria; organization of the multiaxial system; lowering of diagnostic thresholds; combining disorders; and dimensional assessments.

In June 2011, K. Dayle Jones, then chair of the ACA DSM-5 Proposed Revision Task Force, sent a letter to ACA Executive Director Richard Yep. Jones expressed concerns about the prospect of lowered diagnostic thresholds and subthreshold disorders, detrimental consequences, weak empirical evidence, field trial research design problems and delays, poor quality of dimensional assessments, counselors being excluded and psychotropic medications increasing.

In November 2011, ACA President Don W. Locke sent a letter to APA raising concerns about empirical evidence, dimensional and cross-cutting assessments, field trials, the proposed new definition of mental disorder and lack of transparency. I encourage you to read Oldman's scholarly and detailed reply at dsm5.org/Documents/DOC001.pdf. You can also read the AMHCA DSM-5 Task Force draft comments at amhca.org/assets/content/DSM5_Task_Force_ResponsesJune2012.pdf.

Personal cognitive restructuring

I share this brief history of the counseling profession's involvement with the DSM-5 revision process to provide some historical context of the political and social advocacy efforts championed by many of our own. As Paul Peluso, recent chair of the ACA DSM-5 Proposed Revision Task Force, stated in the May Counseling Today article, "We will see how long it takes to get over this disorientation."

With this in mind, I would like to offer some advice to all counselors who will be reading, using or otherwise crossing paths with the DSM-5. That advice is: Engage in some personal cognitive restructuring. By this I mean actively identifying and disputing any automatic irrational thoughts. Let me offer some examples.

Some counselors may catastrophize by telling themselves, "The DSM-5 promotes the medicalization of normal life stressors and encourages people to use psychotropics instead of counseling to achieve mental health. I will no longer have a purpose as a counselor."

Other counselors may overgeneralize by thinking, "The DSM-5 lowers the diagnostic threshold on some disorders. Therefore, most of my clients will never be able to overcome their struggles."

Some counselors may entertain all-or-nothing thinking. For example: "APA's DSM-5 task force and work groups did not include counselors, so I do not need to use this book in my counseling practice."

Mental filter may be displayed in some counselors who think, “The DSM-5 field trials were rushed and unreliable. Therefore, the entire book is flawed.” Other counselors may jump to conclusions by telling themselves, “Money-driven pharmaceutical companies influenced the DSM-5 revision process.” Finally, some counselors may experience magnification by claiming, “The DSM-5 revision process was sloppy, rushed and biased.”

My suggestion to counselors of all specialties is to brush up on their cognitive disputation skills as proposed by Albert Ellis and Aaron Beck. The DSM-5 is here, and it is not the end of the world.

Critical perspectives and responses

I'd like to offer a few of my own critical perspectives and responses to some of the comments my colleagues made in the May Counseling Today. Namely that “a general loosening of diagnostic thresholds” means more people will meet criteria for mental disorders, and the reduced requirements needed for diagnosis may cause counselors to “blur the boundary between normality and pathology.”

It is important that we do not globalize these statements because it depends on which disorders are being addressed — in their full context. The 10th chapter of the DSM-5, on elimination disorders, contains no changes from DSM-IV-TR. The 18th chapter on personality disorders includes no changes to DSM-IV-TR criteria, and the 19th chapter on paraphilic disorders contains no alterations to criteria, although it does entail some important conceptual reformulations.

Regarding disruptive behavior diagnoses (conduct disorder and oppositional defiant disorder), APA work group chair Dr. David Shaffer said changes to the criteria are designed to make the criteria considerably more specific than are DSM-IV-TR criteria. He also said the changes are expected to decrease prevalence of the diagnosis. Specifically, the criteria for oppositional defiant disorder indicate that symptoms must be present more than once a week to distinguish the diagnosis from symptoms common to normally developing children and adolescents.

