# Two Views on the New DSM-5

This is one in a series of pro/con editorials discussing controversial issues in family medicine.

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## The Need for Caution in Diagnosing and Treating Mental Disorders

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Most mental health treatment is provided in primary care, not by psychiatrists or in dedicated mental health services.[1] Not surprisingly, most psychotropic drugs (87% of anxiolytics, 79% of antidepressants, 66% of stimulants, and 51% of antipsychotics) are prescribed by nonpsychiatrists, particularly family physicians.[2]

Rates of psychiatric diagnoses and psychotropic prescriptions have increased rapidly in recent years, largely in primary care. Attention-deficit/hyperactivity disorder has been diagnosed in 11% of school-aged children,[3] compared with the 3% to 5% prevalence reported in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV).[4] Youth bipolar disorder diagnoses increased 40-fold from 1994-1995 to 2002-2003,[5] and autism is diagnosed at a rate 20 times higher[6] than the estimated prevalence in the DSM-IV.[4] Based on DSM-IV criteria, more than 25% of the general population older than 18 years qualify for a current diagnosis of a mental disorder in a year,[7] and nearly 50% qualify for a lifetime diagnosis.[8] More than 20% of American adults take at least one psychotropic drug in a year,[9] most commonly antidepressants or antipsychotics.[10]

Some of the growth in diagnosis and drug treatment represents increased acceptance of mental illness and improved case finding, but much of it is caused by diagnostic inflation and treatment exuberance. In the United States, drug companies misleadingly market psychiatric illness to physicians and patients with a freedom and financial largess unknown in the rest of the world. Family physicians are targeted in many marketing campaigns, some of which encourage off-label prescribing, even though off-label marketing is not permitted.[11] Drug companies also fund disease awareness campaigns that encourage medicalization of life problems (e.g., work-related stress and diagnosis of minor, transient symptoms). There is a positive and significant association between pharmaceutical marketing and rates of antidepressant, antipsychotic, and stimulant use; however, there is no significant correlation between depression prevalence and antidepressant use.[12] Diagnoses are also made loosely by well-meaning physicians when a diagnosis is necessary for a patient to qualify for medical treatment, school services, and disability benefits.[13]

The diagnosis and treatment of mental disorders can be beneficial when done judiciously, but can cause serious unintended consequences when done poorly. Good diagnosis requires training, patience, careful evaluation, and longitudinal observation. Symptom presentations in primary care are more likely to reflect expectable situational reactions than diagnosable mental disorders and, contrary to marketing hype, are usually not the result of "chemical imbalances"[14] that require psychotropic drugs. Most adjustment problems (i.e., difficulties coping with stressors, often resulting in depressed mood and/or anxiety) are self-limiting and improve with time, support, and education. Placebo response rates are so high for mild presentations that drug companies routinely suppress findings that active medication contributes little additional benefit, but causes potentially harmful adverse effects.[15] However, physicians can be persuaded by marketing campaigns that early diagnosis and drug treatment are crucial. If there is doubt about whether a mental disorder is present, watchful waiting is better than premature diagnosis and unnecessary prescribing.[16]

DSM-5, published in May 2013, has stimulated the opposition of more than 50 mental health associations, which have petitioned for an independent scientific review based on the belief that the manual's proposals for change are not safe or scientifically sound. The petition is available at http://www.ipetitions.com/petition/dsm5. DSM-5 seems likely to convert diagnostic inflation into diagnostic hyperinflation by adding new, questionable, and untested diagnoses, and by reducing the thresholds for existing diagnoses. Normal grief may be mislabeled as major depressive disorder, temper tantrums become disruptive mood dysregulation disorder, normal forgetfulness in old age is now mild neurocognitive disorder, overeating is binge-eating disorder, and poor concentration is adult attention-deficit/hyperactivity disorder (and a ticket to stimulant abuse for recreation or performance enhancement).

Crucially, none of the DSM-5 field trials included family physicians.[17] This means that the evidence about the reliability and validity of DSM-5 diagnoses cannot be generalized to the majority of physicians who will use the manual. Family physicians deal with very different patient populations than those treated by psychiatrists in academic settings and specialized mental health services, where most of the trials occurred.

Primary care physicians should not blindly follow DSM-5's lead toward looser psychiatric diagnoses and should exercise much greater caution in the prescription of psychotropic drugs. DSM-5 diagnoses are not official, and clinicians who are required to use diagnostic codes for reimbursement can access the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes for free online at http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html, or can continue to use DSM-IV until ICD-10-CM codes come into use in October 2014.

EDITOR'S NOTE: Dr. Frances was chair of the DSM-IV Task Force, and has written two books critical of DSM-5.

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