Reflections on DSM 5 and ICD 11

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1. Terminology and structure

**DSM IV TR**

(1) Substance-Related Disorders

(1.1) Substance Use Disorders

  * Abuse
  * Dependence

(1.2) Substance Induced Disorders

  * Intoxication
  * Withdrawal
  * Substance-Induced Mental Disorders
    - Delirium,
    - Dementia,
    - others

**DSM 5**

(1) Substance-Related and Addictive Disorders

(1.1) Substance-Related Disorders

(1.1.1) Substance Use Disorders

(1.1.2) Substance Induced Disorders

  * Intoxication
  * Withdrawal
  * Other Substance / Medication-Induced Disorders

(1.2) Non-Substance-Related Disorders

  * Gambling Disorder
2. Other changes

**DSM IV TR**

(1) Diagnostic criteria
   * Abuse: 4
   * Dependence: 7

(2) Dimensionality
   * None

(3) Medically induced intoxication or withdrawal
   * Relevant for diagnosis

**DSM 5**

(1) Diagnostic criteria
   * Substance Use Disorder: 11
     - legal
     + craving

(2) Dimensionality
   * Mild: 2-3 criteria
   * Moderate: 4-5 criteria
   * Severe: 6+ criteria

(3) Medically induced intoxication or withdrawal
   * Not relevant for diagnosis
     + opioids
     + sedatives, hypnotics, anxiolytics
     + stimulants

(4) Many minor changes
   * remission criteria
   * coffein/cannabis: + withdrawal
   * structure of substance classification
3. Issues to consider/discuss

(1) A further step towards a symptom-based description of mental disorders
   * no more: dependence, addiction
   * “... addiction is not applied as a diagnostic term in this classification, ......”. “... the word is omitted from the official DSM-5 substance use disorder diagnostic terminology because of its uncertain definition and its potentially negative connotation.”
   * but not consistant: „addiction“ is used in the title (for non-substance related disorders)
   * but not in the subtitle

(2) No diagnosis if under „appropriate“ medical supervision
   * understandable
   * but: risk to neglect a major problem

(3) Lack of comparability
   * DSM IV TR
   * ICD 10 / 11
3. Issues to consider/discuss (cont.)

(4) General „statement of concern“ on DSM 5 (see Francis Allen, 2013)
   * External scientific review is missing
   * Lack of reliability and validity
   * Wrong labeling of people that would do better without diagnosis
   * Inappropriate allocation of mental health resources – away from those, who really need it
   * Consequence of lower diagnostic thresholds: inappropriate use of psychopharmaceutical drugs?

BUT:
   * Increase in prevalence rates not empirically confirmed
   * Diagnosis ≠ need for treatment
   * Critics are not necessarily DSM 5 specific
   * Idea: DSM 5 as “living document”, open for alterations

* Conclusion: Towards an objectification of debate!
4. Towards ICD 11
– What is the current state?

* **Maintenance of the traditional ICD format** for mortality and morbidity reporting

* **Three-stage revision process**
  1. systematic review of scientific, clinical and public health evidence
  2. creation of a draft ICD-11 and field-testing
  3. development of meaningful linkages to standardized health care terminologies

* **Currently**: Beta-Draft publicly approachable and modifiable on WHO website

* **Aim**: collecting suggestions, discussions and evidence from experts and interested public

* **Expected year of publication**: 2017

* **SUD**:
  + no integration of harmful use and dependence
  + no integration of pathological gambling
4. Some conclusions for journal editors

(1) Encourage studies on validity of diagnostic criteria, e.g.
   * Relevance of single items
   * Comparability of SUD and GD
   * Inclusion of internet (gaming) disorders and other similar disorders

(2) Encourage studies on comparability of diagnoses, e.g.
   * Population screenings
   * Clinical groups

(3) Encourage commentaries and discussions, e.g.
   * Clinical consequences: patients
   * Treatment delivery: mild disorder