To improve precision regarding duration and severity and to reduce the likelihood of overdiagnosis, all of the DSM-5 sexual dysfunctions, except substance- or medication-induced sexual dysfunction, now require a minimum duration of approximately six months. Regarding the new diagnosis of gender dysphoria for children, Criterion A1 (“a strong desire to be of the other gender or an insistence that he or she is the other gender”) is now necessary but not sufficient to meet the diagnosis, which makes the diagnosis more restrictive and conservative.

According to Jack Drescher, a member of the DSM-5 work group on sexual and gender identity disorders, “It’s really a narrowing of the criteria because you have to want the diagnosis. It takes psychiatrists out of the business of labeling children or others simply because they show gender-atypical behavior.”

Moreover, criteria for the new category emphasize the phenomenon of “gender incongruence” rather than cross-gender identification, as was the case in DSM-IV-TR. By separating gender dysphoria from sexual dysfunctions and paraphilias (with which it had previously been included in DSM-IV-TR in a chapter titled “Sex and Gender Identity Disorders”), work group members said they hope to diminish stigma attached to a unique diagnosis that is used by mental health professionals but for which treatment often involves endocrinologists, surgeons and other professionals.

In a discussion about the new diagnosis of avoidant/restrictive food intake disorder, Timothy Walsh, chair of the DSM-5 eating disorders work group, commented: “We have good data to indicate that if the criteria are rigorously applied by people familiar with the syndrome, only a relatively small number of people will meet the criteria. The lifetime prevalence of the disorder, we believe, is less than 5 percent, and we have good data that individuals who meet the criteria have a significantly higher frequency of anxiety and depression.”

Two new diagnoses — REM sleep behavior disorder and restless legs syndrome — have been added, which should significantly reduce the use of “sleep disorder—not otherwise specified.” The criteria for insomnia include a frequency threshold of three nights per week and duration of at least three months. The text also includes dimensional measures of severity.

For post-traumatic stress disorder (PTSD), there are now four symptom clusters in DSM-5 (as opposed to three in DSM-IV-TR): re-experiencing, avoidance, persistent negative alterations in mood and cognition, and arousal. In the DSM-5, PTSD is now developmentally sensitive. Diagnostic thresholds have been lowered and criteria modified for children 6 and younger.

Criteria for both acute stress disorder and PTSD are now more explicit concerning how the distressing or traumatic event was experienced: directly, witnessed or indirectly. The DSM-5 work group members believe the changes to the PTSD criteria are unlikely to affect epidemiology of the disorder, but if there is any effect, it will be to lower the prevalence slightly.

To diagnose a substance abuse disorder in the DSM-IV-TR, individuals only needed to present with one criterion, whereas to diagnose a substance-related disorder in the DSM-5, individuals must present with a minimum of two criteria. And to avoid overdiagnosing substance abuse solely on legal involvement (as happened with the DSM-IV-TR), the DSM-5 replaced this criterion with craving.

In diagnosing schizophrenia, counselors will notice an important conceptual change from DSM-IV-TR. An individual can no longer meet Criterion A for psychosis with a single bizarre delusion, but must have a minimum of two symptoms — one of which must be one of the core psychotic symptoms of “delusions, hallucinations or disorganized thinking.”

Regarding the diagnosis of intellectual disability (formerly “mental retardation” in the DSM-IV-TR), the DSM-5 criteria mark a move away from relying exclusively on IQ scores and toward using additional measures of adaptive functioning. DSM-IV-TR criteria had required an IQ score of 70 as the cutoff for diagnosis. The new criteria recommend IQ testing and describe “deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility.”

The ninth chapter of the DSM-5 eliminates several diagnoses (somatization disorder, hypochondriasis, pain disorder and undifferentiated somatoform disorder), removes some redundancies and extraneous features in previous criteria, and more clearly delineates the separate diagnoses that make up this chapter.

To diagnose an individual with somatic symptom disorder, the individual must be persistently symptomatic for at least six months, ruling out random or intermittent symptom presentations.

