The British Psychological Society

DSM-5: The future of psychiatric diagnosis (2012 - final consultation)

British Psychological Society response to the American Psychiatric Association

June 2012

About the British Psychological Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of almost 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge".

We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for the American Psychiatric Association to contact us in the future in relation to this consultation response. Please direct all queries to:-

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About this Response

This response was prepared for the British Psychological Society by Dr Catherine Dooley, CPsychol, AFBPsS, committee member of the Division of Clinical Psychology (DCP), Chair of the DCP's Professional Standards Unit, and member of the Division of Neuropsychology and the Faculty for Psychology Specialists Working With Older People, with contributions from: Isabel Clarke, CPsychol, member of the DCP, Chair of the Faculty of Psychosis and Complex Mental Health (FPCMH), and member of the Transpersonal Section; Dr David Harper, CPsychol, AFBPsS, member of the DCP and the FPCMH; Lucy Johnstone, CPsychol, AFBPsS, past committee member of the DCP, and member of the FPCMH; Professor Peter Kinderman, CPsychol, AFBPsS, past Chair of the DCP; David Traxson, CPsychol, committee member and commenting on behalf of the Division of Educational and Child Psychology; and David Trickey, CPsychol, member of the DCP and the Faculty for Children and Young People.

We hope you find our comments useful.

David J Murphy CPsychol
Chair, Professional Practice Board

Response

The British Psychological Society (BPS) thanks the American Psychiatric Association for the opportunity to respond to this consultation.

General comments

The BPS welcomes recognition that DSM 5 needs further consultation, but does not consider that the updated proposals fully address the serious reservations raised in our response to the 2011 consultation (BPS, 2011).

The validity of the basic categories is assumed, rather than evidenced from research into distress across both psychiatric and 'normal' populations which might challenge the appropriateness of the paradigm. In this circular process, both the original suggestions and subsequent modifications are based more on committee decision and public responses than on patterns arising out of the identification of underlying mental phenomena.

In the absence of such signs, judgments about pathology are inevitably grounded in subjective and cultural norms. This is particularly obvious in the case of 'Personality Disorders', (criterion 'D' for 'Personality Disorder': "*The impairments in personality functioning and the individual's personality trait expression are not better understood as normative for the individual's developmental stage or socio-cultural environment*"), but also applies across the spectrum of functional diagnoses.

The BPS continues to believe that, by not taking account of the evidence for the dimensional spectrum of psychiatric symptoms such as low mood, hearing voices, unusual beliefs and so on across the general population, retention of a categorical model is a methodological flaw, particularly but not exclusively for 'functional' rather than 'organic' disorders.

We also are concerned that the revised proposals have failed to take account of the growing body of evidence implicating relationship and social factors as the primary risks for mental distress across the range of psychiatric presentations, including 'psychosis'. A recent editorial in the *British Journal of Psychiatry* (Read and Bentall, 2012) summarised this research and called for a paradigm shift in our understanding of mental distress. We recommend a return to basic science without preconceptions.

We consider that, as it stands, the revised DSM-5 would lead to an ongoing risk of pathologising individuals while obscuring well-established social and relationship causal factors. A considerable body of evidence from service users/survivors testifies to the damaging consequences of this approach (eg Geekie *et al*, 2012.)

Finally, as outlined in our 2011 response (BPS, 2011), we are particularly concerned about "catch-all" categories which have a particularly weak conceptual basis, as demonstrated by the fact that one third of people diagnosed with a personality disorder fall under the heading 'Not otherwise specified' (Traxon, 2010). This includes all catch-all terms such as "atypical ….." and "sub-clinical, normal variation ….."). Personality disorder and psychoses are particularly troublesome as they are not adequately normed on the general population, where community surveys regularly report much higher prevalence and incidence than would be expected. A more scientific approach, less likely to lead to the over-diagnosing of conditions such as ADHD and bipolar disorder in children, would be to research the extent of such experiences within the wider population without making a prior assumption of pathology.

