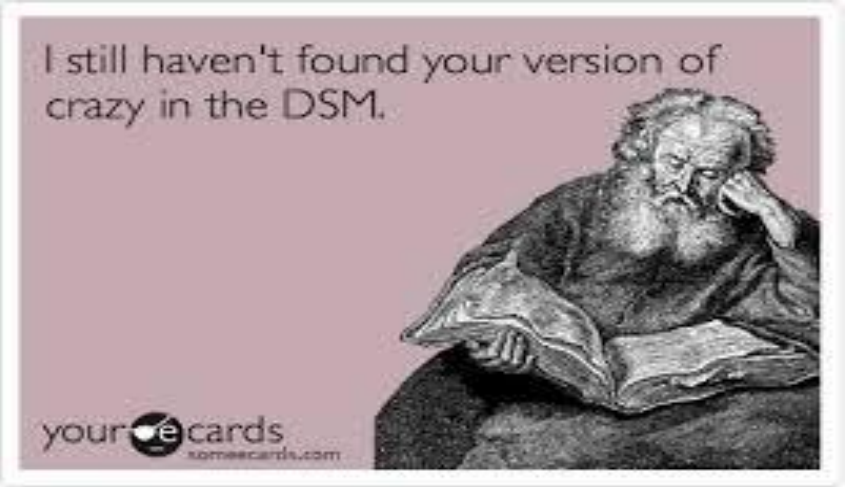
History and Critique of the DSM
Friend or Foe

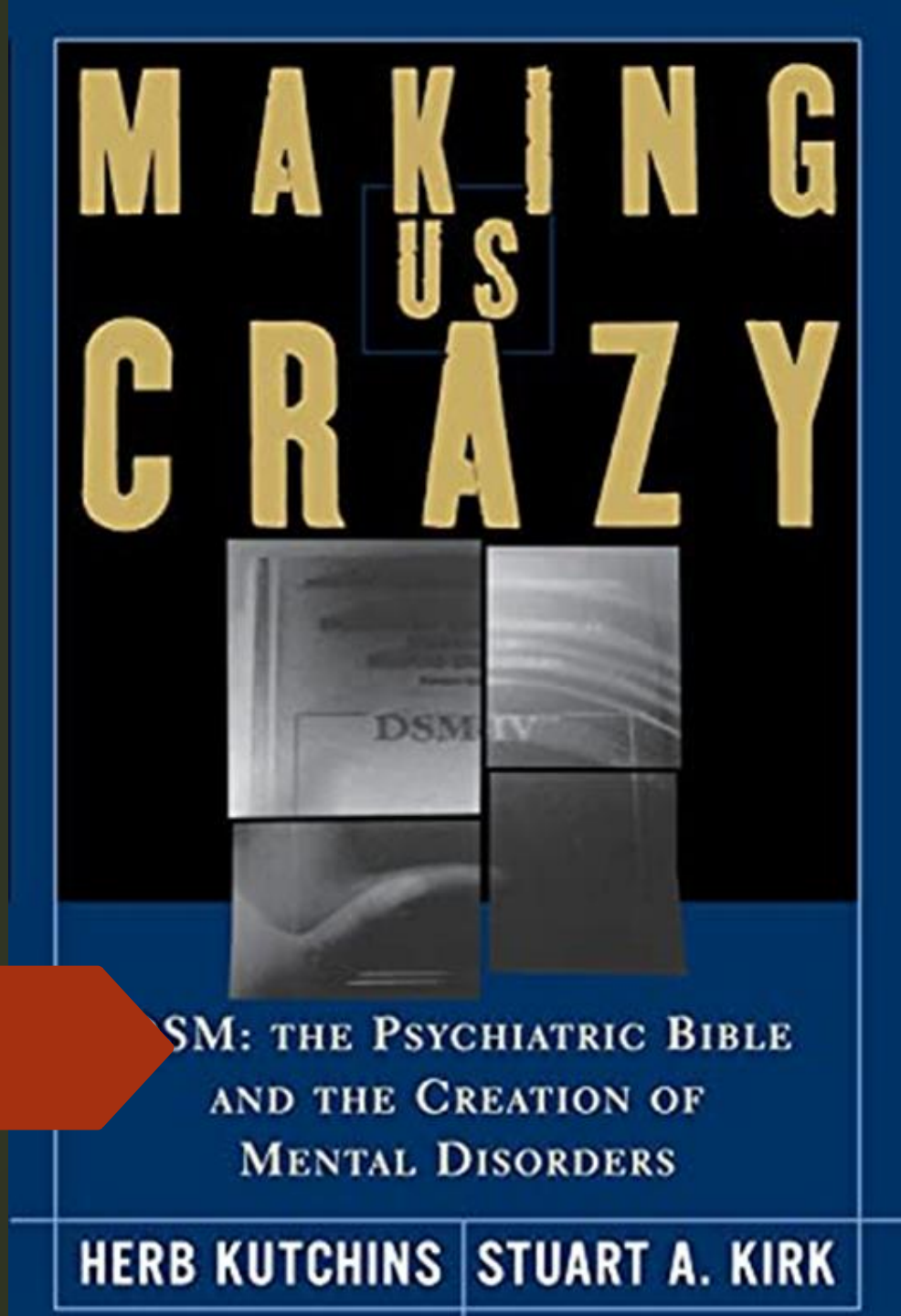


Jeffrey E. Hansen, Ph.D.

Center for Connected Living, LLC

Vice is a monster of so frightful mien
As to be hated needs but to be seen
Yet seen too oft, familiar, with her face,
We first endure, then pity, then embrace.

Are Kutchins and Kirk right?



Mental Disorders

Background narrative on the DSM

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association (APA) and offers a common language and standard criteria for the classification of mental disorders.

It is used, or relied upon, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and policy makers together with alternatives such as the ICD-10 Classification of Mental and Behavioral Disorders, produced by the WHO.

The DSM is now in its fifth edition, the DSM-5, published on May 18, 2013. The DSM evolved from systems for collecting census and psychiatric hospital statistics, and from a United States Army manual.

Revisions since its first publication in 1952 have incrementally added to the total number of mental disorders, although also removing those no longer considered to be mental disorders.

Background narrative on the DSM

The International Classification of Diseases (ICD) is the other common manual for mental disorders. It is distinguished from the DSM in it covers health as a whole.

While the DSM is the most popular diagnostic system for mental disorders in the US, the ICD is used more in Europe and other parts of the world, giving it a far larger reach than the DSM.

The DSM-IV-TR (4th. ed.) contains specific codes allowing comparisons between the DSM and the ICD manuals, which may not systematically match because revisions are not simultaneously coordinated. Though recent editions of the DSM and ICD have become similar due to collaborative agreements, each one contains information absent from the other.

Background narrative on the DSM

While the DSM received praise for standardizing psychiatric diagnostic categories and criteria, it also generated controversy and criticism.

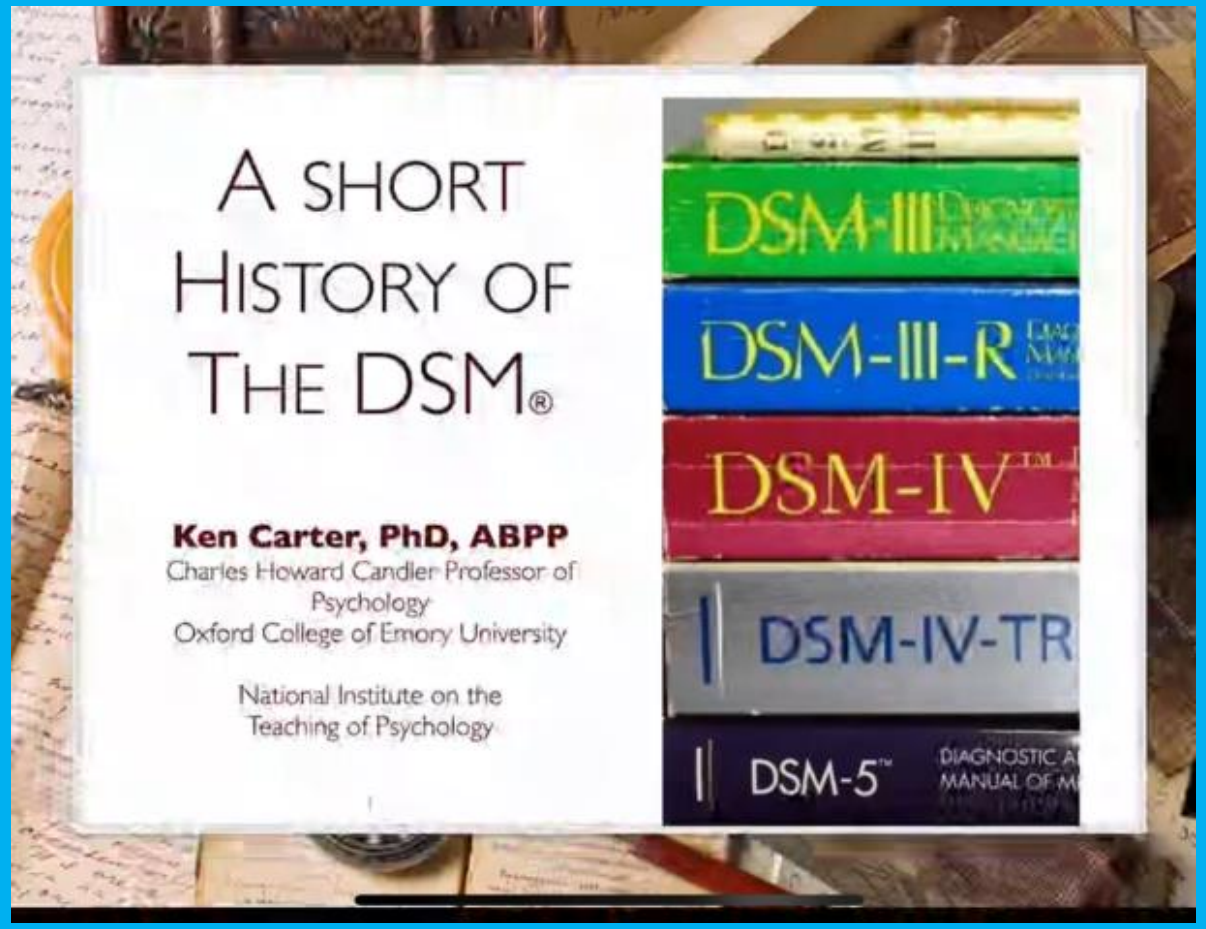
Critics, including the National Institute of Mental Health, argue the DSM represents an unscientific and subjective system.

