International Journal of Clinical and Health Psychology (2014) **14**, 221–231

International Journal of Clinical and Health Psychology

www.elsevier.es/ijchp

THEORETICAL STUDY

From DSM-IV-TR to DSM-5: Analysis of some changes

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Received 22 May 2014; accepted 10 June 2014
Available online 9 July 2014

KEYWORDS
Diagnosis;
Classification;
DSM-5;
DSM-IV-TR;
Theoretical study

Abstract The publication of the fifth edition of the DSM has intensified a debate begun some time agowith the announcement of the changes in diagnostic criteria proposed by the APA. This article analyzes some of these modifications. Some interesting points where it is right, such as the inclusion of dimensionality in both diagnostic classes and in some disorders, the inclusion of an obsessive-compulsive spectrum, and the disappearance of subtypes of schizophrenia. It also analyzes other more controversial points, such as the consideration of the attenuated psychosis syndrome, the description of a persistent depressive disorder, reorganization of the classic somatoform disorders as somatic symptom disorders, or maintenance of three large clusters of personality disorders, always unsatisfactory, along with an announced, but marginal, suggestion of the dimensional perspective of personality impairments. The new DSM-5 classification opens many questions about the diagnostic validity which it attempts to improve, this time taking an approach nearer to neurology and genetics than to clinical psychology.
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PALABRAS CLAVE
Diagnóstico;
Clasificación;
DSM-5;
DSM-IV-TR;
Estudio teórico

Del DSM-IV-TR al DSM-5: análisis de algunos cambios

Resumen La publicación de la quinta edición del DSM ha avivado un debate iniciado tiempo atrás, desde el anuncio de los cambios en los criterios de diagnóstico propuestos por la APA. En este artículo se analizan algunas de estas modificaciones. Se plantean aspectos interesantes y acertados, como la inclusión de la dimensionalidad tanto en las clases diagnósticas como en algunos trastornos, la incorporación de un espectro obsesivo-compulsivo o la desaparición de los subtipos de esquizofrenia. También se analizan otros aspectos más controvertidos como la consideración del síndrome de psicosis atenuada, la descripción de un trastorno depresivo persistente, la reordenación en trastornos de síntomas somáticos los clásicos trastornos somatoformes, o el mantenimiento de los tres grandes grupos de trastornos de la personalidad,

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http://dx.doi.org/10.1016/j.ijchp.2014.05.002
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siempre insatisfactorios, junto con un planteamiento anunciado, pero marginal, de la perspectiva dimensional de las alteraciones de la personalidad. La nueva clasificación del DSM-5 abre numerosos interrogantes acerca de la validez que se pretende mejorar en el diagnóstico, en esta ocasión, asumiendo un planteamiento más cercano a la neurología y la genética que a la psicopatología clínica.
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To judge by the success of its sales (Blashfield, Keeley, Flanagan, & Miles, 2014), the publication of a new edition of the DSM has immediately become an event. This study is intended to analyze some aspects that the fifth edition of the DSM (American Psychiatric Association APA, 2013b) contributes. It is materially impossible to consider all its sections, at the same time that it requires aneducational effort for its explanation: disappearance of hypochondria or of concepts such as somatization, substance dependence, appearance of spectra, new disorders, etc. Therefore, a selection has been made of what might be the most outstanding from a clinical, psychopathological viewpoint.

The Manual's presentation states its intention of improving the validity of previous editions and of being based on research. However, the sources to which it alludes are from neuroscience and genetics. Although the text considers psychological (and social) factors, it is not this type of research that structures the DSM-5. In fact, future contributions from the *Research Domain Criteria* (RDoC),the principles of which are directed at understanding mental disorders as cerebral disorders, dysfunctions of brain circuitry evaluable by the instruments of cognitive neuroscience, and of developing the biological basis for symptoms,are proposed for inclusion (Insel, 2013; Insel et al., 2010).

Needless to say, the DSM is not a psychopathology text, although, as it is a Manual that has to guide diagnosis (still clinical), treatment and research, it is quite relevant to underline the obvious: that the biologicist perspective (Adam, 2013) conditions the subject of study. As a matter of fact, we could starttalking about a NeuroDSM, given the proliferation of the prefix: Neurodevelopmental disorders, Neurocognitive disorders, or Functional neurological symptom disorder. This seems to minimize or discard any contribution of psychological research from the start.

In view of the evidence accumulated (Blashfield et al., 2014), in addition to decreasing the unspecified categories, among the DSM-5 goals were development of clusters and dimensions of disorders. Dimensionality appears in some disorder spectra, in some disorders (scales for diagnostic criteria of intellectual disability, autism spectrum and schizophrenia), partially in others (domains are defined in neurocognitive disorders, but the structure is categorical), and in determining severity (not in all diagnoses). It is curious in this sense that inspite of following contributions from neuroscience and genetics, and although the data matchmuch wider sets of disorders depending on their susceptibility and pathogenesis (Craddock & Owen, 2010; Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013), in reality the resulting clusters are much more limited (e.g., schizophrenia spectrum, but separated from bipolar disorders and autism spectrum). And even within the schizophrenia spectrum, there would be no reason (by genetic criteria) for distinguishing schizophreniform disorder from schizophrenia, and by the way, harmonizing the DSM-5 with the ICD-10.

It is not a matter of forcing a choice between categorical and dimensional. As Wakefield and First (2013) point out, numerous dimensional variables end up generating a point of inflection (points of rarity) based on which categories are established. Perhaps the most difficult thing to accept is that mental disorders (or that all of them) are natural classes by definition. But it is deficient in that decisions are made in favor of some dimensions and not others which are also backed by research (e.g., related to personality), or that do not develop one of the crucial dimensions, the one establishing the level of distress (Sandín, 2013).

One of the questions that remain under discussion about the diagnostic classifications and their lack of validity has to do with the definition of mental disorder itself. Although we are not going to concentrate our analysis on this point, it is advisable to remember that to a large extent, diagnostic decisions do not depend so much on specific symptoms (None pathognomonic) (Malhi, 2013), and do on clinically significant distress and impairment in areas of functioning. So the doubt arises of whether what makes a person suffer is a mental disorder (this is where the issue related to bereavement arises), or whether it is a matter of processes and variations not coinciding with social demands and personal opportunities (e.g., Circadian rhythm sleep-wake disorders) (Wakefield, 2013). In this sense, the need of finding the precise point at which distress and significant clinical deterioration become unmanageable or disabling (Bolton, 2013) has been noted. Therefore, the new edition of the DSM has lost a perfect occasion for an indispensable dimension.

A first analysis of this work shows that the number of general diagnostic classes of mental disorders has increased to 21, when in the DSM-IV there were 16 (excluding the chapter on Other conditions that may be a focus of clinical attention). This increase in diagnostic classes seems right in some cases of disorders that have little to do with each other (e.g., paraphilic disorder and sexual dysfunctions) or in cases like the Obsessive-compulsive disorder and related disorders, takenout of the Anxiety disorders.

Apart from this, an apparently minor question like the number of diagnoses in each DSM edition mismatch in different analyses (Blashfield et al., 2014; Mayes & Horwitz, 2005; Sandín, 2013; Spitzer, 2001), as it depends on what categories are included: with description and criteria, forms

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