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DSM-5: Plus ça change …

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By Constance Cummings

Cross-posted from The FPR Blog.

John Gever of MedPage Today, has done a terrific summary of the proposed changes to the DSM ("DSM-5: What's In, What's Out").

The umpteenth person just described the DSM-5 process to me as a major rehaul. Is it? Aside from the changes in how we want to sort the world of persons living with psychiatric disorder (and everyone would agree it's still a flawed taxonomy as long as we don't understand cause), there are two interesting developments that presage better things to come for the *next* next edition.

The first is the inclusion of cross-cutting dimensional assessments ranging from normal to pathological (consider Tanya Luhrmann's work on the experience of "hearing voices" in her new book, When God Talks Back). As Gever explains:

> These are indicators of severity for certain symptoms. They may be common "cross-cutting" features that appear in conjunction with many disorders, such as suicide risk and anxiety. Or they may be specific to a particular disorder, such as the frequency of flashbacks in PTSD.

The second is the use of biomarkers for sleep-related disorders like narcolepsy.

> Many sleep-wake disorders in DSM-5 will require polysomnography for a diagnosis. Also, narcolepsy is set to become narcolepsy/hypocretin deficiency, with the latter condition diagnosed on the basis of hypocretin measurements in cerebrospinal fluid.

Otherwise, as historian Edward Shorter argues in a 5/9 Scientific American blog post nothing has essentially changed.

According to Shorter, the main difficulty is that the principal diagnoses of psychiatry are “artifacts.” He goes on to discuss major depression, schizophrenia, and bipolar disorder, specifically. All of these disorders are loosely grouped clusters of symptoms for which we currently lack causal explanations. (The interesting exception is melancholia, which doesn’t appear in the current DSM but which may well be an actual category of illness rather than composed of something that can be ranged along a continuum.)

This matters because, Shorter writes, “[y]ou can’t develop drugs for diseases that don’t exist.”

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