General comments
For all the reasons stated above, the BPS, having reviewed the currently proposed revisions of the new diagnostic criteria in DSM 5, continues to have major concerns. These have, if anything, been increased by the very poor reliabilities achieved in many of the recent field trials (Huffington Post, 2012), especially given the limited time available to attempt to achieve more satisfactory outcomes. Since validity depends, at the very least, on acceptable levels of reliability, the unavoidable conclusion is that many of the most frequently-used categories will be unable to fulfil their purported purposes, i.e. identification of appropriate treatments, signposting to support, providing a basis for research, etc. Additionally, given that the potentially harmful effects of psychiatric medication are well-documented, the BPS is concerned that the risks of over-diagnosis outlined earlier may result in the inappropriate use of potentially significant adverse consequences. References: BPS (2011) http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf Accessed May 2012 Geekie, J., Randal, P., Lampshire, D., & Read, J. (eds) (2012). *Experiencing psychosis: personal and professional perspectives*. London, New York: ISPS for Routledge. Huffington Post (2012) http://www.huffingtonpost.com/allen-frances/dsm-5-reliability-tests_b_1490857.html Accessed June 2012 Jiron, C., Chiodo, A., & Sherrill, R. (1995). *Is ADHD being overdiagnosed*? Paper presented at the National Academy of Neuropsychology, San Francisco, CA. Lane C. (2009) *Shyness – How Normal Behaviour Became a Sickness*. New Haven, USA: Yale University Press Read J. & Bentall R. P. (2012) Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *British Journal of Psychiatry,* 200: 89-91. Traxson,D (2010) The Medicalisation of Normal Healthy Childhood.- *BPS-DECP Debate Magazine* – Sept 2010.

Comments on specific disorders			
Code	Title	Comment on Proposed Revision	Comment on Severity
A 06	Attention Deficit/Hyperactivity Disorder	Although not a revision, we are concerned that the use within the descriptor of *"……for at least 6 months to a degree that is inconsistent with developmental level….."* could be part of the explanation for the finding that young-for-age-group children are more likely to be diagnosed and medicated for ADHD (Morrow *et al*, 2012). Indeed, Elder (2010) also reinforces the point that younger children in an age cohort show more immature behaviour and should not be stigmatised as a result. In fact, the differential diagnosis rates for the existing condition between the U.S. and the U.K. of 8% to 1.5% are in themselves evidence of the potential risk for over-diagnosis based on cultural or geographical variables. Further evidence raising doubts about the validity of the diagnostic criteria was described by Jiron *et al* (1995) in a study of children who were diagnosed with ADHD and subsequently referred to a specialist clinic due to their poor response to standard interventions. They found that 75% of the sample experienced a wide range of alternative causes of their symptoms, including post-concussion, depression, learning disability and adjustment problems as the primary cause of their behavioural functioning References: Elder, T. (2010) The Importance of Relative Standards in ADHD Diagnosis: Evidence based on exact birth dates. *Journal of Health Economics,* 29, (5), p641-656 Jiron, C., Chiodo, A., & Sherrill, R. (1995). *Is ADHD being overdiagnosed*? Paper presented at the National Academy of Neuropsychology, San Francisco, CA. Cont'd/….	

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		Morrow, R. L., Garland, E. J., Wright, J. M., Maclure, M., Taylor, S., Dormuth, C. R. (2012). *Influence of relative age on diagnosis and treatment of attention-deficit/hyperactivity disorder in children*. http://cmajopen.com/content/184/7/755.full.pdf+html Accessed June 2012.	
A 07	Attention Deficit/Hyperactivity Disorder (ADHD) Not Elsewhere Classified	Regarding the wording *"….may be coded in cases in which the individuals are below threshold for ADHD or for whom there is insufficient opportunity to verify all criteria. However, ADHD-related symptoms should be associated with impairment, and they are not better explained by any other mental disorder.*" We are concerned that this wording is so vague as to be impossible to operationalise in a consistent way raising the potential for an unscientifically based 'false positive' diagnosis to be made. Usually if a person is below the threshold for something then logically they do not have the condition so it is unclear why this is not the case here.	
Within section: *Schizophrenia Spectrum and Other Psychotic Disorders*	Attenuated Psychosis Syndrome (proposed for section III of the DSM-5)	The BPS welcomes the continued debate and deferment of decision on the inclusion of this category, and the recommendation for future research. In considering the risk of transition to full disorder, studies that compare individuals with equivalent symptoms but who have found or been presented with different contextualisations for their anomalous experiences have not been considered. Cont'd/….	

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		Research (e.g. Brett *et al* 2009, Heriot-Maitland 2011) indicates a powerful role for contextualisation in determining whether such experiences become problematic and associated with significant impairment of functioning or not. Considered alongside studies on the stigmatizing effect of psychotic diagnosis, we believe that caution in including this lower level of diagnosis is indicated because of the iatrogenic harm attendant on medical conceptualisation of disorienting anomalous experiences, which can be distressing, but might otherwise be viewed more benignly, and managed with social support. References: Brett, C.M.C., Johns, L., Peters, E., & McGuire, P. (2009) The role of metacognitive beliefs in determining the impact of anomalous experiences: A comparison of help-seeking and non-help-seeking groups of people experiencing psychotic-like anomalies. *Psychological Medicine*. 39, 939-950. Heriot-Maitland, C., Knight, M. and Peters, E. (2011). A qualitative comparison of psychotic-like phenomena in clinical and non-clinical populations. *British Journal of Clinical Psychology*. doi: 10.1111/j.2044-8260.2011.02011.x	

