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The *DSM-5* Controversies: How Should Psychologists Respond?

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The American Psychiatric Association (APA) published *DSM-5* in May 2013. The revision process was fraught with controversy. In the first section of this article, we briefly summarise the controversies related to the actions of the APA and the Task Force responsible for the revision process. These include allegations of secrecy, accusations of conflicts of interest, apprehension over a promised paradigm shift, concerns about the definition of mental disorder, charges of medicalizing normality, and claims of poor methodology. In the second section, we briefly summarise the controversies related to some of the revisions to the *DSM-5* disorders and diagnostic criteria. In the third section, we argue that *DSM-5* development was unnecessarily contentious for reasons that could have been foreseen and prevented. Because incremental updates to the *DSM-5* are anticipated in the near future (American Psychiatric Association, 2010, *APA modifies DSM naming convention to reflect publication changes*, Washington, DC: Author), we propose that psychologists external to the revision process should use their unique expertise to assist in resolving the controversies that have beset the *DSM-5* and thereby facilitate a less contentious development of the next iteration of the *DSM*.

Keywords: *DSM-5*, controversies, psychologists

The American Psychiatric Association (APA) published the *DSM-5* in May 2013 (APA, 2013). The revision process was fraught with controversy. Our purpose is to summarise those controversies and then to examine how psychologists might respond to them. We reviewed the literature using PsycINFO, PsychiatryOnline, Medline, and Google Scholar databases using *DSM V*, *DSM-V*, *DSM 5*, and *DSM-5* as search terms, through December 2012. Two major areas of controversy were identified. The first was the way the APA and *DSM-5* Task Force conducted the revision process. The second related to some of the proposed revisions to the disorders and diagnostic criteria that were posted on the APA's website, *DSM-5 Development* (APA, 2010b; the proposed disorders, criteria sets, and rationales were removed from the website in 2012.) The search yielded a plethora of articles. Consequently, we reviewed only as many articles as necessary to provide an awareness of the main controversies and to provide a context for understanding why we believe that psychologists should respond to them.

Background

The *DSM-5* Task Force was responsible for the revision process. In 2006, David Kupfer, MD, was appointed Chair and Darrel Regier, MD, MPH, was appointed Vice-Chair. Members of 13 Work Groups were announced in 2008. The Task Force developed four guiding principles (Kupfer, Regier, & Kuhl, 2008). The first was that proposals be based on empirical evidence. The second was that continuity with previous versions of *DSM* be maintained when possible. The third, and most controversial, was the removal of all limitations on the amount of change that could occur. The fourth was that *DSM-5* be a living document that could be updated periodically. The APA (2010a) replaced the conventional Roman numeral with an Arabic numeral to permit incremental updates using decimals (e.g., *DSM-5, 5.1, 5.2*).

Controversies Related to the Task Force

The issue of secrecy is one of the most significant controversies surrounding the development of the *DSM-5*. Robert Spitzer, MD (2008), Chair of the *DSM–III* and *DSM–III–R* Task Forces, reported that Regier had denied his request for the minutes of Task Force meetings in order to maintain *DSM-5* confidentiality. Spitzer (2008) was incredulous. He reported that all Task Force and Work Group members were required to sign an *acceptance form* that prevented them from discussing their work publicly. Spitzer said the confidentiality agreement was unprecedented in the development of prior *DSM*s. He argued that the development of *DSM-5* in secrecy indicated a failure by the Task Force to understand the necessity for an open and transparent revision process (Spitzer, 2008). Allen Frances, M. D., Chair of the *DSM–IV* Task Force, stated that the best way to avoid unforeseen problems was to solicit as much outside opinion as possible (Frances, 2009a). A series of exchanges between Spitzer and Frances and the APA and Task Force ensued. Schatzberg, Scully, Kupfer, and Regier (2009) described the development of *DSM-5* as open and inclusive. They defended the confidentiality agreements as necessary to protect intellectual property. They also accused Frances and Spitzer of being motivated by the royalties they receive from earlier *DSM*s.