There are ongoing issues concerning the validity and reliability of the diagnostic categories; the reliance on superficial symptoms; the use of artificial dividing lines between categories and from "normality"; possible cultural bias; and medicalization of human distress.

The publication of the DSM, with tightly guarded copyrights, now makes APA over $5 million a year, historically totaling over $100 million.

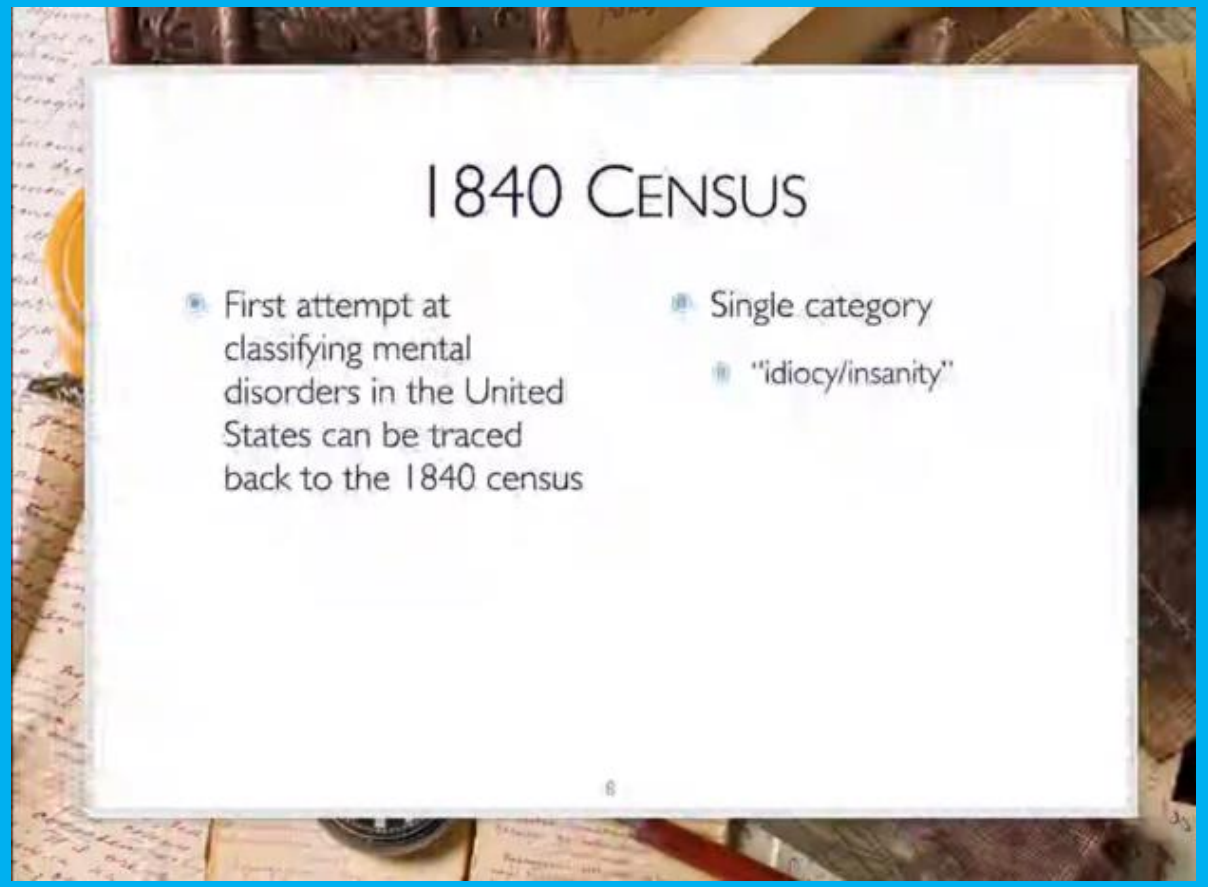
Click here to listen to Professor Ken Carter's review of the DSM on which several of the following slides are based:

https://www.youtube.com/watch?v=PMQRFRQcQI8&ab_channel=NationalInstituteontheTeachingofPsychology

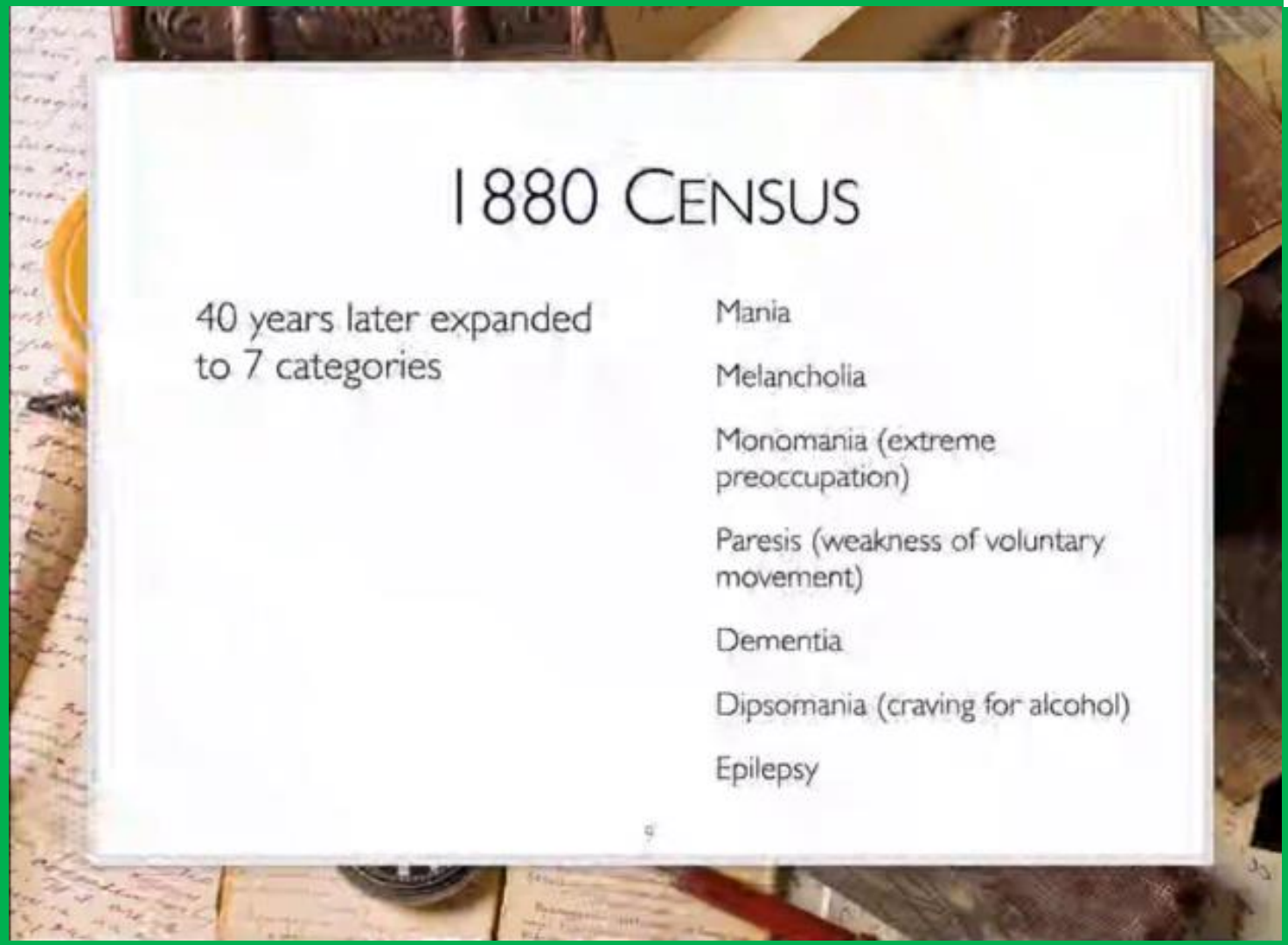


Click here to listen to Lustica Hennessey's video on the history of the DSM on which several of the following slides are based:

