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DSM 5 – Is It Irrelevant in day to day Clinical Practice

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ABSTRACT *DSM-5 the fifth edition of the classification of psychiatric disorders by the American Psychiatric Association was launched admist great pomp serving a panacea for psychiatrists to enable them label patients with psychiatric illnesses. Though elaborate the classification does not fit well with day to day routine clinical practice. The following commentary is a means of illustrating some pitfalls of the new classification.*

KEYWORDS : DSM-5, Psychiatry

INTRODUCTION

The fifth edition of the diagnostic and statistical manual of mental disorders (DSM-5) has been released with great vigour and enthusiasm in 2013. This manual which is supposed to be followed by psychiatrists worldwide as a guidebook for the classification of psychiatric disorders in fact is marred by controversy and criticism. There have been additions of various conditions and terms that would often pass off as normal that have been now labelled as psychiatric conditions. In fact critics believe it is easy now to diagnose anyone with some mental illness or the other as a result of this book. DSM-5 was meant to be a patient and clinician friendly manual to help in the diagnosis of psychiatric disorders but has in fact made psychiatric classification further cumbersome and difficult. Omissions and additions in DSM-5 that should not have been there have added new dilemmas to clinical practice. The one major change I can quote with sarcasm is the inclusion of Arabic numerals instead of roman numerals to label the 5th edition of this big yet clinically redundant book. The present article looks at some of the clinical fallacies of this classification from both a general and an individual disorder perspective.

PROBLEMS CAUSED BY DSM-5 IN CLINICAL PRACTICE

- Surveys done on psychiatrists and mental health professionals perspectives on DSM-5 revealed that 80-90% doctors in routine clinical practice rarely used a diagnostic classification system to label patients. In fact they rely on intuition and clinical skills as well as a clinical diagnosis aimed at treatment delivery and cure rather than classification and labelling of the psychiatric condition.
- DSM-5 is rarely used in day to day clinical practice and the reasons cited include it being unpractical and cumbersome with complicated terms that confuse patients and clinicians alike.
- In routine clinical practice, we all prefer a clinical evaluation and a holistic approach to diagnosis rather than one that is criteria based. We prefer a description and analysis of symptoms by the patient rather than rigid criteria based description as mentioned by classification systems. We prefer broad clinical classifications rather than a rigid boxing of patients into categories with fuzzy boundaries and rigid walls.
- Criteria based diagnosis involves rote and semantic memory where one has to be remember points and number of criteria where patients are then fitted into a diagnosis like filling of a form. Psychiatric clinical examination and diagnosis must in fact be clinical and descriptive approach which involves the narrative and thereby uses episodic memory rather than just a semantic approach.
- The ICD-10 classification of psychiatric disorders is descriptive and elaborate unlike the rigid criteria bound diagnosis method of DSM-5. DSM-5 is rather American based though global in approach whereas ICD is a universal based classification system.
- The interpretation of diagnostic criteria is always subjective though the criteria for diagnosis is objective. Patients can always be questioned, cross questioned and manipulated into answering yes or no and then diagnosed as having or not having a psychiatric disorder. This may be done during the clinical interview while diagnosing a patient for job fitness or leave as well as when recruiting patients for clinical trials where they must adhere or fit into various diagnostic criteria. Many children have often been diagnosed as autism in order to avail of health insurance and facilities while they may not meet a clinical diagnosis of autism but fit into DSM criteria by manipulative interviewing. The interpretation of diagnostic criteria is highly clinical and must be based on the clinical judgement of the clinician rather than criteria points but DSM turns clinicians into people who tick criteria and make diagnosis while we need clinicians who listen to the patient's entire story and then make diagnoses.
- Psychiatric diagnosis is often symptomatic and based on clinician experience. The DSM criteria does not mention any investigation or rating scale measure to confirm criteria but purely relies on the subjective experience of the clinician's interpretation. For example a group of sleep disorders is purely diagnosed by clinical criteria without a reliance on sleep based investigations.
- The clinical picture of various psychiatric patients presenting with the same disorder varies and psychiatry is a highly volatile showing marked heterogeneity in clinical presentations. Very often clinical criteria in DSM-5 have rigid durations of symptomatology and number of symptoms that must be met for diagnosis of a disorder that is often not possible as all patients may not present in that manner. Thus many patients may not be diagnosed as having a psychiatric disorder due to lack of meeting criteria which are rigid and inflexible.

DSM-5 AS A POOR TOOL FOR PSYCHOEDUCATION

- DSM-5 is further marred by complicated terms for diagnosis of various psychiatric disorders and symptoms that are highly clinical and may not be comprehended by patients. For example a simple term like premenstrual syndrome has been labelled premenstrual dysphoric disorder which is complicating for the patient. Even symptomatology has been described in complex medical terms which psychiatrists may follow whereas patients may often use varying terms to refer to symptoms keeping in mind their diverse backgrounds and multilingual colloquial usages.
- One often has to be using the simplest terms in psychoeducation keeping in mind the varying literacy levels of patient's relatives where a bipolar disorder may be described as happy sad syndrome or kabhi khushi kabhi gham in Hindi. The symptom description of individual patients may also vary and their personal interpretation of names for symptoms must be understood when considering psychiatric assessment and evaluation unlike rigid complex clinical criteria.

DSM-5 AS A POOR TOOL IN TEACHING UNDERGRADUATE AND POST GRADUATE STUDENTS

- Case descriptions and vignettes are a must when teaching various psychiatric disorders from a clinical perspective as an interactive framework with the visual image of the patient stays in mind when diagnosing future similar patients.
- DSM-5 involves complex symptoms and criteria that need to be

mugged up by students rather than a conceptual and dimensional diagnostic formulation for various psychiatric disorders. Genetic, environmental and social as well as personal factors need interpretation in psychiatric diagnosis which is often left unattended by DSM criteria.

DSM-5 AS A POOR CRITERIA FOR RESEARCH

- Majority of patients are diagnosed clinically. In fact if we use the rigid criteria of DSM it will be very difficult to get patients that fit into the set criteria and recruitment for clinical studies and clinical trials will suffer. In many research studies though patients are chosen clinically it is often just mentioned as a formality that DSM diagnostic criteria were followed.
- Certain disorders have such rigid and difficult criteria that they often have to be modified In order to hasten and enable recruitment for clinical studies or drug trials. This is more so in cases of rare conditions like rapid cycling bipolar disorder.

DSM-5 AND INIDVIDUAL PSYCHIATRIC CONDITIONS

- The removal of I.Q. cut offs as a must for intellectual impairment formerly known as mental retardation makes I.Q. assessment redundant and makes a diagnosis of intellectual disability highly subjective.
- The inclusion of various sub headings under specific learning disorder shall make certification and diagnostic description very difficult.
- Expanded criteria for schizophrenia and autistic spectrum disorder shall increase the number of patients diagnosed with these disorders.
- The inclusion of premenstrual dysphoric disorder as a psychiatric disorder shall enable most women to be diagnosed with a psychiatric disorder.
- Various terminology being introduced will make diagnostic classification non uniform and difficult for medical fraternity to follow.
- Sleep disorders diagnosed without any sleep laboratory procedures.
- Criteria for dementias complicated with no major mention of neuroradiological evidences.
- DSM-5 not validated across multiple studies in comparison to DSM-IVTR.