Controversy over conflicts of interest also marred the *DSM-5* development. The pharmaceutical industry spends twice as much on drug promotion as on research and development (Batstra & Frances, 2012). Consequently, concern that the industry might

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have an influence on the development of *DSM*s (Pilecki, Clegg, & McKay, 2011) led the APA to develop a mandatory disclosure requirement. Cosgrove and Krimsky (2012) concluded that the APA's conflicts of interest policy was inadequate. They noted that 69% of the *DSM-5* Task Force had direct industry ties, an increase from the *DSM–IV* Task Force. Although Kupfer and Regier (2009) assured that the *DSM-5* disclosure policy was sufficient to limit industry bias, concern over the development of industry-friendly diagnoses persists (Obiols, 2012).

A controversy arose as to whether the Task Force should implement a paradigm shift in psychiatric diagnosis. Clinicians and researchers have expressed growing frustration with the *DSM–IV*'s atheoretical and categorical nature. The expectation that syndromes would be refined until the etiology of each was discovered has not been realised (Kendler & First, 2010) and has resulted in a desire by some for a paradigm shift in diagnosis (First, 2010b). Two proposals were called paradigm-shifting. The first was to make *DSM-5* etiologically based, and the second was to supplement diagnostic categories with dimensional ratings (Kendler & First, 2010). Regarding the first, it is clear that the etiology clearly favoured was a biological one (Kupfer & Regier, 2011). The controversy relates to plausibility. Many argued that it will be decades before our knowledge of the pathophysiology of mental disorders permits a shift to classification based on etiology, and the strategy was attacked for being premature and disruptive (Frances, 2009b; Phillips, 2010b; Vanheule, 2012). Regarding the second, Regier, Narrow, Kuhl, and Kupfer (2009) stated that the incorporation of dimensional measures would constitute a major difference between *DSM–IV* and *DSM-5*. The desire to replace or supplement the *DSM–IV* categorical system with a dimensional system has been well received in theory (Jones, 2012b). The controversy relates to clinical utility—the extent to which the measures are user-friendly. Many argued that the dimensional measures proposed for *DSM-5* would be a time-consuming administrative burden and, consequently, would be ignored by busy clinicians (First, 2010a; Phillips, 2010b). Additionally, Frances (2010d) and Jones (2012b) suggested that the Task Force did not have the time or the psychometric expertise to construct the measures, which therefore might not be psychometrically sound. Despite the enthusiastic claim by Regier et al. (2009), the measures were placed in Section III of *DSM-5*: Conditions for Further Study (APA, 2013).

Consistent with the intention to shift to a classification system based on a biological etiology, controversy arose over a proposed change to the definition of a mental disorder (Stein et al., 2010). One part of the *DSM–IV* (APA, 2000) definition requires that the syndrome be ". . .a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (p. xxxi). Stein et al. (2010) proposed that the wording in *DSM-5* be changed to: "that reflects an underlying psychobiological dysfunction" (p. 1761). First and Wakefield (2010) recommended that the *DSM–IV* wording be retained because the word *or* allowed for a disorder that is not intrinsically biological. McLaren (2010) lamented that Stein et al. had an "implicit ideological commitment to biological reductionism" (p. 193). The definition ultimately used in *DSM-5* includes the less provocative phrase, "a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (APA, 2013, p. 20).

Controversy flared over the potential of *DSM-5* to foster a medicalization of normality. Frances and Widiger (2012) concluded that the *DSM-5* could trigger nine epidemics of mental disorder. They stated that five new diagnoses were characterised by symptoms common in the general population, such as binge eating, minor neurocognitive problems, mixed anxiety−depression, prepsychotic symptoms, and temper dysregulation. They also claimed that lowering the diagnostic thresholds for four existing disorders—attention deficit hyperactivity disorder (ADHD), generalised anxiety disorder, posttraumatic stress disorder (PTSD), and substance dependence—would result in millions of people with false-positives who would pay a high price in medication side effects, stigma, and insurability problems.