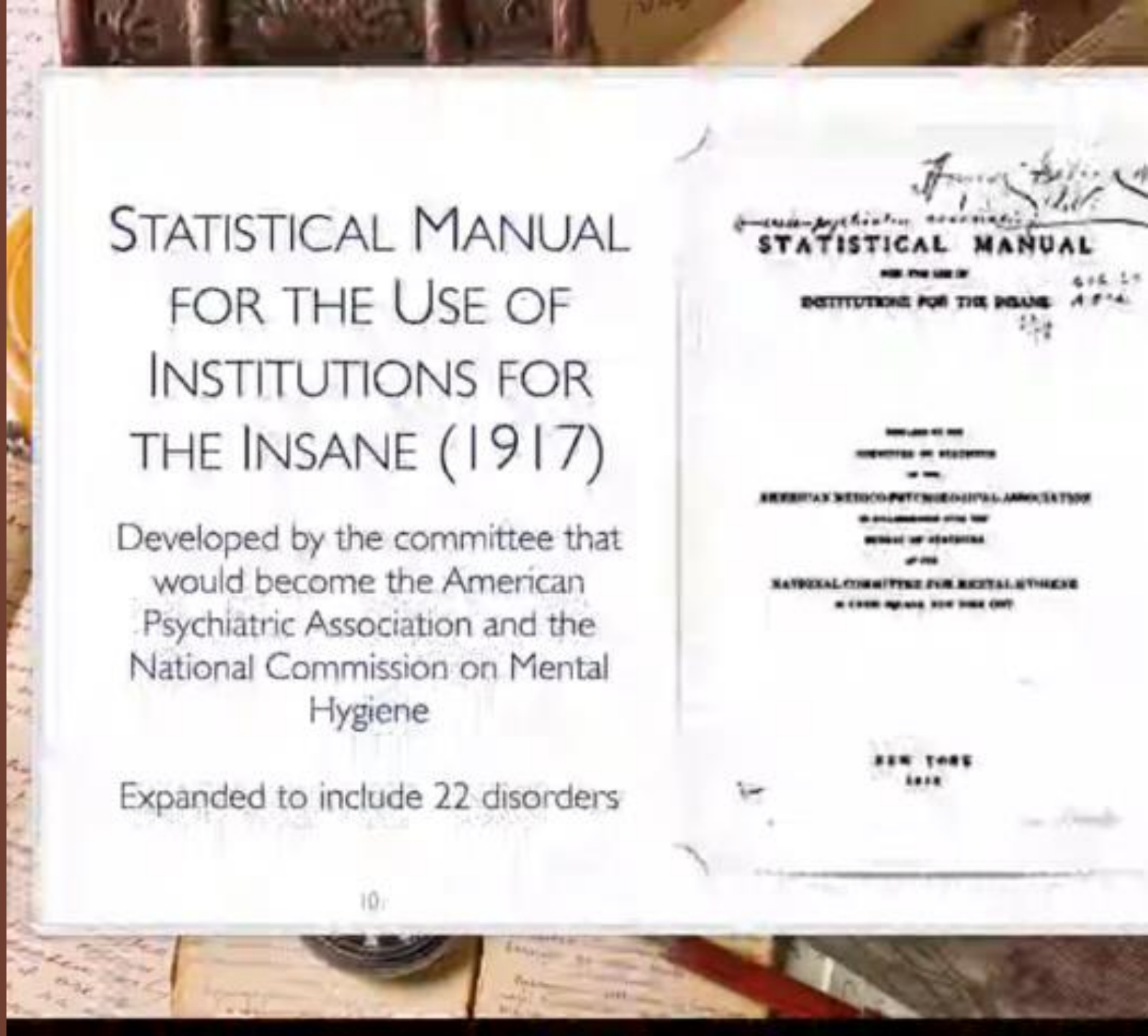
https://www.youtube.com/watch?v=xKf_QEix4EQ&ab_channel=HennesseyLustica