To diagnose bipolar-related disorders in the DSM-5, counselors must properly assess for and actively include an individual’s activity and energy level, in addition to the classic heightened and elevated mood symptom used in DSM-IV-TR. This diagnostic modification will lead to a reduction in the misdiagnosis of bipolar disorder in adolescents and adults, and challenges counselors to be more systematic in their diagnostic formulation. The new diagnosis of disruptive mood dysregulation disorder should significantly reduce the overdiagnosis of bipolar disorder in children that occurred with DSM-IV-TR.

Chapter 2 of the DSM-5 contains the newly modified autism spectrum disorder (considered a neurodevelopmental disorder). The diagnostic criteria have been collapsed into two core symptoms, with one of the two containing two symptoms that must be met: deficits in social communication and social interaction (so, essentially, still three symptoms).

The DSM-5 criteria were tested in real-life clinical settings as part of the field trials, and analysis from that testing indicated there will be no significant changes in the prevalence of autism spectrum disorder. More recently, the largest and most up-to-date study, published by Marisela Huerta et al. in the October 2012 issue of *The American Journal of Psychiatry*, provided the most comprehensive assessment of the DSM-5 criteria for autism spectrum disorder based on symptom extraction from previously collected data.

The study found that DSM-5 criteria identified 91 percent of children with clinical DSM-IV-TR pervasive developmental disorder diagnoses. The remaining 9 percent will be properly diagnosed as having a communication disorder, reducing the misdiagnosis of autism spectrum disorder.

With the DSM-5, several of an individual’s attention-deficit/hyperactivity disorder symptoms must be present prior to age 12, as compared with age 7 in the DSM-IV-TR. However, this change is supported by substantial research published since 1994 that found

no clinical differences between children identified by age 7 versus later in life in terms of course, severity, outcome or treatment response.

Regarding depressive disorders, the DSM-5 aims to provide an accurate diagnosis for people who need professional help and no diagnosis for those who do not. Therefore, several strategies are provided to help clinicians using the DSM-5 to differentiate major depression, “normal” bereavement and pathological bereavement, including changes in diagnostic criteria as well as in the text.

It is true that diagnostic criteria for binge eating disorder in the DSM-5 reduce from twice per week to once per week for recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances. These episodes should also be marked by feeling a lack of control.

The new DSM-5 diagnosis of mild or moderate neurocognitive disorder (dementia) reflects an attempt to move upstream toward identifying and diagnosing Alzheimer’s and other neurocognitive disorders earlier.

For acute stress disorder, previous DSM-IV-TR criteria requiring dissociative symptoms were too restrictive. Individuals can meet DSM-5 diagnostic criteria for acute stress disorder if they exhibit any nine of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance and arousal. Yet these criterion reductions do not necessarily mean that rates of individuals qualifying for these diagnoses will increase as long as counselors balance this out with a focus on the entire person.

Now what?

In the DSM-5, the multi-axial system of previous editions is eliminated, and chapters are now arranged according to a life span or developmental approach (which fits the paradigm of counseling). Disorders affecting children appear first, and those more common in older individuals appear later. The intention throughout is to group disorders that are similar to one another across a range of validators, including symptoms, neurobiological substrates, familiarity, course of illness and treatment response.

With all of these changes, it is imperative that counselors remember this mantra: The DSM-5 does not make diagnoses; counselors, systematically and objectively using standardized and nonstandardized testing, specialized clinical assessment techniques and case conceptualization procedures, make diagnoses that are developmentally and culturally sensitive. Let me repeat: Counselors make diagnoses, not the DSM-5!

I love these words from the DSM-IV-TR: “The specific diagnostic criteria included in the DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion” (emphasis added). Furthermore, “a common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have.”

With these words, let's embrace the DSM-5 and properly use it as one of our many social change tools to promote growth, development and wellness in our clients. Talk to you next month!

Bio

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