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Short communication

Avoiding the pitfalls of the DSM-5: A primer for health professionals

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1. Background

The Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) [1], is the leading system guiding the diagnosis of mental disorders. Accurate diagnoses of mental disorders are fundamental to guiding treatment and supportive care and have potential impacts on resources available to individuals [2]. However, the DSM has the allure of 'tick box' diagnosis rather than biopsychosocial formulation and treatment planning, as well as multiple limitations impacting validity [2,3]. Further, even with accurate diagnosis, there are strong concerns related to the reliability and validity of DSM diagnoses for clinical practice and research efforts [2,3,4]. Understanding these limitations can help reduce errors and sub-optimal clinical decisions, treatment and supportive care service provision. The purpose of this primer is to assist health professionals in avoiding pitfalls by presenting five key considerations applicable to the DSM: (1) Binary Categories, (2) Comorbidity, (3) Within-Disorder Symptom Heterogeneity, (4) Physical Symptoms, (5) Distress and Impairment Criteria. Fig. 1 provides a graphical summary of the five considerations.

1.1. Consideration 1: binary categories

DSM is a binary system where an individual either meets or does not meet diagnostic criteria for a disorder [5]. Diagnosis, or non-diagnosis, can impact referral, treatment streams, treatment techniques, and supportive care resources [2,6]. However, empirical research shows that mental health is dimensional with symptoms presenting on a continuum of severity, rather than in categorical disorders [4,5,7,8]. Modern statistical analysis of symptom level data does not support the disorder categories presented within the DSM [4,9,10]. An individual who does not meet criteria for a DSM disorder may still experience significant mental ill-health and require treatment and supportive care [2,11]. A health professional using the DSM must consider the impact of diagnosis and non-diagnosis in their clinical management of individuals.

1.2. Consideration 2: comorbidity

Individuals who meet DSM criteria for one disorder will, as likely as not, meet diagnostic criteria for multiple disorders [11]. Estimates suggest over half of people who meet diagnostic criteria for one DSM

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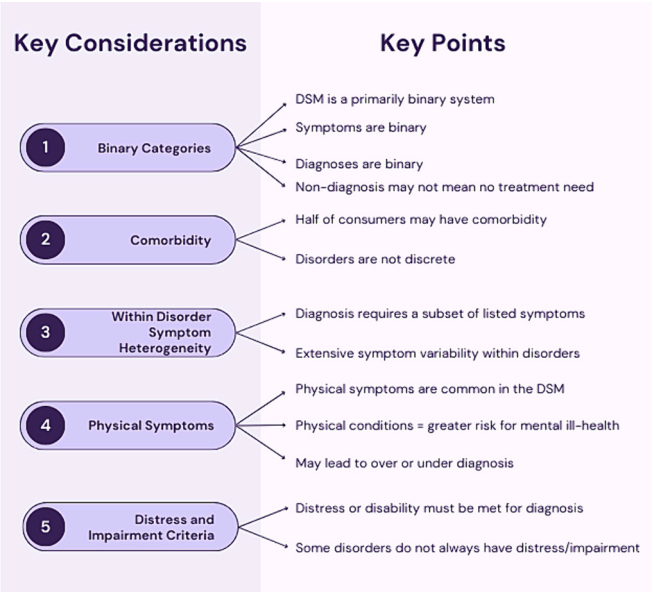

Fig. 1. Five Key Considerations Applicable to the DSM.

disorder will meet diagnostic criteria for two disorders, and a 50% subset of those will meet criteria for a third [2,12]. This is not surprising as a large number of symptoms listed within the DSM cross multiple disorders [9]. For example, 36.8% of symptoms listed within adult psychopathology in section II of the DSM-5 overlap with multiple disorders [9]. This suggests that DSM diagnostic categories are not discrete. Therefore, treating disorders as single entities within assessment and treatment may not be valid, and may not facilitate person-centred, individualized mental health care [3,13]. Comorbidity makes clinical diagnosis and treatment planning complex and requires the health professional to carefully consider the applicability of research findings to clinical practice. For example, the majority of clinical trials of psychological and psychiatric treatment exclude people with comorbidities [8]. This means that for at least half of individuals, even empirically-based interventions for their diagnosis may not be fit for the individual [14]. A health professional using the DSM must consider the potential for, and impact of, comorbidity across DSM diagnoses.