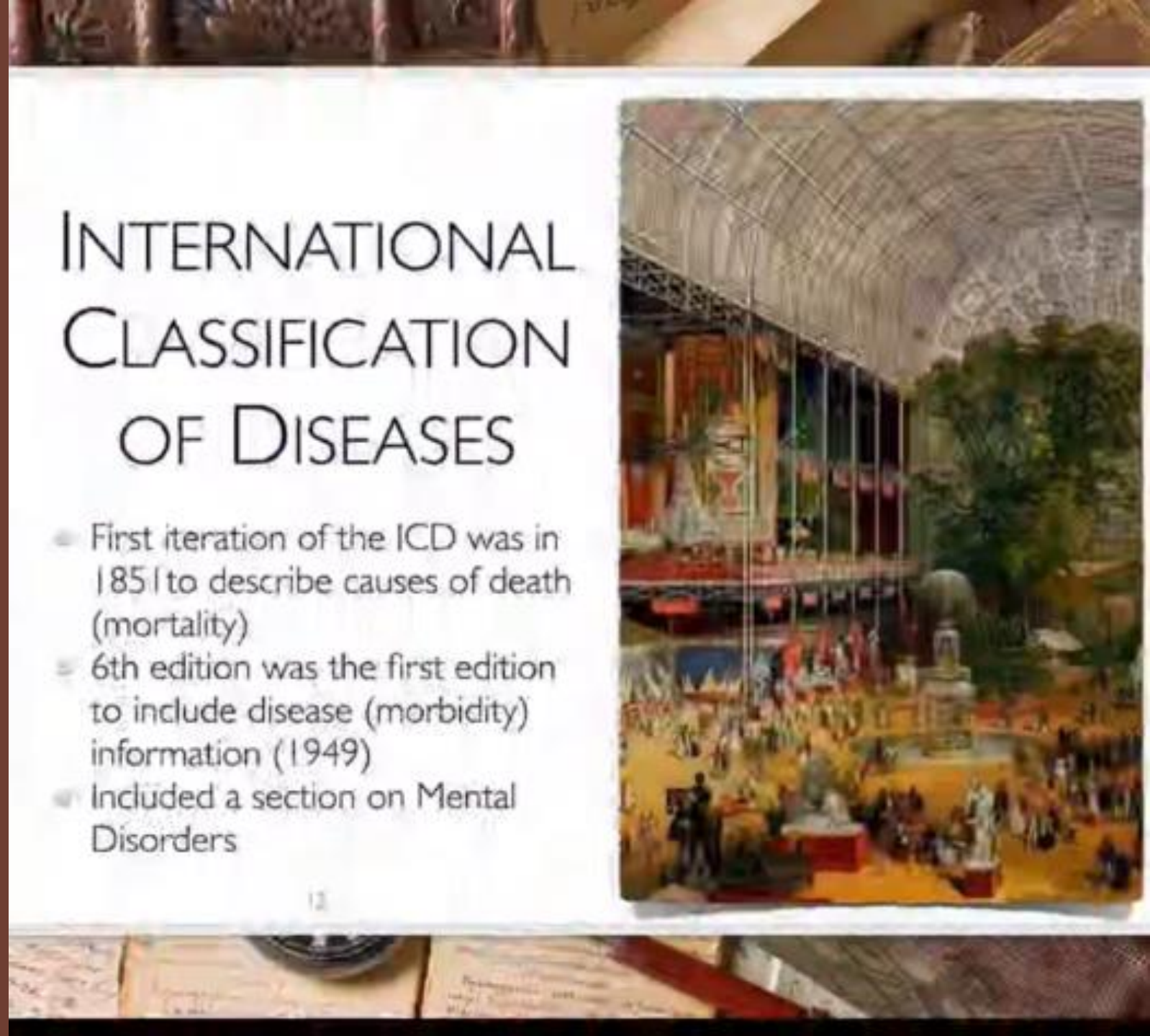
Precursors of the DSM



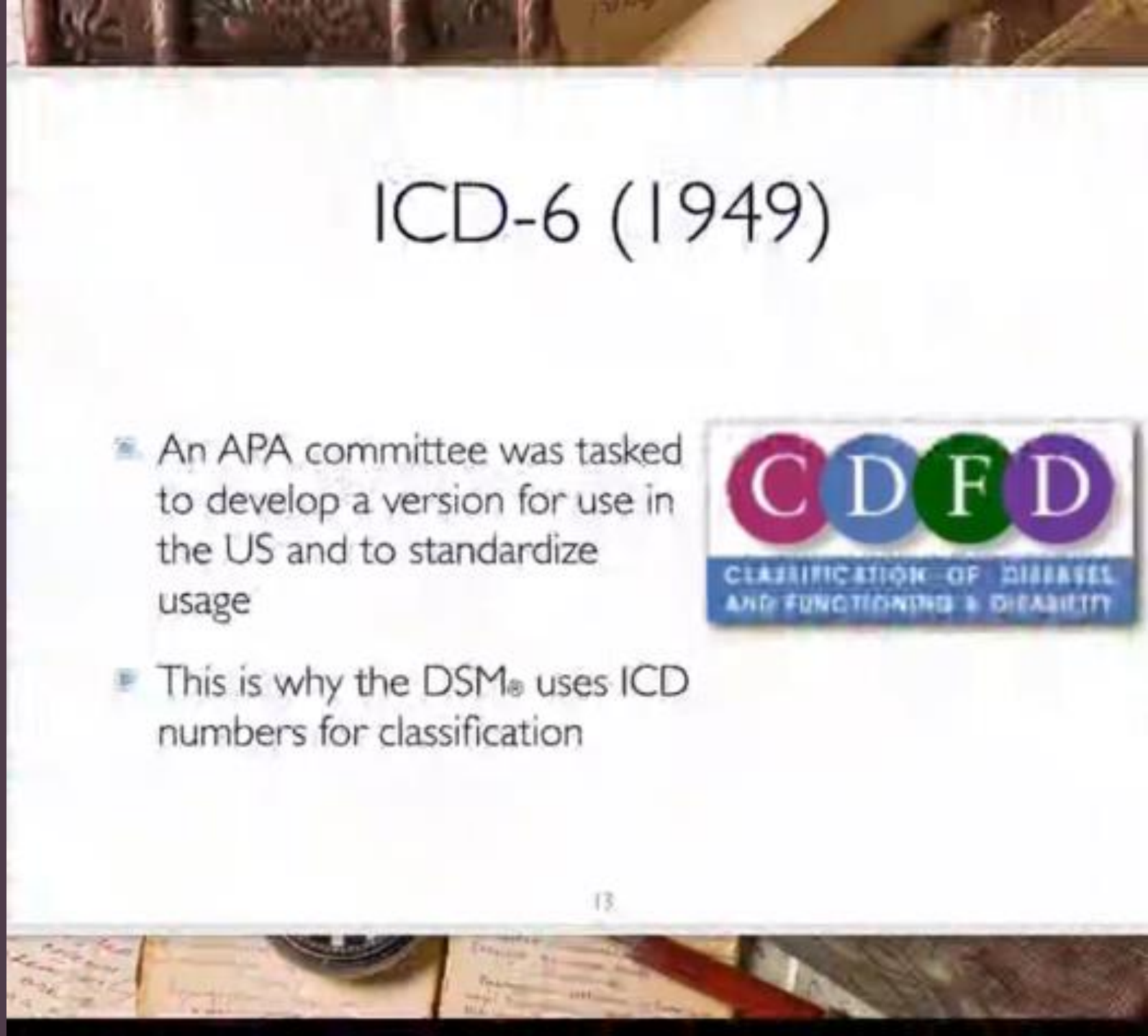
Precursors of the DSM



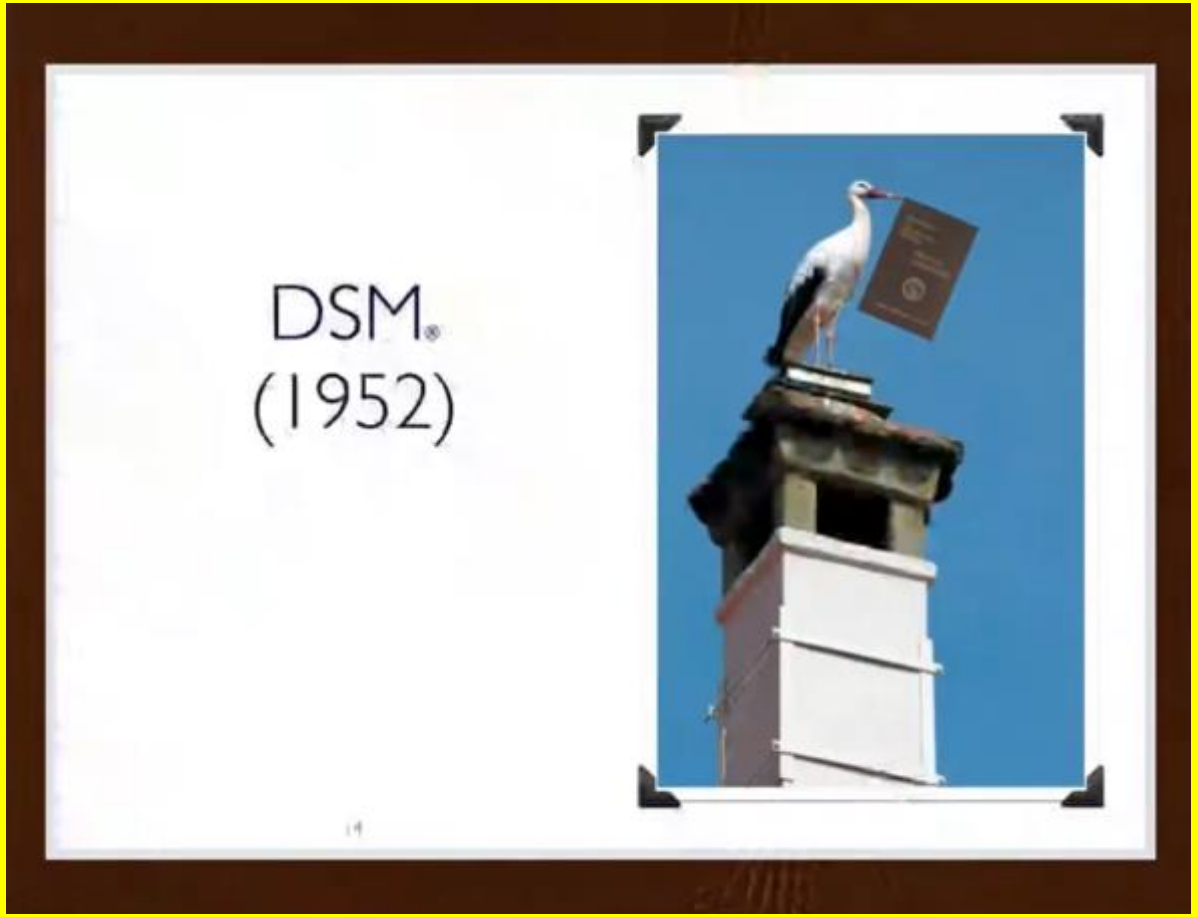
The ICD - a globally used diagnostic tool for epidemiology, health management and clinical purposes.



The ICD – 6
The ICD has connections with the DSM



First version of the DSM arrives in 1952



DSM-I

DSM-I

- An adaptation of Medical 203 and the "Standard"
- Psychodynamic approach
- Listed disorders and defined them briefly
- Mainly intended to help keep statistical records

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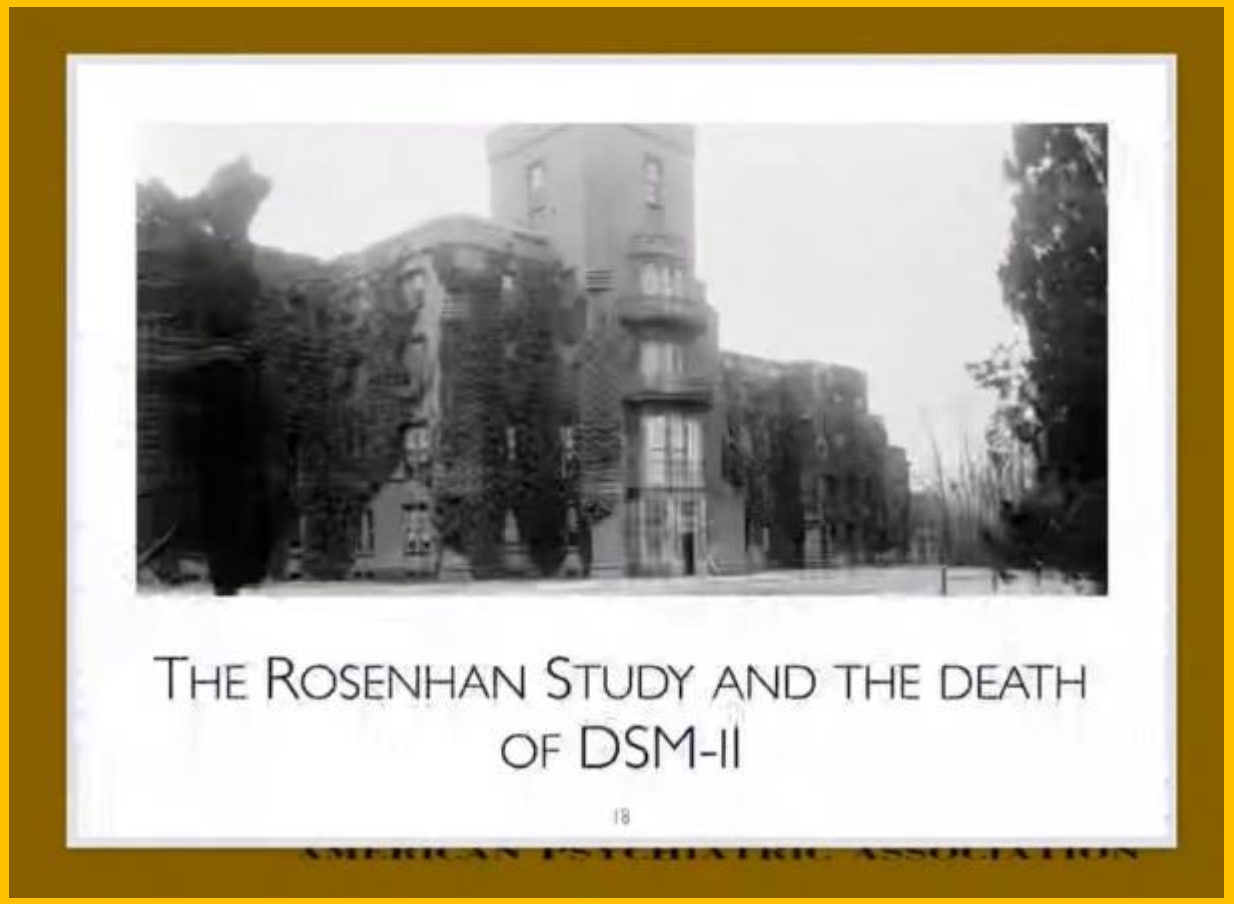
DSM-II

Rosenhan Study

Rosenhan's 1973 study **aimed to investigate the reliability of staff in psychiatric hospitals to identify the sane from the insane**. He wanted to see if people who posed as mentally ill would be identified by staff in psychiatric hospitals as sane rather than insane.