The Task Force's methodology for guiding the empirical review process sparked several controversies. Frances (2009a) expressed concern that the Task Force had not developed an a priori methodology for Work Groups to follow, and they had been encouraged to think innovatively, with little guidance. Regarding the methodology for the field trials, Jones (2012a) summarised their primary limitations. She noted that the ambitiousness of the Task Force placed a great burden on the field trials to ensure that the revisions were reliable, valid, and would not result in excessive false-positives. The trials occurred in small routine practice settings and academic/large clinical settings. The latter were to occur in two phases. Phase I was to evaluate the draft diagnostic criteria and phase II was to evaluate required revisions. The clinician attrition rate in the small routine practice settings was enormous. Thus, the clinicians who completed the trials were unlikely to be a representative sample, and yet they tested the dimensional measures in clinical practice as well as the new diagnostic criteria for milder disorders where false-positives are most likely because of the fuzzy boundary between mild disorder and normal variation. The field trials in academic/large clinical settings were beset by missed deadlines and, consequently, Phase II, the quality control phase, was dropped to meet the May 2013 publication deadline. Finally, although concern had been raised about increased false-positives, the field trials did not compare *DSM–IV* and *DSM-5* prevalence rates for the same disorders. Jones (2012a) also noted that Kupfer and Regier had claimed that *DSM-5* would be more valid than *DSM–IV*, yet no tests of predictive validity were undertaken, and a planned test of convergent validity was abandoned. These limitations are cause enough for concern, but the issue that ignited the most controversy was the measurement and interpretation of reliability. Spitzer developed the methodology used for determining diagnostic reliability in *DSM–III* and *–IV* (Spitzer, Williams, & Endicott, 2012). Structured interviews were used to separate the unreliability of clinicians from the unreliability of the diagnostic criteria. Kappas below 0.4 were considered unacceptable, those between 0.4 and 0.6 were considered fair, and those above 0.6 were good to excellent. Kraemer, Kupfer, Clarke, Narrow, and Regier (2012) proposed that, for *DSM-5*, kappas between 0.2 and 0.4 be considered acceptable, perhaps because they had chosen to use unstructured interviews to simulate actual clinical practice (Jones, 2012a). A firestorm of criticism ensued.

Controversies Related to Proposed Disorders

Our literature review revealed too many criticisms of too many proposals to present them all. Accordingly, we reviewed only a

representative sample to provide an understanding of why we believe that psychologists should respond to them. We used alphabetical order, not order of importance. The number of citations does not reflect the number of published criticisms.

The Psychotic Disorders Work Group asserted that young people with attenuated psychosis syndrome (APS) could be identified and that early treatment is most effective. The main controversy surrounding APS is the risk of false-positives, which was found to range from 50−84%. Other concerns included apprehension that pharmaceutical companies would market antipsychotics overzealously to consumers despite the health risks, worry about how stigma might affect young adults, and concern that ordinary clinicians might not be able to distinguish APS from certain nonpsychotic disorders or the extremes that exist in normal teenage behaviour (Corcoran, First, & Cornblatt, 2010). Ultimately, APS was included in Section III *(*APA, 2013).

The Neurodevelopmental Disorders Work Group proposed to replace the individual diagnoses comprising the pervasive developmental disorders with a single diagnosis: autism spectrum disorder (ASD; Worley & Matson, 2012). The most contentious aspect of this change was the elimination of Asperger's disorder (AD). The rationale for this change was that a number of researchers found no difference between AD and high-functioning autistic patients, and so a single spectrum disorder was seen as more consistent with the data (see Worley & Matson, 2012). Not all researchers agreed with this interpretation, but the major controversy related to stigma. It was argued that many of those currently diagnosed with AD, as well as their families, identify positively with this condition and, consequently, they would reject a diagnosis of ASD because of the greater stigma associated with the term *autism* (see Szatmari, 2011).