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B 08	Schizophrenia		Regarding the rationale for introduction of dimensionality. The BPS welcomes this development. In justifying dimensionality for hallucinations and delusions, reference is made to the impact of new ways of thinking about these symptoms introduced by CBT. Elsewhere the overlap between diagnoses is noted. The insights of CBT, particularly recent developments employing mindfulness to impact on the way in which the individual relates to their symptoms, with beneficial results (Chadwick *et al*, 2005; Chadwick *et al,* 2009) could lead to giving greater weight to factors such as social functioning, distress and employability, as opposed to symptoms, in diagnosing the disorder and the severity. Such a change of emphasis would accord with the Recovery initiative (Shepherd *et al,* 2008). References: Chadwick, P.D.J., Newman-Taylor, K. & Abba, N. (2005). Mindfulness groups for people with distressing psychosis. *Behavioral & Cognitive Psychotherapy, 33(3)*, 351-360. Chadwick P, Hughes S, Russell D, Russell I, & Dagnan D.(2009) Mindfulness groups for distressing voices and paranoia: a replication and randomized feasibility trial. *Behavioral Cognitive Psychotherapy*. 37(4):403-12. Shepherd, G., Boardman, J. & Slade, M. (2008) Making Recovery a Reality. http://www.centreformentalhealth.org.uk/publications/making_recovery_a_reality.aspx?ID=578 Accessed June 2012.

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G03	Posttraumatic Stress Disorder	Overall the revision is a very welcome clarification of the criteria. Specifically, the addition of cognitive elements in section D, and the decrease in avoidance symptoms in section C are especially valuable and clinically useful changes. <u>Subtype: PTSD in preschool children:</u> Including a subtype for preschool children is an extremely important and helpful step in classifying (and decreasing) reactions to traumatic events in young children, and is a very welcome addition to the criteria. In the preschool children subtype, the avoidance symptoms are split into two separate groups (C1&2), both of which refer to external stimuli. We suggest this separation is unnecessary, particularly as only one symptom is required from either of the two groups, and it would be more straightforward to merge the two. With regard to the criteria defining the event in the preschool children subtype "*A.2. witnessing, in person, the event(s) as they occurred to others, especially primary caregivers*". We suggest that that the phrase "*especially* primary caregivers" could potentially confuse the diagnosis, as exposure either does or does not fulfil the criteria.	<u>Subtype: PTSD in preschool children:</u> The severity scale is obviously aimed directly at the person who has been traumatised, whereas with the preschool subtype, diagnosis and classification will be made based more on the report of the carers. It would be very helpful to make a note to this effect in the severity text.

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S03	Mild Neurocognitive Disorder	The BPS is concerned that the proposed new diagnostic category "Mild Neurocognitive Disorder" might be diagnosed in elderly people whose memory decline simply reflects normal ageing. We welcome the use of an objective psychometric criterion within this particular DSM-5 diagnosis but has concerns about potential for misdiagnosis of normal ageing given that the evidence is that less than 40% of people diagnosed progress to dementia (Mitchell & Shiri-Feshki, 2009) We would further highlight the importance of valid psychological interpretation of test results since the proposed psychometric threshold encompasses one in eight of the normal population. There is a particular danger that cognitive functioning of people from ethnic minorities is under-represented on psychometric tests. Reference: Mitchell, A. J. & Shiri-Feshki, M. (2009) *Rate of progression of mild cognitive impairment to dementia – meta analysis of 41 robust inception cohort studies.* http://www.ncbi.nlm.nih.gov/pubmed/19236314# Accessed June 2012.	
Q00	Oppositional Defiant Disorder	The BPS remains concerned that the criteria lack statistical rigor and will exacerbate 'false positive' diagnoses in future practice. The descriptors do not adequately or rigorously define a coherent pattern of behaviours. There is very little use of the conventional behavioural descriptors of frequency, intensity, duration and occurrence.	

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Q 04	Disruptive Behaviour Disorder Not Elsewhere Classified	Regarding the descriptor "*This category is for individuals who exhibit symptoms of Conduct Disorder, Oppositional Defiant Disorder, or both disorders but the number of symptoms does not meet the diagnostic threshold for either diagnosis and there is evidence of clinically significant impairment associated with the symptoms."* Although there is only a minor wording change from DSM IV, this is another example of a 'catch all' category which will broaden the rates of diagnosis of such conditions. As mentioned previously, we are concerned that these could cause stigma, iatrogenic harm and result in significant side effects due to the unnecessary medication prescribed as a result of false positive diagnoses.	

End