Rosenhan Study Design

- Between 1969 and 1972, Prof. David Rosenhan, a psychiatrist at Stanford University, sent eight pseudo-patients to 12 psychiatric hospitals without revealing this to the staff. None of the pseudo-patients had any symptoms or history of mental disorders.
- In all 12 instances, pseudo-patients were diagnosed with a mental disorder and hospitalized. In no instance was the misdiagnosis discovered during hospitalization.
- In some of the 12 hospital stays, pseudo-patients observed significant deficits in patient-staff contact.
- In a follow-up study at one hospital, Prof. Rosenhan asked staff to rate patients seeking admission on a 10-point scale, from “highly likely to be a (healthy) pseudo-patient” (1 or 2) to “least likely to be a pseudo-patient.” Staff were aware of the previous study and told one or more pseudo-patients would be sent their way, unannounced. Forty-one (21.24%) of 193 patients received a 1 or 2 score. No pseudo-patients were, in fact, sent.
- These findings provided convincing evidence against the accuracy and validity of psychiatric diagnoses.
- The current state of psychiatric diagnoses is still broadly at odds with recent neurological findings, leading to uncertainty regarding their accuracy. A number of interventions are proposed or underway to correct this. None counts with widespread support yet.

Rosenhan Study

Rosenhan Study

- In 1973 Rosenhan had pseudopatients present themselves to psychiatric hospitals with a single complaint
- Behaved normally once admitted into the hospital
- Normal everyday behavior was seen as abnormal

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DSM - III (1980)

The sift to a disease model

DSM – III (1980)

In 1974, the decision to create a new revision of the DSM was made, and Robert Spitzer was selected as chairman of the task force. The initial impetus was to make the DSM nomenclature consistent with that of the International Classification of Diseases (ICD).

The revision took on a far wider mandate under the influence and control of Spitzer and his chosen committee members.[40] One added goal was to improve the uniformity and validity of psychiatric diagnosis in the wake of a number of critiques, including the famous Rosenhan experiment.

There was also felt a need to standardize diagnostic practices within the United States and with other countries, after research showed that psychiatric diagnoses differed between Europe and the United States.[41] The establishment of consistent criteria was an attempt to facilitate the pharmaceutical regulatory process.

DSM – III

Much of the criteria were establish by consensus and in many cases, by psychiatrists merely taking votes. Not very scientific or objective.

RESEARCH DIAGNOSTIC CRITERIA (1979)

Many of the DSM-III criteria were adopted from the Research Diagnostic Criteria (RDC) and the Feighner Criteria, developed by a group of research oriented psychiatrists

Criteria were established by consensus

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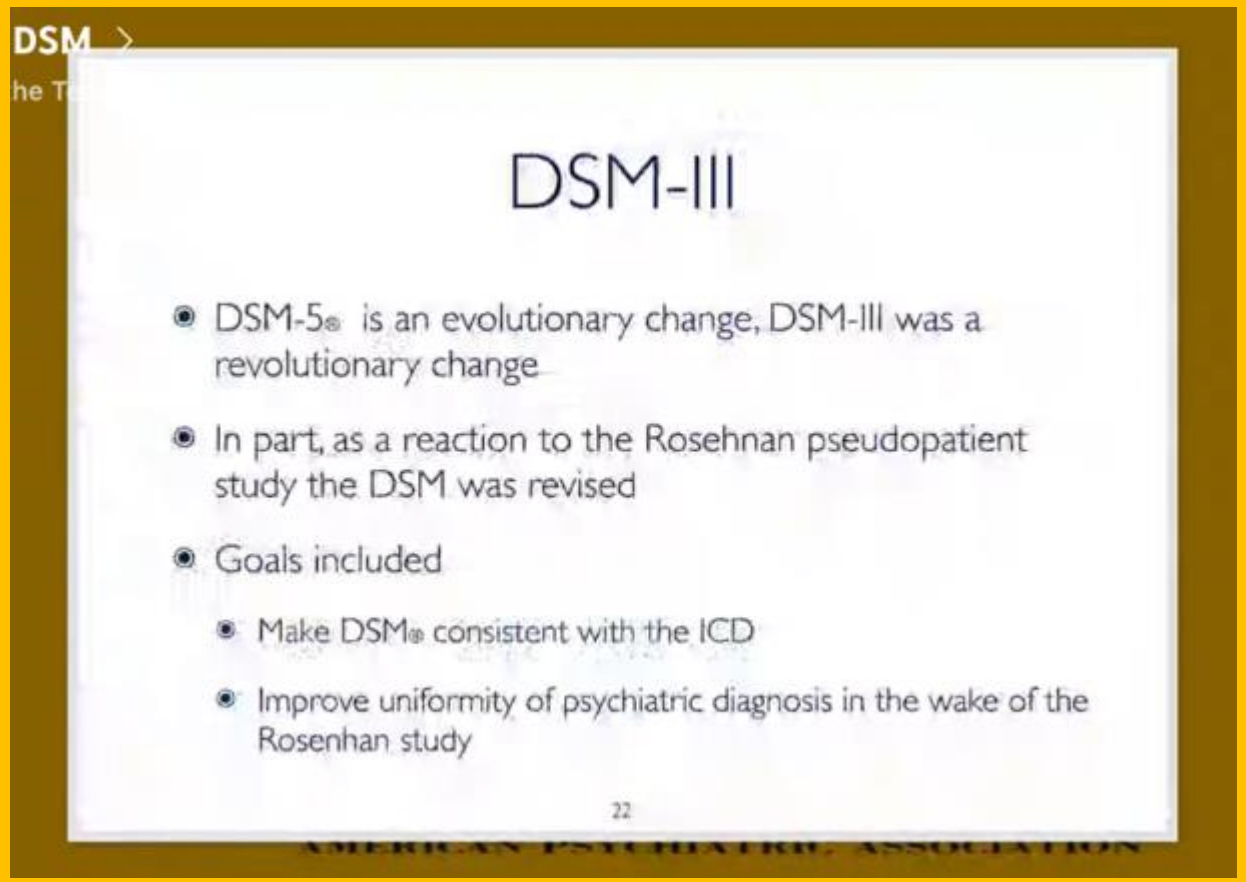
Research Diagnostic Criteria

DSM – III

Ostensibly with good intention but not with a good result in that it reified the disease model

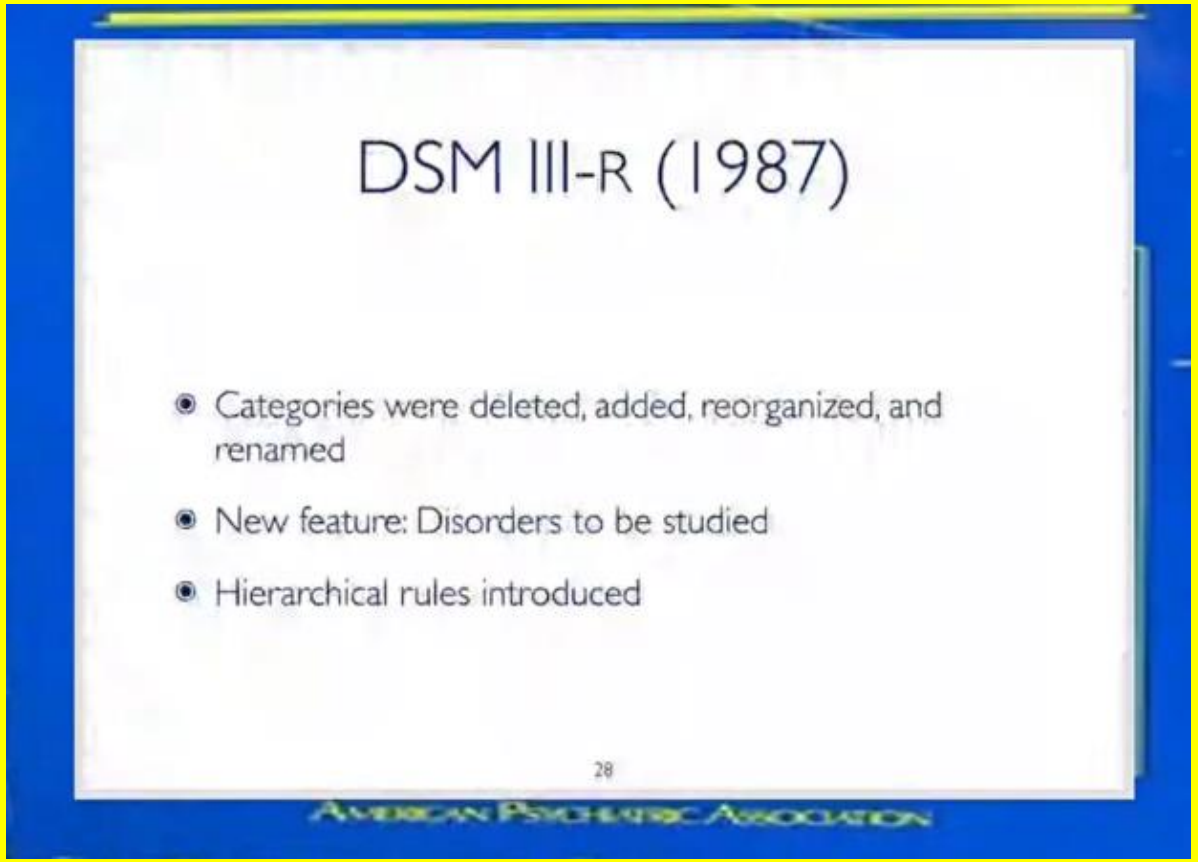


Features of the DSM - III

Professor James Davies from Oxford University in is superlative lecture offers an inside look on how the DSM – III was developed. Take a listen by clicking the link below and you will learn how utterly unscientific the process actually was.

https://www.youtube.com/watch?v=6JPgpasgueQ&ab_channel=CouncilforEvidence-basedPsychiatry

DSM III-R


DSM III-R (1987)
Categories were deleted, added, reorganized, and renamed
New feature: Disorders to be studied
Hierarchical rules introduced
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American Psychiatric Association

DSM III-R (1987)

- In 1987, DSM-III-R was published as a revision of the DSM-III, under the direction of Spitzer.
- Categories were renamed and reorganized, with significant changes in criteria. Six categories were deleted while others were added. Controversial diagnoses, such as pre-menstrual dysphoric disorder and masochistic personality disorder, were considered and discarded. "Ego-dystonic homosexuality" was also removed and was largely subsumed under "sexual disorder not otherwise specified", which could include "persistent and marked distress about one's sexual orientation."[32][43]
- Altogether, the DSM-III-R contained 292 diagnoses and was 567 pages long. Further efforts were made for the diagnoses to be purely descriptive, although the introductory text stated for at least some disorders, "particularly the Personality Disorders, the criteria require much more inference on the part of the observer" [p. xxiii].[27]

DSM – IV (1994)

In 1994, DSM-IV was published, listing 410 disorders in 886 pages. The task force was chaired by Allen Frances and was overseen by a steering committee of twenty-seven people, including four psychologists. The steering committee created thirteen work groups of five to sixteen members, each work group having about twenty advisers in addition.