1.3. Consideration 3: within-disorder symptom heterogeneity

DSM provides a range of symptoms for each disorder with an individual only needing to present with a subset of symptoms to meet the criteria for the disorder [1]. Thus, two individuals diagnosed with the same disorder can present with extensive variability within their symptom profiles [1,9]. For example, there are 945 unique symptom combinations of the nine DSM-listed symptoms of Major Depressive Disorder [15]. A diagnosis alone may not provide the necessary information to inform clinical practice to a degree that facilitates optimal care [3,14,16]. A health professional using the DSM must consider the potential of significant within-disorder symptom heterogeneity and target specific symptom sets.

1.4. Consideration 4: physical symptoms

Symptom criteria for DSM disorders often include physical symptoms, such as changes in weight, appetite, sleep, and energy levels as commonly listed symptoms across mood and anxiety disorders [17]. While physical symptoms can be core characteristics of psychopathology, they must be critically considered when using the DSM. For example, cancer survivors have an elevated risk of mental ill-health [2,3,18–20], but many physical symptoms experienced by cancer survivors and listed in the DSM – such as fatigue, weight change, and insomnia – are not *necessarily* symptoms of mental state, but rather side-effects of cancer and its treatments [2]. This may lead to over- and under-diagnosis of mental disorders [3,2,21,22]. Further exacerbating this issue, physical symptoms such as these are also some of the most commonly occurring and disorder-overlapping symptoms listed in the DSM [9]. A health professional using the DSM must consider the potential impacts of physical symptoms on mental health diagnosis and avoid the assumption that an individual's physical symptoms are characteristics of psychopathology.

1.5. Consideration 5: distress and impairment criteria

DSM commonly includes distress or impairment criterion that must be met for diagnosis. Thus, if an individual presents with a symptom profile meeting the criterion for a disorder (e.g., social anxiety disorder), unless these symptoms cause significant perceived distress or impairment, they cannot be diagnosed with that disorder [23]. Empirically, symptoms and functioning are not always strongly related, and many disorders carry symptoms with no significant distress [23]. For example, even marked social anxiety may not cause significant distress or have a marked impact on the daily functioning of a individual depending on their context (e.g., works from home in a role that does not require collaboration, online orders their groceries, etc) [23]. A health professional using the DSM must consider the impact of the distress and impairment criteria on their assessment, case conceptualisation, and treatment and supportive care decision-making.

2. Conclusion

In this primer, five critical considerations for health professionals who use the DSM, or work with DSM-diagnosed individuals are provided. These considerations are not exhaustive but provide fundamental considerations for health professionals to make informed choices in practice. Cautious application of the DSM, considering its limitations, is essential. Recently, there has been strong discussion regarding discarding the DSM generally and within some sub-domains of mental health, such as psycho-oncology, due to issues such as those presented in this primer [2,3]. To overcome some of these DSM pitfalls, health professionals may consider dimensional models of mental health, such as the Hierarchical Taxonomy of Psychopathology (HiTOP) [5,8], as an alternative, or to be used in concert with the DSM. The HiTOP model is an empirically-based structure that views psychopathology as a collection of higher and lower-order domains each of which presents on a dimension of severity [5]. Emerging evidence suggests that HiTOP has the potential to alleviate many of these potential pitfalls and considerations of the DSM and improve case conceptualisations and individual-clinician communication [3,2,13,24]. Readers interested in the potential of applying HiTOP within clinical practice should refer to Kotov et al., [8] Ruggero et al., [14] and Hopwood et al. [16].

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