The Childhood and Adolescent Disorders Work Group proposed a new disorder for *DSM-5* originally called temper dysregulation disorder with dysphoria (TDD) and later renamed disruptive mood dysregulation disorder. It is one of the depressive disorders in *DSM-5* (APA, 2013). One reason for its inclusion was to address the overdiagnosis of bipolar disorder in children (APA, 2013). Axelton (2010) applauded the intention, but criticised the solution because temper dysregulation is a symptom of other disorders. Frances and Widiger (2012) argued that TDD would lead to the misdiagnosis of difficult children and promote the overprescription of antipsychotic medications for children, despite their associated risks.

The *DSM–IV* diagnosis of gender identity disorder (GID) was changed to gender dysphoria (GD) in *DSM-5* (APA, 2013). The most controversial aspect of GD is whether it is a valid disorder. Some researchers had argued that GID should not be considered a mental disorder in children because any discomfort GID children feel is not due to their gender identity but rather to the gender role assigned to their sex. Also, children with GID show no psychopathology (see Bockting, 2009). Regarding adults, it had been argued that if GID is a disorder, it is better conceptualised as a physical one, because the most commonly recommended treatment is medical, not psychiatric (Bockting, 2009; Meyer-Bahlburg, 2010). Ironically, an ethical dilemma would have arisen had GD been deleted from the *DSM-5*; transgender adults would become ineligible for insurance coverage for reassignment surgery (Bockting, 2009; Meyer-Bahlburg, 2010).

Hypersexual disorder was proposed for *DSM-5*. The primary controversy relates to the validity of the disorder. According to the 2010 APA website and Kafka (2010), there is evidence that hypersexual behaviour is associated with public health concerns, such as marital discord, increased risk of sexually transmitted diseases, and unwanted pregnancies, and there is a demand from mental health consumers for a diagnosis for those with hypersexual behaviour. Wakefield (2012) was critical of these points. He argued that the proposed diagnostic criteria failed to distinguish normative variation from pathology, that people who have more sex might be at greater risk of sex-related problems, but would also enjoy more sex-related benefits, and that demand from consumers did not validate a diagnosis. Wakefield also asserted that the diagnosis would provide a psychiatric excuse for those who had exercised bad judgment. This disorder was not included in *DSM-5*.

The Mood Disorders Work Group proposed to remove the bereavement exclusion for a major depressive disorder (MDD). The controversy relates to validity. The Work Group argued that there is no evidence to distinguish between symptoms caused by bereavement from those caused by other stressors (see Wakefield & First, 2012). However, Wakefield and First (2012) reviewed studies that demonstrated that MDDs caused by bereavement could be distinguished from MDDs caused by other stressors. Additionally, First (in First, Pies, & Zisook, 2011) argued that medicalizing grief would stigmatize individuals and expose them needlessly to harm, such as drug side effects and discrimination by insurance companies due to a mental disorder diagnosis. Regardless, the bereavement exclusion was removed from *DSM-5* (APA, 2013).

In *DSM-5*, a distinction is made between a *paraphilia* and a *paraphilic disorder*. A paraphilia is *ascertained* according to the A criterion (i.e., fantasies, urges, or behaviours) and a paraphilic disorder is *diagnosed* according to the A and B criteria (i.e., distress, impairment, or harm to others) (see Krueger & Kaplan, 2012). The primary controversy relates to the utility of ascertaining a paraphilia in the absence of a disorder. Krueger and Kaplan (2012) reviewed the literature on the distinction. It would be advantageous to researchers who want to study persons who meet the A criterion only. However, critics noted that it would cause confusion. Those ascertained as having a paraphilia might be mistaken as having a mental disorder diagnosis.