The work groups conducted a three-step process: first, each group conducted an extensive literature review of their diagnoses; then, they requested data from researchers, conducting analyses to determine which criteria required change, with instructions to be conservative; finally, they conducted multi-center field trials relating diagnoses to clinical practice.[44][45]

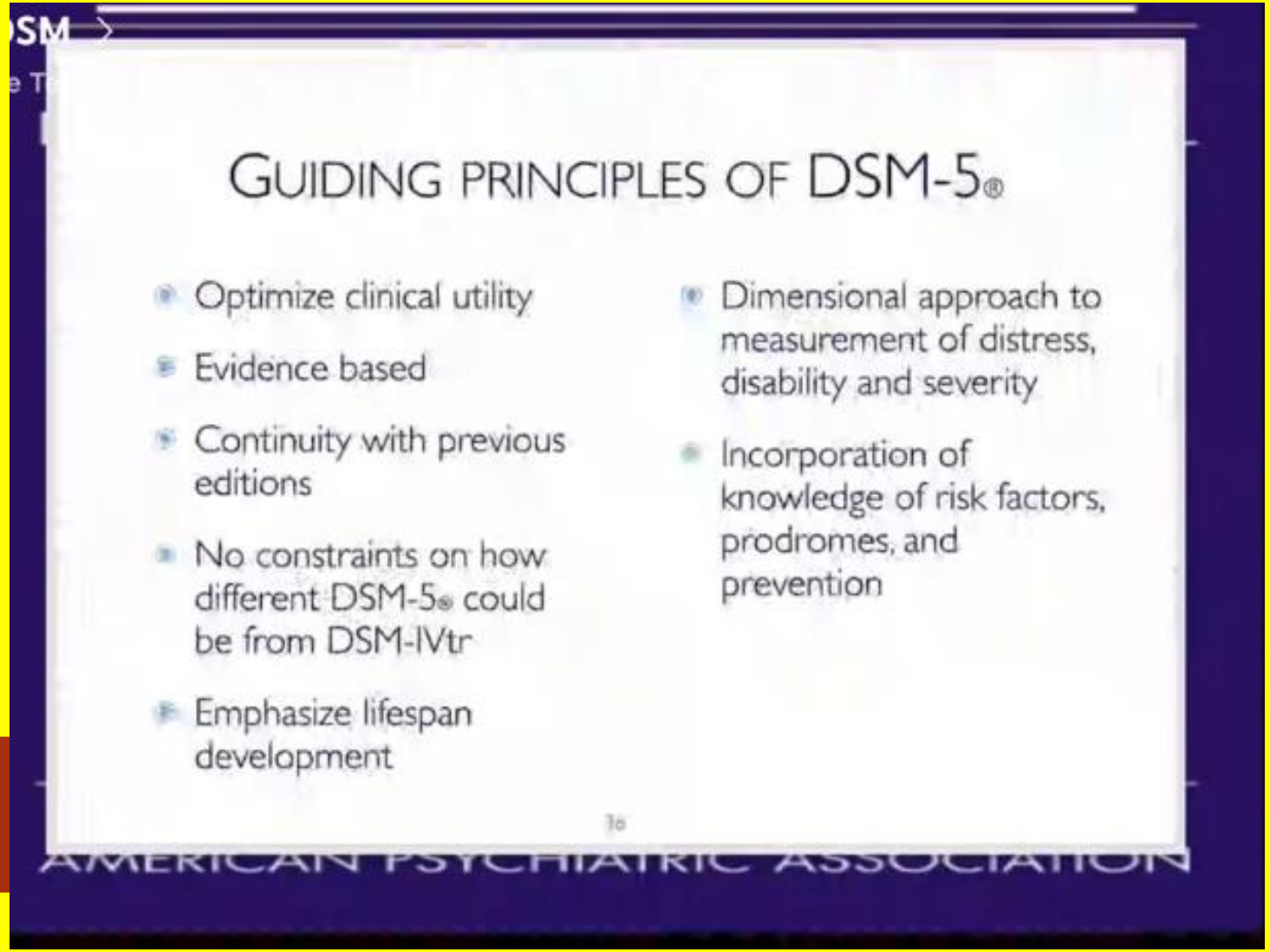
A major change from previous versions was the inclusion of a clinical-significance criterion to almost half of all the categories, which required symptoms causing "clinically significant distress or impairment in social, occupational, or other important areas of functioning". Some personality-disorder diagnoses were deleted or moved to the appendix.[27]

Flaws of the DSM-IV

DSM 5 (2013)

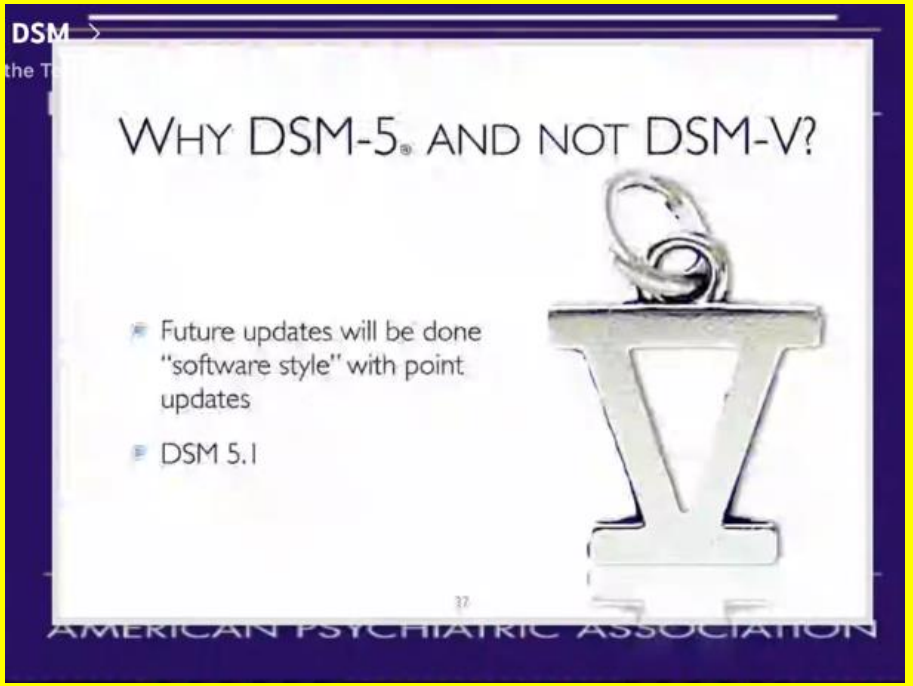
- The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the DSM-5, was approved by the Board of Trustees of the APA on December 1, 2012.[58]
- Published on May 18, 2013,[59] the DSM-5 contains extensively revised diagnoses and, in some cases, broadens diagnostic definitions while narrowing definitions in other cases.[60] The DSM-5 is the first major edition of the manual in 20 years.[61] DSM-5, and the abbreviations for all previous editions, are registered trademarks owned by the American Psychiatric Association.[3][62]
- A significant change in the fifth edition is the deletion of the subtypes of schizophrenia: paranoid, disorganized, catatonic, undifferentiated, and residual.[63] The deletion of the subsets of autistic spectrum disorder—namely, Asperger's syndrome, classic autism, Rett syndrome, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified—was also implemented, with specifiers regarding intensity: mild, moderate, and severe.

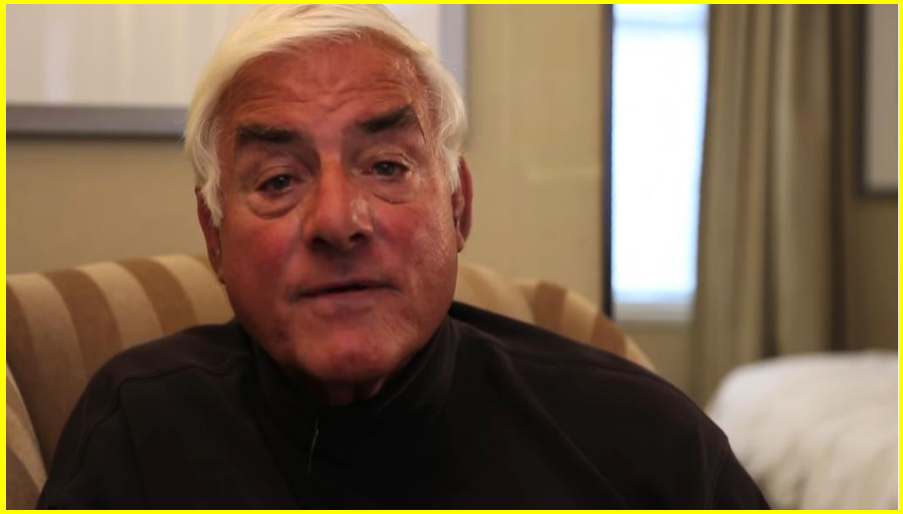
DSM 5 Principles



Click here to listen to Cinemartyr's video on the calling out the DSM V: https://www.youtube.com/watch?v=MW4GC5-WVW0&ab_channel=CINEMARTYR

Click here to listen to psychiatrict, Dr. Allen Francis' critique of the DSM V: https://youtu.be/-AMvrcBvYWk





Worried Well

"The Worried Well"

Those desperately needing psychiatric help are often neglected while the bulk of the treatment goes to the "worried well."

