For decades, clinicians have recognized that their practices greatly benefit from scientifically based diagnostic criteria, iteratively improved through ongoing research. Consequently, in planning DSM-5, the APA’s Task Force and Board of Trustees demanded strong scientific justification for proposed new diagnoses or alterations in diagnostic criteria from DSM-IV-TR to DSM-5. The Scientific Review Committee that appraised proposals in light of available evidence (1) strongly influenced APA’s decisions regarding changes in DSM.

Since scientifically driven diagnostic advances affect clinical practice, the Board of Trustees created a Clinical and Public Health Committee (CPHC) to review and assess how proposed changes might influence and be received by the broader psychiatric community. Moreover, since in certain situations good clinical and public health reasons beyond scientific imperatives also exist to alter or retain diagnostic criteria, the CPHC was asked to consider proposals reflecting these issues as well.

For each proposal, the CPHC received detailed documentation from the DSM-5 Work Group offering evidence and rationales supporting their proposals, the Scientific Review Committee’s reviews, and, on occasion, resubmissions and rereviews from Work Groups and the Scientific Review Committee when initial submissions were reworked.

To review each proposal, the CPHC recruited three to eight external expert reviewers who were independent of the Work Group’s proposals and who were free of industry ties. CPHC reviewers were asked to consider the extent to which new proposals might improve (or harm) diagnostic processes and affect overdiagnosis, underdiagnosis, or inappropriate diagnosis for each condition. Reviewers were also asked if proposals made better logical sense than their predecessors and if the new proposals were more culturally sensitive than DSM-IV criteria. These external reviews were then deliberated by the eight-person CPHC who then formulated recommendations.

In most instances, the CPHC’s recommendations agreed well with the Scientific Review Committee’s. For many conditions we recognized the considerable difficulties challenging the Work Groups’ always well-intentioned attempts to improve criteria, particularly for diagnoses based fundamentally on patients’ often spotty recollections and clinicians’ sometimes value-biased observations (2).

Research findings pushed the boundaries of clinical care in several instances. To illustrate, the proposal for mild neurocognitive disorder as a new diagnostic entity was, from our perspective, supported by significant clinical, epidemiological, and radiological evidence and was shown to be a valid clinical entity with therapeutic and prognostic implications. Its advent may encourage clinicians to more carefully diagnose these conditions and intervene at earlier stages. In deliberating the proposal to remove the bereavement exclusion from the diagnosis of major depressive episode, a subject of considerable contention in the professional community and media, the CPHC was persuaded by the quality of scientific evidence and by good clinical arguments. In this latter instance, clarifying text was added to assist clinicians in navigating the subtle but important distinctions to be considered.
However, other proposals generated less support. Even after considerable deliberation and reworking, both scientific and clinical utility concerns led to placing the innovative but complex personality disorder proposals into Section 3 for further study.

While sharing the Scientific Review Committee’s premise for requiring strong supporting evidence, the CPHC also considered several other issues. We reviewed proposals where little quantitative evidence existed for unusual conditions, where good clinical sense augmented moderately weak evidence, where various professional and public constituencies interpreted available evidence differently, where controversial proposals merited careful review for potentially adverse unintended consequences, and where logical inconsistencies in DSM-IV-TR required fixing. At each level of review, opinions about various proposals were mixed, leading to extensive and fruitful discussions.

The committee pondered imprecise boundaries separating normal behavioral variation and budding psychopathology. At what points do typical surges of adolescent libido become hypersexual disorder? When does excessive caffeine consumption morph into caffeine use disorder? At what point do these conditions impair? Ultimately, hypersexual disorder was not included in DSM-5 and caffeine use disorder was assigned to Section 3 for further study.

The CPHC also understood that although many diagnoses are imprecise constructions, as noted by Hyman (3), diagnostic labels tend to become reified. Clinicians risk self-deception via the “Rumpelstiltskin phenomenon,” the illusion that naming something offers understanding and control.

We considered that diagnoses are occasionally put to unintended purposes. Some individuals use their diagnostic labels to find personal meaning and distinctiveness, a version of “identity politics.” And some patients, families, and advocates preferentially claim and adhere to certain diagnoses (eschewing others that may be more accurate) to secure and maintain social and economic benefits.

Importantly, we understood that while psychiatric nosology rightfully strives for increasingly rigorous scientific validity, for practitioners diagnoses continue to primarily serve utilitarian functions. As described by Panzetta (4), diagnoses should permit individuals to communicate about valid pathological conditions reliably; offer meaningful guidance on etiology, prognosis, intervention, epidemiology and public policy; and facilitate functions such as billing and reimbursement.

The CPHC’s recommendations were submitted to the APA President and then to yet another deliberating body, the Summit Group. At the Summit Group, the views of the proposing Work Groups, Scientific Review Committee, CPHC, a forensic psychiatry review group, the chair of a committee of reviewers from the APA Assembly, several other consultants, and the Board of Trustee’s Executive Committee were carefully considered before recommendations were sent to the Board of Trustees. The Board of Trustees deliberated further before finally voting on whether to accept or reject proposed changes. With this rigorous process, each proposal was thoroughly reviewed at multiple layers of oversight. Consequently, in our view, the diagnoses and criteria sets included in DSM-5 represent the profession’s best efforts to integrate scientific reliability and validity with clinical and public health utility.

The diagnoses and criteria sets included in DSM-5 represent the profession’s best efforts to integrate scientific reliability and validity with clinical and public health utility.
From the CPHC’s perspective many diagnoses require considerable additional clarification. High on this list are the personality disorders, variations and nuances of mood disorders, links between psychological trauma and the traumatized brain, schizophrenia, and other psychoses.

The shortcomings of our largely descriptive nosology have stimulated the Research Domain Criteria Project initiative at NIMH (5). Findings from these efforts will be essential to advance the quality of our diagnostic models. We trust that interested experts will further illuminate these conditions and continue contributing to the evolutionary discussions necessary for future improvements in DSM.

References
4. Panzetta AF: Toward a scientific psychiatric nosology: conceptual and pragmatic issues. Arch Gen Psychiatry 1974; 30:154–161

JOEL YAGER, M.D.
JOHN S. MCINTYRE, M.D.

From the Department of Psychiatry, University of Colorado School of Medicine, Aurora, Colo., and the Department of Psychiatry, University of Rochester, Rochester, N.Y. Commentary accepted for publication in April 2013 (doi: 10.1176/appi.ajp.2013.13030347).

The authors report no financial relationships with commercial interests.