DSM-5 and the rise of the diagnostic checklist

Steve Pearce

The development and publication of *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) produced a peak in mainstream media interest in psychiatry, and a large and generally critical set of scientific commentaries. The coverage has focused mainly on the expansion of some categories, and loosening of some criteria, which together may lead to more people receiving diagnoses, and accompanying accusations of the medicalisation of normal living. Instructions given to members of DSM-5 work groups appear to have encouraged this.[1] This has not been the only source of disquiet. The influence of the pharmaceutical industry on the members of the appointees to DSM diagnostic work groups, which constructed the new rubrics, has caused concern,[2] as remuneration and insurance coverage in the USA depends partly on DSM diagnosis, and the pharmaceutical industry has been accused of encouraging the development of new diagnoses as a way to increase profitability.[3] Societal impact has been an explicit part of the development of DSM-5, as outlined in the article in this issue.[4] Reasons for decisions by DSM-5 workgroups have included enabling sufferers to receive treatment which would not be available without a DSM diagnosis (a local US concern), or encouraging people to seek help. These have been instrumental in the creation of new diagnoses, and in some cases such reasons have been held to substitute for scientific evidence.[4]

The membership of the various groups involved in constructing DSM-5 was appointed overwhelmingly from among US clinicians; unlike International Classification of Diseases (ICD), DSM is aimed at the US market, although it is used much more widely. In some cases, experts walked out, leading for example to the loss of all non-US members of the Personality and Personality Disorders Work Group.[5] Members of the groups were asked to sign confidentiality agreements in an apparent attempt to safeguard revenue, damaging transparency in the process.[6] Peer review does not operate in the accepted way, and opinion is at times presented as fact in the accompanying guidance.[7] Sales of the manual provide substantial income for the American Psychiatric Association.[5]

Given these concerns, and its cultural specificity to the USA,[8] why has DSM achieved such popularity among clinicians elsewhere?

THE USE OF DIAGNOSTIC LISTS

The prominence of diagnostic manuals in psychiatry is unique among medical specialities, and stems from the virtually complete absence of useful diagnostic tests. Investment in brain scanning and genetic research has not to date led to any useful developments in this area.[9] The consequent reliance on patient's' reports of their subjective experience, which may be unreliable[10] and are culturally conditioned, encourages clinicians to look for diagnostic certainty elsewhere. This has led to the increasing use of rating scales and diagnostic lists. The success of DSM-III is attributable to previous problems achieving diagnostic agreement, leading to widely differing rates of diagnosis of mental illness between the UK and the USA.[11]

The use of rating scales lends the appearance of objectivity to a record of the patient's experience, but comes with the risk of abstraction from the patient experience in terms of narrative and context. Rating scales are developed to maximise change under treatment,[12] rather than to give a comprehensive view of the clinical situation, but can over time come to be regarded as the latter. Only information that can be quantified is seen as reliable, and ratings from such scales often come to be valued more highly than expert opinion.

The proliferation of diagnostic lists, such as the DSM-5, adds to the difficulties introduced by reliance on rating scales. Consensus-based lists afford clinicians a sense of certainty, which may account for the popularity of DSM over the internationalist ICD, which gives descriptions and guidelines rather than numbered lists with cut-offs. DSM style diagnostic lists may appear to enable clinicians without specific training in diagnosis, or with less exacting training, to make reliable diagnoses. Such a development may help contain costs, and can appeal to ideas of empowerment of non-medical professionals. Detailed knowledge of diagnostic process and phenomenology becomes less important, and training in these subjects can suffer as a result.[13] Their use is closely related to the recent introduction of care cluster allocation, a checklist-based method of allocating mental healthcare resources loosely linked to psychiatric diagnosis.[14] However, consensus-based diagnostic lists have drawbacks. They have a tendency to give the illusion of certainty and confidence in diagnostic decisions, which are not supported by research[1] and fail to reliably differentiate mental disorders from mental and behavioural states such as homosexuality which are not taken to signify disorder.[15] They produce broad categories which make it difficult to identify subgroups responding to particular interventions.[12] They encourage an approach to nosology embodied in the use of claims of societal impact in DSM-5 referred to above,[4] and are vulnerable to links to pharmaceutical companies. As long as there is consensus among the members, anything the committees feel might usefully be included, for any of a range of reasons, can be included. The absence of objective diagnostic tests leaves the work groups with a free hand to recognise new disorders, or expand existing disorders based on idiosyncratic criteria. Together with the substitution of rating scales for clinical experience and expertise, the uncritical use of diagnostic checklists puts clinicians and researchers at risk of an overconfident and decontextualised approach to diagnosis.

This debate is not restricted to psychiatry. In other medical specialities, the redefinition of asymptomatic markers of risk as disease has provoked a similar debate in conditions such as high blood pressure, breast cancer and high blood sugar.[16] However, in psychiatry the problems are accentuated by the lack of objective measures of disease and the impact of cultural variations in the expression of distress. Busy clinicians for whom diagnostic certainty is valuable may be drawn to a manual which appears to provide it.

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