The Paraphilias Subworkgroup proposed a new disorder, paraphilic coercive disorder (PCD). The rationale was based, in part, upon research by Thornton (2010), who explained that the term *coercive paraphilia* is justified when coercion is the erotic focus of a sexual act. He argued that some men who rape warrant this diagnosis. The primary controversy relates to whether it is a valid disorder. Wakefield (2012) countered that research has shown that fantasies of sexual coercion are common, and he noted the impossibility of distinguishing between the rare paraphilic rapist and the rapist who simply is a criminal. Frances (2011b) explained that PCD needs to be better validated in light of its potential for misuse in legal settings. The *DSM–IV* diagnosis of paraphilias not otherwise specified has been used to civilly commit some sexually violent predators (SVPs) in the United States after their prison sentence has been served. Frances expressed concern that an apparently more credible PCD diagnosis would legitimize the civil commitment when the validity of PCD is questionable. Ultimately, this disorder was not included in *DSM-5*.

The Paraphilias Subworkgroup also proposed the expansion of pedophilia to include hebephilia (sexual attraction to young adolescents). The rationale provided for inclusion of pedohebephilic disorder was that studies using phallometric testing indicated that hebephilia exists as a sexual age preference (see Good & Burstein, 2012). The primary controversy related to the validity of hebephilia as a mental disorder. Frances and First (2011) argued that the chief concern was not whether pedophilia and hebephilia could be distinguished phallometrically, but whether hebephilia is a mental disorder. Good and Burstein (2012) and Wakefield (2012) argued that it is not because the normality of adult sexual attraction to young adolescents is well documented. Additionally, Frances and First (2011) argued that lawyers would use the diagnosis of pedohebephilic disorder to civilly commit some SVPs when it is not a valid mental disorder. In the end, pedohebephilic disorder was not included in *DSM-5*, and the diagnostic criteria for pedophilic disorder remain essentially the same as in *DSM–IV* (APA, 2013).

The original proposal for the diagnosis of personality disorders (PD) involved rating the degree of match to five PD prototypes (i.e., antisocial/psychopathic, avoidant, borderline, obsessive−compulsive, and schizotypal) and the degree of impairment on 37 traits. After critical feedback, the Work Group abandoned the prototype-matching model, reduced the number of traits to 25, and added a sixth PD type (narcissistic). This is a hybrid categorical−dimensional system (see Skodol, 2012). There are four primary controversies. One, Livesley (2010) argued that the Work Group's taxonomic principles were confused because psychopathology cannot be both categorically and dimensionally distributed. Two, Livesley (2010) expressed concern that prototype matching involves the use of heuristics, which are not appropriate for scientific decision-making. Widiger (2011) argued that prototype matching is less reliable than the criteria-counting approach of *DSM–IV*. In contrast, Phillips (2010b) and Westen, DeFife, Bradley, and Hilsenroth (2010) argued the opposite, insisting that prototype matching is consistent with clinicians' natural cognitive processes. In contrast, again, First (2010a) and Frances (2011c) argued that the human mind naturally organizes information into categories rather than dimensions (e.g., blue or green rather than wavelengths). Three, Livesley (2010) and Tyrer (2012) stated that, although dimensions are a more valid way of describing personality traits, the PD dimensional assessments proposed for *DSM-5* were so complex that they lacked clinical utility. And, four, Livesley (2010) and Widiger (2011) acknowledged that the excessive co-occurrence among the *DSM–IV* PDs was a problem, but reducing the number from 10 to five (later six) as a solution was draconian, arbitrary, and not empirically based. Despite all the fervour, the 10 PDs and categorical model of *DSM–IV* were retained in *DSM-5*, and the hybrid categorical−dimensional with six PDs was placed in Section III (APA, 2013).