Allen Francis *Saving Normal*

DSM 5

Lack of validity

'The weakness (of DSM-5) is its lack of validity.

Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are **based on a consensus about clusters of clinical symptoms, not any objective laboratory measure**'." *NIMH*

http://www.psychiatrictimes.com/blogs/dsm-5/role-biological-tests-psychiatric-diagnosis#sthash.dnFJpHT0.dpuf

Psychiatrist Dr. Allen Francis – staunch critic of the DSM 5

3. Biological Testing

The clearest evidence supporting this disappointing fact is that not even 1 biological test is ready for inclusion in the criteria sets for *DSM-5*

See more at:
http://www.psychiatrictimes.com/articles/warning-sign-road-dsm-v-beware-its-unintended-consequences?verify=0A#sthash.dgCH2FBY.dpuf

Allen Frances is a professor emeritus at Duke University and was the chairman of the DSM-IV task force.

Frances, Allen (26 June 2009). "A Warning Sign on the Road to DSM-V: Beware of Its Unintended Consequences" (Full text). *Psychiatric Times*. Retrieved 2009-09-06.

Problems with the DSM

1. Secrecy

Robert Spitzer

DSM-5 task force members sign a nondisclosure agreement.

"Transparency is necessary if the document is to have credibility..."

Psychiatrists Propose Revisions to Diagnosis Manual, via PBS Newshour, Feb 10, 2010 (interviews Frances and Alan Schatzberg on some of the main changes proposed to the DSM-5)

Problems with the DSM

2. False Epidemics

Disruptive Mood Dysregulation Disorder *or* DMDD

Dr. Peter Kinderman
University of Liverpool

Complicated Grief Disorder *or* CGD

"large numbers of the diagnostic thresholds have been lowered" which means more people eligible for diagnosis, thus psychiatric drugs.

Problems with the DSM

2. False Epidemics

Kinderman said that DMDD

Disruptive Mood Dysregulation Disorder

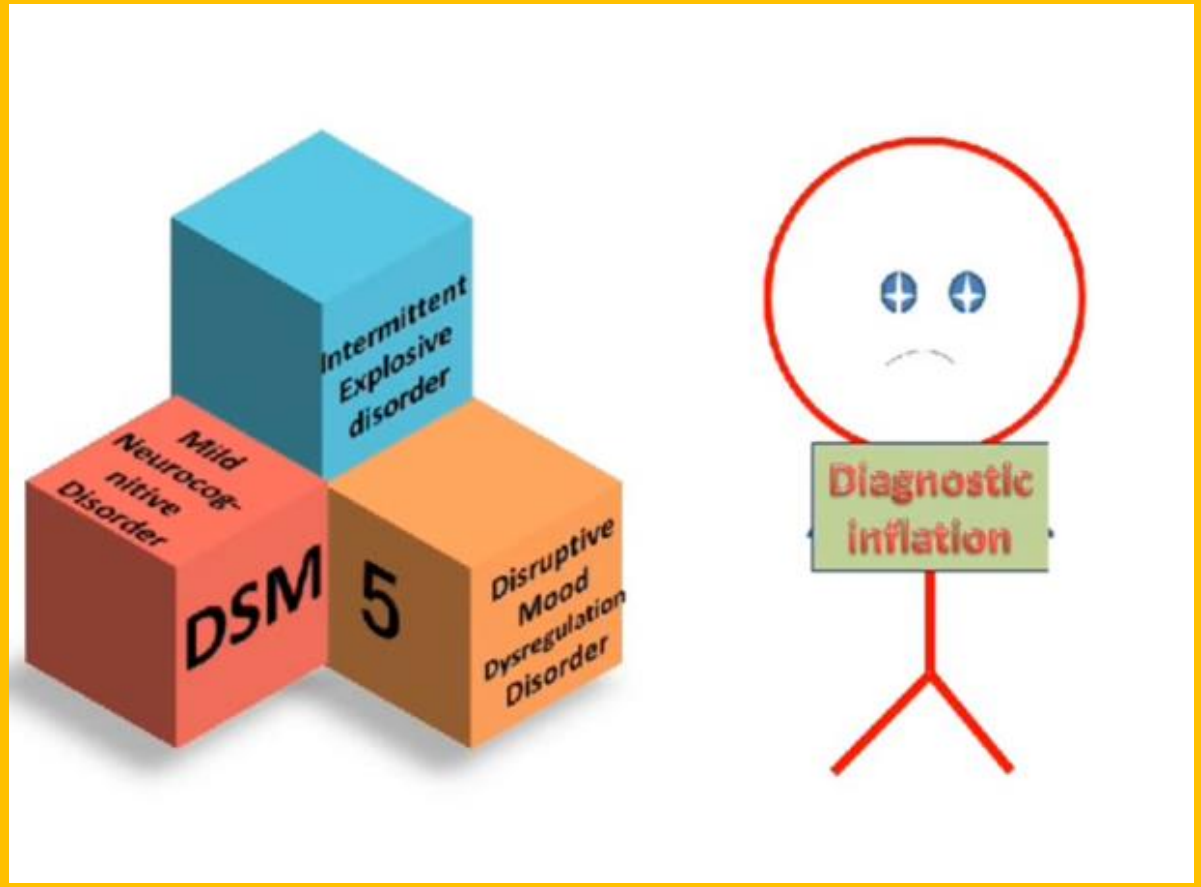
broadly translatable to having

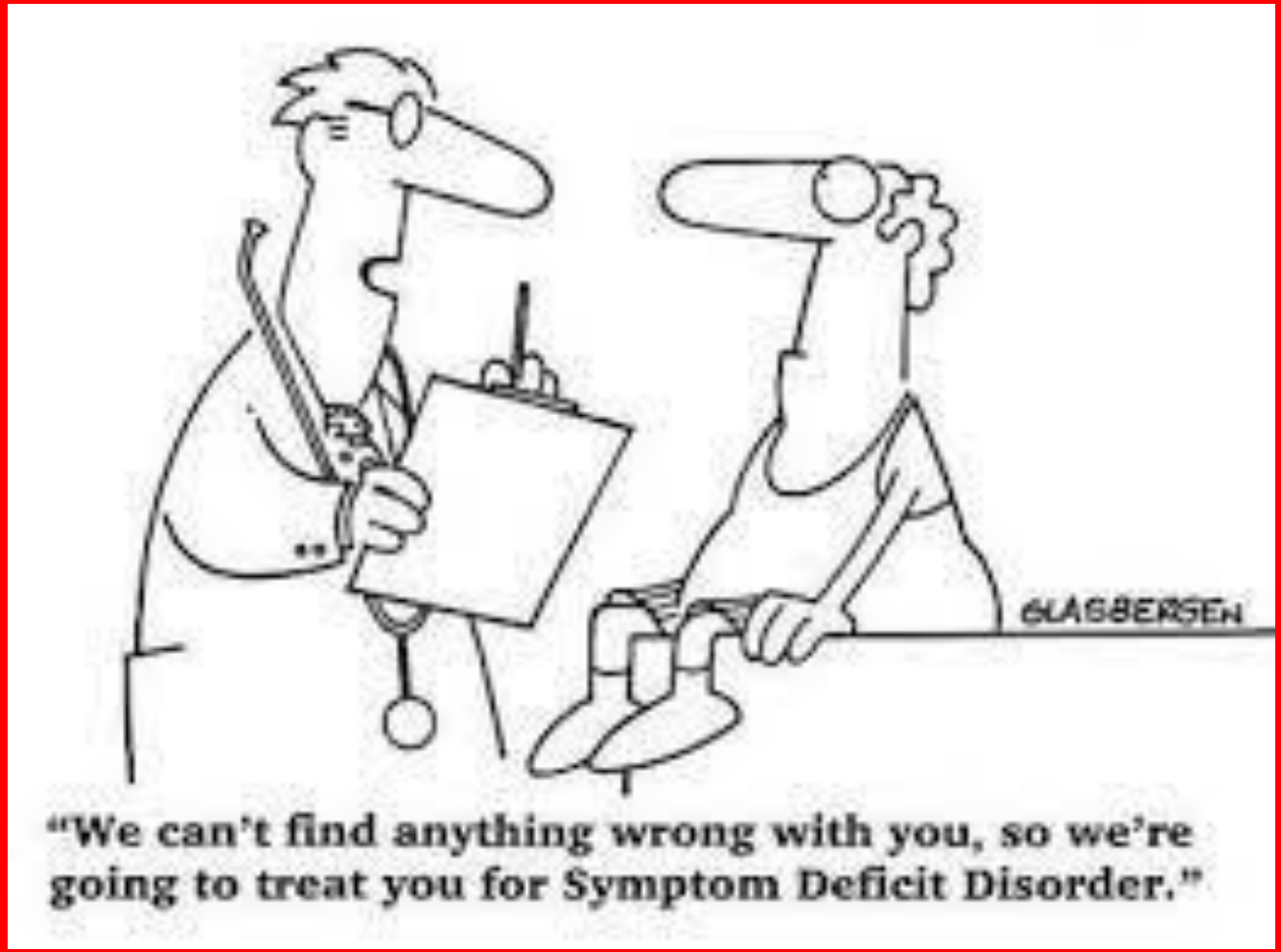
"Temper Tantrums"

http://www.psychologytoday.com/blog/side-effects/201202/dsm-5-controversy-is-now-firmly-transatlantic

Problems with the DSM 5

It makes it far too easy to make a diagnosis. Anyone of us could get diagnosed.





