The DSM-5 and the mental health clinician as consultant

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How and why do we account for mental distress and illness?

Today, the Diagnostic and Statistical Manual of Mental Disorders, commonly called the DSM, is the predominant way to account for mental distress and illness. Indeed, the DSM has been so widely adopted that it is often characterized as the psychiatric bible.

Like a bible, the community that makes the most use of it also assembles it. The American Psychiatric Association (APA) is the only physician group that produces the definitive diagnostic manual for their specialty. Now, after a decade of meetings, task forces, literature reviews, and field trials, the APA will release DSM-5 at the organization's annual meeting in May 2013.

Like a bible, the DSM-5 is a collection of different texts, more like a library than a single book, organized around a similar theme. In DSM-5, the categories have been reorganized and the diagnostic criteria revisited. The authors integrated diagnoses usually made in childhood or adolescence alongside similar diagnoses usually made in adulthood. Reactive Attachment Disorder is in now the same diagnostic category as Posttraumatic Stress Disorder. Both within and across diagnostic groups, the DSM-5 is organized on a developmental model. Within the Anxiety Disorders chapter, they discuss Separation Anxiety Disorder and Selective Mutism before Generalized Anxiety Disorder. The authors organized diagnostic categories to reflect either similar symptoms, as in the Sexual Dysfunctions, or related underlying pathology, as in the Schizophrenia Spectrum Disorders.

While the authors of the DSM-5 are still finalizing the diagnostic criteria, we assured of several important changes. First, we will see several new diagnoses. Disruptive Mood Regulation Disorder will be introduced to address concerns about the overdiagnosis of pediatric bipolar disorder. Premenstrual Dysphoric Disorder will return to this edition of the DSM. Hoarding and Binge Disorders will both be included. Second, we will see important changes to several major diagnoses. The subtypes of Schizophrenia will be removed. Dementia will be reconceptualized as Major or Mild Neurocognitive Disorder. Substance Use Disorders will replace substance abuse and dependence disorders. Third, we will see the introduction of dimensions. Dimensions are common signs and symptoms of mental illness that cut across our current diagnoses, allowing us to, for example, identify and follow the sleep problems experienced by a person with Schizophrenia.

Like a bible, the DSM also implies a vision of its readers, why they read these texts, and the social circumstances in which they are read.

In the pre-history of the DSM, psychiatric diagnostic manuals were primarily used for record-keeping. The United States Census wanted to count the number of people in psychiatric asylums, so they worked with the APA to create the ***Statistical Manual for the Use of Institutions for the Insane***. This manual chiefly accounted for varieties of psychosis. The manual implied that psychiatrists supervised people living in institutions and helped the government count them. Although this diagnostic manual went through ten editions, it proved inadequate outside of the asylum.

After World War II, members of the APA produced DSM-I to coordinate their diagnostic manual with the World Health Organization's International Classification of Diseases (ICD) and to better account for the patients they were seeing outside of asylums. The DSM-I and its immediate successor, DSM-II, relied on psychoanalytic accounts of mental distress and illness. These initial drafts of the DSM were designed for outpatient practice and envisioned the clinician as an analyst.

In contrast, the authors of DSM-III implicitly envisioned the psychiatrist as an academic researcher. DSM-III was born out of concerns that DSM-I and DSM-II diagnoses were unreliable for clinical practice, but especially for research. In contrast, the DSM-III set aside questions of etiology, of why people develop mental disorders, in favor of clear descriptions of the symptoms of mental disorders. The authors often organized symptoms into

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checklists that proved ideal for academic psychiatrists conducting epidemiologic studies and clinical trials.

While the authors of the DSM-IV largely refined the DSM-III model, they also embraced the then-novel idea of evidence-based medicine. The authors conducted literature reviews and multicenter field trials. In doing so, they involved so many people that the acknowledgements section of the DSM-IV runs for more than twenty pages. Psychiatric diagnoses were now the products of large committees. Implicitly, they imagined the psychiatrist as a physician whose clinical practice was guided by evidence-based medicine.

While the precise contents of the DSM-5 may shift during its final months of production, it appears that the DSM-5 imagines the psychiatrist as a consultant. At time when mental health providers are both rare and being tasked with more assessments, the DSM-5 is implicitly designed to funnel people from primary care providers to a mental health clinician who will provide time-limited services focused on accurate diagnose and the establishment of a treatment plan. For example, the DSM has a series of screening tools designed to be either self-administered or administered by a primary care provider. The authors also wrote several chapters for the use of non-mental health clinicians. Instead of a diagnostic manual for the involved relationship implicit in a psychoanalytic practice, the DSM-5 was written for use in consultation.

If psychiatrists and other mental health clinicians are working primarily as consultants, then we are tasked with a corresponding responsibility. We need to redouble our efforts to ask the right questions. We need to learn how to ask questions that establish accurate and reliable diagnoses. We also need to figure out how to do so while forming therapeutic alliances, which remain the cornerstone of all mental health treatments.

SUGGESTED READING

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