The Work Group on Anxiety Disorders proposed to remove PTSD from the anxiety disorders and place it into a new category entitled trauma and stressor-related disorders (Friedman, Resick, Bryant, & Brewin, 2011). Some researchers questioned the data used to justify the move (Zoellner, Rothbaum, & Feeny, 2011). Others criticised the failure to remove criteria common to other anxiety disorders and depression (Koffel, Polusny, Arbisi, & Erbes, 2012). In *DSM–IV*, attention had focused on the A1 (nature of the trauma) and A2 (emotional response) indicators of trauma (Friedman et al., 2011), and a *DSM-5* controversy relates to the definition of trauma and malingering. Researchers expressed concern about the expansion of the concept of trauma over successive *DSM*s, a phenomenon known as *conceptual bracket creep* (McNally, 2009). The Work Group attempted to resolve this problem by clarifying the A1 criterion, but First (2010c) concluded that the new wording remained too broad. First (2010c) suggested that some of the wording was "so vague so as to be a potential new source of creative litigation" (p. 258). Nevertheless, the A1 criterion in *DSM-5* (APA, 2013) is essentially identical to the draft criterion criticised by First.

The Work Group on Substance-Related Disorders proposed a new category of disorder entitled substance use and addictive disorders (APA, 2013). The Work Group proposed to include nonsubstance behavioural addictions in this category based on the contention that behavioural and substance addictions share a natural history (Mihordin, 2012). Gambling disorder is the only behavioural addiction to date. Three major controversies developed: (a) Frances and Widiger (2012) argued that the empirical evidence that pathological gambling shares significant commonalities with substance use disorders is meagre; (b) Kaminer and Winters (2012) asserted that patients and families would reject the term *addiction*, because it is stigmatizing, and this would reduce treatment seeking; and (c) Mihordin (2012) alleged that the inclusion of behavioural addictions in *DSM-5* represents a medicalization of life choices that is unlikely to stop with gambling disorder, and that some patients would use the diagnosis as an excuse for eschewing personal responsibility. Nonetheless, the disorder is in *DSM-5* (APA, 2013).

How Should Psychologists Respond?

We have summarised many of the controversies that beset the *DSM-5* revision process. Because *DSM-5* is now a fait accompli, we suggest that psychologists offer assistance in making the next iterations (APA, 2010a) less contentious.

The Revision Process

Change is a powerful stressor. The *DSM-5* Task Force should have anticipated that a substantial revision of the *DSM–IV* would generate substantial anxiety, and they should have taken preemptive steps to minimise it. Early consultation with, rather than exclusion of, predictably interested parties could have reduced anxiety and suspicion. The response of the APA to the allegations of secrecy was so ineffective that 4 years after Spitzer raised the issue, the accusation was still being made (Kaliski, 2012). Moreover, the Task Force used inflammatory language. As Phillips (2010a) observed, ". . .the authors of DSM-V must surely rue their invocation of the Kuhnian phrase, 'paradigm shift' to describe—and promise—what we might expect in the new DSM" (p. 1). The term *paradigm shift* implies a significant change and, therefore, it was sure to generate significant anxiety. Industrial−organisational psychologists should suggest tactics and strategies for instigating change that foster trust rather than suspicion. Social psychologists might agree that the controversy over secrecy could have resulted in the APA, Task Force, and Work Groups becoming an *ingroup*, with others like Spitzer, Frances, and similar thinkers becoming an

outgroup. Social psychologists should clarify the problems that can arise from *ingroup bias* (VandenBos, 2007). Greater consultation with mental health professionals might have prevented the possible creation of in- and outgroups, and instead have fostered a *superordinate goal* that might have reduced hostility and mistrust (VandenBos, 2007).