"We can't find anything wrong with you, so we're going to treat you for Symptom Deficit Disorder."

Problems with the DSM 5

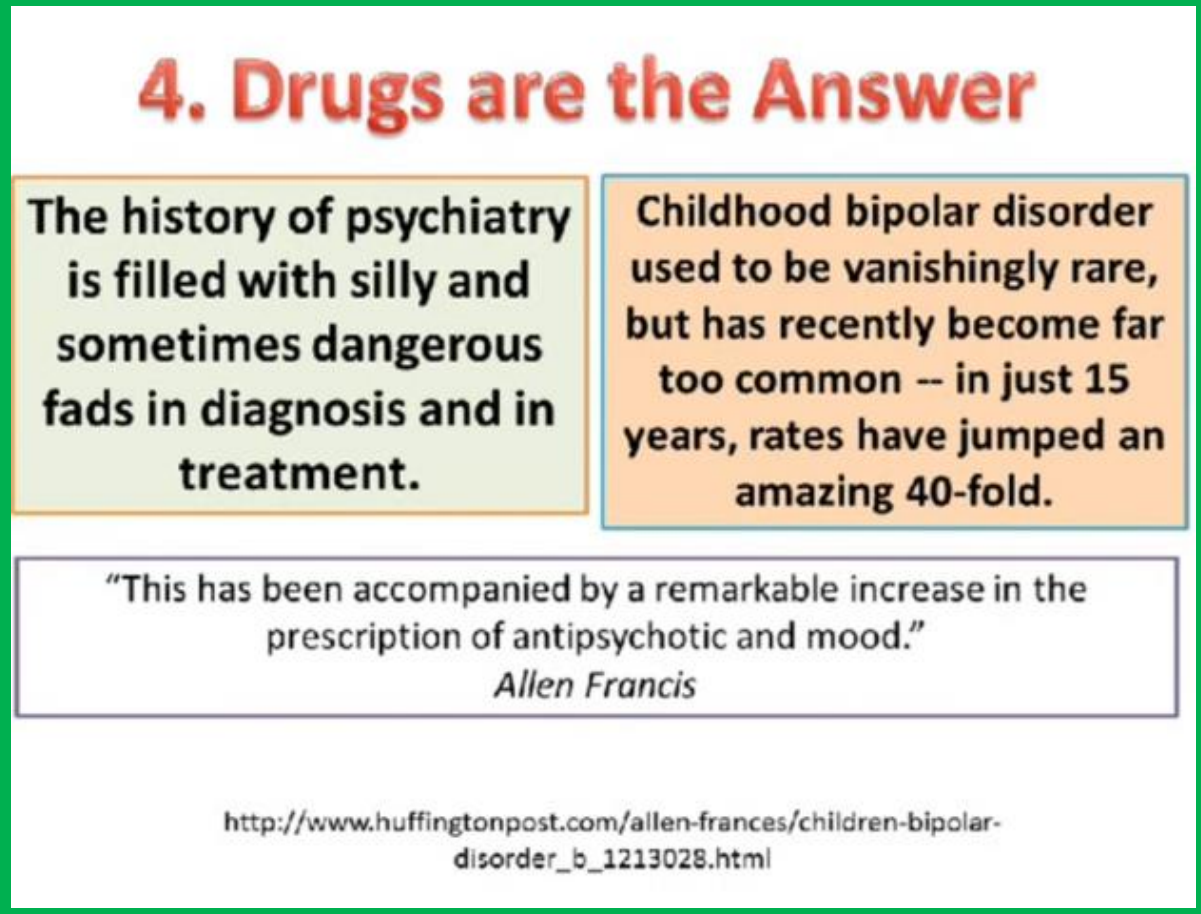
2. False Epidemics

About ***MND***, Kinderman also said ....

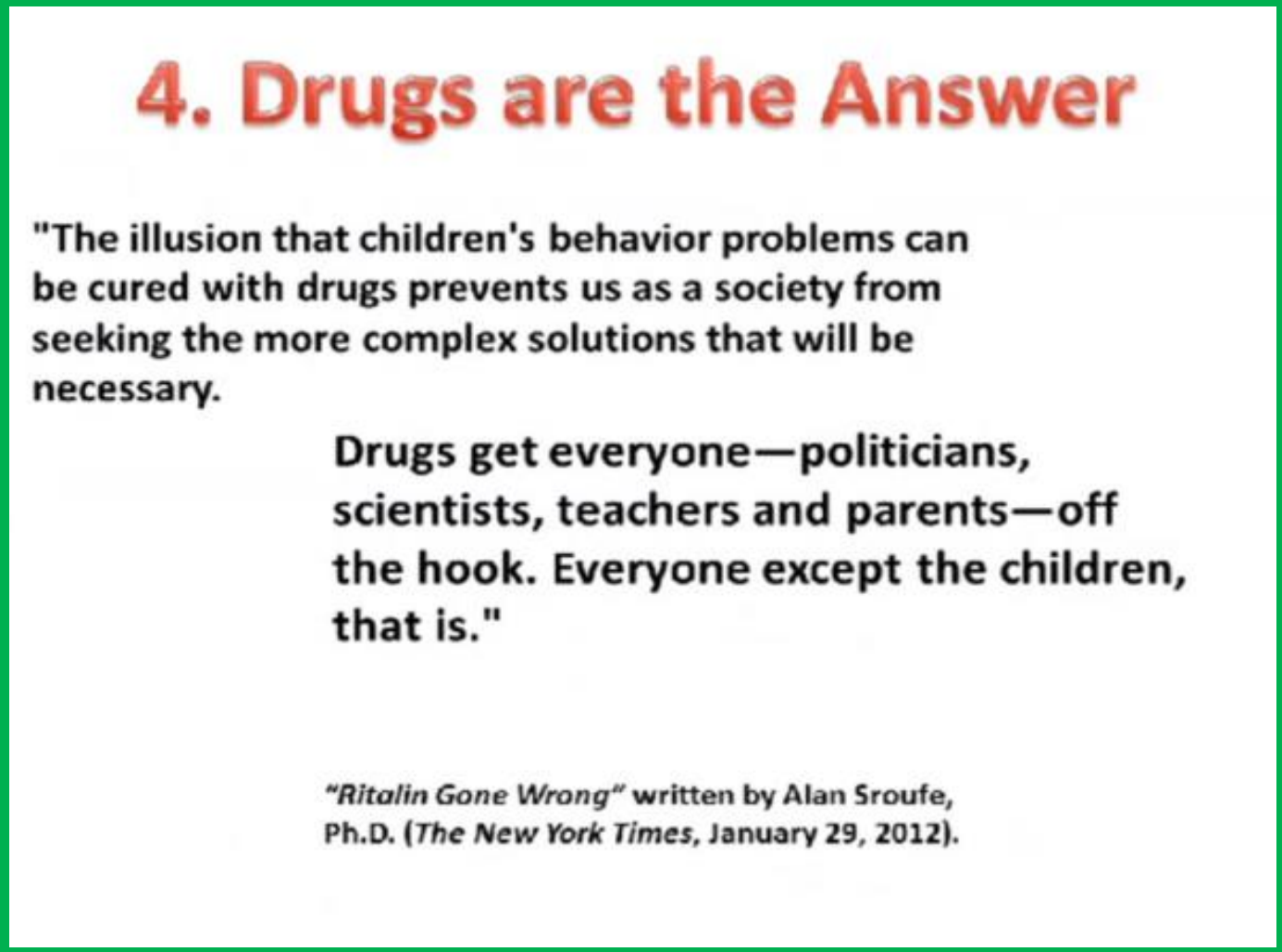
"Mild Neurocognitive Disorder"
was tantamount to targeting seniors
for "being a bit forgetful."

Problems with the DSM 5

It makes everything a disorder which helps to pace the way for drugs being the answer to everything.



DSM 5 makes everything a disorder which helps to pace the way for drugs being the answer to everything



Problems with the DSM 5

5. Imprecise Diagnosis

PTSD is diagnosed primarily on self-reporting of the individual.

DSM 5-R – coming soon to a theater near you!

A revision of DSM-5, titled DSM-5-TR, was published in March 2022, updating diagnostic criteria and ICD-10-CM codes.[67]

It features a new disorder, Prolonged Grief Disorder, as well as new codes available to clinicians of any discipline for flagging and monitoring suicidal behavior without the requirement of any other diagnosis.[67] It also features a fully updated Introduction and Use of the Manual to guide usage and provide context for important terminology.[67]

Changes to criterion and specifiers included changes for Autism Spectrum Disorder, Bipolar I Disorder, Bipolar II Disorder, Alternative DSM-5 Model for Personality Disorders, Depressive Episodes with Short-Duration Hypomania, and more.[68] Additionally, changes to text were made for Intellectual Developmental Disorder, Delusional Disorder, Disruptive Mood Dysregulation Disorder, Acute Stress Disorder, Somatic Symptom Disorder, and more.[68]