Editorials: *Controversies in Family Medicine*

Two Views on the New DSM-5

DSM-5: A Diagnostic Guide Relevant to Both Primary Care and Psychiatric Practice

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Despite endorsement of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5) by the director of the National Institute of Mental Health and the president of the American Psychiatric Association,[1] the largest psychiatric association in the world, the editor of the 20-year-old DSM-IV has questioned changes in the way DSM-5 classifies some mental disorders. In particular, he and others have raised concerns about DSM-5 being too inclusive, thus stigmatizing what might be considered normal conditions as mental illness.[2]

In developing DSM-5, we recognized the importance of presenting diagnostic criteria that characterize mental disorders as accurately as possible, using the best science available to us. As the introduction clearly states, the criteria are not an exhaustive list of all the characteristics of underlying disorders, but provide a systematic review of the signs and symptoms most commonly expressed by individuals who present with these disorders. The clinical utility and predictive validity of this criteria-based approach have been borne out in clinical trials, treatment response, and an increasing number of laboratory correlates—particularly for larger groupings of mental disorders, as opposed to the rigidly defined disorders in DSM-IV.[3]

Because syndrome-based diagnoses of medical conditions are usually developed in specialized settings where there is a high concentration of such conditions, it is always a challenge to identify criteria that provide precise thresholds between normal variations and pathology in primary care and community populations. This is important because primary care physicians diagnose and treat the largest proportion of patients with mental disorders, including many individuals with severe disorders, who cannot or will not accept referrals to psychiatrists and other mental health specialists.[4]

The challenge to identify the right diagnostic thresholds for DSM-5 was no different than that encountered for DSM-III and DSM-IV. There was substantial concern that the prevalence rates of mental disorders found in epidemiologic studies of community and primary care treatment populations using DSM-III were too encompassing of normal variations.[5] As a result, DSM-IV required the additional criterion of "clinically significant distress and impairment" for all mental disorders.[6] One analysis documented a decrease in the prevalence of mental disorders in adult community populations from 28% to 18% when the clinical significance criterion was used with the other disorder-specific DSM diagnostic criteria.[6]

DSM-5 maintains use of the clinical significance criterion but has sought to further restrict diagnostic inclusiveness through a more dimensional approach to diagnosis that can be linked to measurement-based care—specifically, the addition of dimensional severity measures to better identify the need for and response to treatment. A good example included as a recommended severity measure in DSM-5 is the well-known nine-item Patient Health Questionnaire (PHQ-9), which was developed by the editor of DSM-III and reflects the nine criteria for major depressive disorder; at least five of the criteria are required for a diagnosis. Although the criteria require a score of only 5 to meet the diagnostic threshold,

a higher score of 10 is generally considered clinically significant depression and the benchmark to warrant treatment.

DSM-5's inclusion of such tools to supplement careful clinical evaluations will be useful not only in identifying diagnostic thresholds, but also in determining whether the level of psychopathology truly merits intervention. In patients with lower PHQ-9 scores, for example, physicians could opt for watchful waiting or initiation of supportive therapy. More active intervention, such as antidepressant therapy, specialty referral, or collaborative care, would be recommended only if the patient's symptoms do not respond to the initial approach.[7] Thus, although the criteria are relatively broad so as to be sensitive to patient presentations in both specialty and primary care, a combination of clinical judgment, assessment of symptom severity, and clinically significant distress or impairment is required to determine if diagnosis and/or treatment is appropriate. Because most of the actual diagnostic criteria for individual disorders have changed very little, the clinical significance requirement remains essential in DSM-5, and additional dimensional measures are recommended to make threshold determinations, there is no evidence that DSM-5 will lower diagnostic thresholds.

Data from the field studies, as well as secondary data analyses conducted by many of the work groups in developing their DSM-5 criteria drafts, provided reassurance that changes would not dramatically inflate the prevalence of mental disorders as diagnosed in specialty mental health settings.[8,9] However, moving the entire mental health specialty and primary care professions toward more dimensional rather than discrete diagnoses will require regular use of quantitative assessments to more precisely capture symptoms, identify comorbidities, and track changes in disease severity and treatment response. This approach is already prominent in the rest of medicine, where physical abnormalities are often operationalized by grades, stages, or severity levels rather than solely by their presence or absence.

There is an adage that says that the best way to predict the future is to create it. DSM-5's future is still unclear, but we are optimistic that by having welcomed an extensive review process and taken active steps to make DSM-5 more applicable to all of medicine, we have generated an approach that signifies a much improved future for the diagnosis and classification of mental disorders.

EDITOR'S NOTE: Dr. Kupfer was chair and Dr. Regier was vice chair of the DSM-5 Task Force.

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