The *DSM-5* Work Groups are *groups*, and therefore group processes will apply to them. Because group processes can lead to poor decisions, social psychologists should be interested in studying how these processes might have operated within the Work Groups. *Group polarization* is the enhancement of a group's prevailing opinion following the discussion of an idea that most members already support, and it can lead to poor decision-making (VandenBos, 2007). With respect to the *DSM-5*, some Work Groups were said to be similar in opinion and limited in diversity (Franklin, 2010; Kramer, 2011). This would be fertile ground for group polarization to occur. *Groupthink* is the type of thinking that occurs when the desire for harmony in a decision-making group overrides good judgment (VandenBos, 2007). Antecedents of groupthink include: (a) insulation of the group; (b) an absence of methodological decision-making procedures; (c) lack of variety among group members; (d) the need to make urgent decisions; and (e) rationalizing group decisions rather than discussing possible alternatives. It is quite possible that these antecedents were present in some of the Work Groups: (a) The confidentiality agreement and alleged secrecy, discussed under *Controversies Related to the Task Force*, suggests that the Work Groups were insulated. (b) Task Force had not developed an a priori methodology for Work Groups to follow (Skodol, 2012). (c) Franklin (2010) noted that the *DSM-5* Paraphilias Subworkgroup had limited diversity. The Chair of the Subworkgroup, Ray Blanchard, PhD, was also is the first author of the research study upon which the pedohebephilia proposal was based. Kenneth Zucker, PhD, Chair of the *DSM-5* Sexual and Gender Identity Disorders Work Group, was the chief psychologist where the research was conducted. Further, Blanchard and Zucker served as editors of the journal that published the study. Kramer (2011) observed that all members of the Subworkgroup were specialists whose interest was restricted to that of controlling sex offenders. As a second example, Lilienfeld, Watts, and Smith (2012) observed that the PD Work Group consisted of scholars who were all similar in their theoretical orientations. Lilienfeld et al. cited research showing that groups with more diversity tend to make better decisions and are less prone to groupthink. (d) Critical publication deadlines were missed (Frances, 2011a), so it is likely that there was an urgent need to make decisions. (e) The Work Groups rationalized decisions without considering alternatives according to Frances (2010c), who stated that the rationales provided for all the *DSM-5* proposals shared "An uncritical and 'cheerleading' presentation of the data and arguments that would support the proposal" (para. 3). This brief analysis raises the possibility of a groupthink phenomenon. Frances (2010b) asked, "How can such smart and scrupulous people make so many bad suggestions?" (para. 36). Groupthink and group polarization might be the culprits. Social psychologists should examine how the Work Groups functioned and provide advice as to how to prevent common problems associated with group processes.

Some of the controversies discussed under *Controversies Related to Proposed Disorders* relate to the thinking of Task Force and Work Group members, and to the thinking of clinicians. Consider the thinking of the former. Decisions are made when revising a *DSM*, and it is likely that the decision-makers will be subject to common cognitive errors. *Belief perseverance* involves clinging to one's initial conception after the basis on which it was formed has been discredited (VandenBos, 2007). Regarding APS, early studies suggested that conversion rates to full psychosis were 40−50%, but more recent studies have reported numbers as low as 12% (Corcoran et al., 2010). Belief perseverance might have caused the Work Group to hold to their original decision to include APS based on the earlier studies, despite more recent disconfirming research. *Confirmation bias* occurs when there is a tendency to search for information that confirms one's preconceptions (VandenBos, 2007). This cognitive error might have been operating when the Work Group members who proposed PCD assumed that men who showed a penile response to sexual activity depicting coercion meant that these rapists were aroused *only* by the coercive elements of the stimuli (Knight, 2010). The thinking of some members of the PD Work Group might reflect confirmation bias as well. Livesley (2012) observed that the Work Group members were aware of evidence that PDs do not fit a categorical model, yet they proposed a categorical−dimensional hybrid model (and ultimately a categorical model) rather than a pure dimensional model. Livesley examined the publications of the Work Group members and found that the five PDs initially proposed for retention correlated with the research interests of the Work Group members (also see Blashfield & Reynolds, 2012). Hence, the members might have focused only on evidence that confirmed their bias. Experts in cognitive psychology should inform the field of typical cognitive errors and recommend strategies for minimising them during future Work Group deliberations. Now consider the thinking of clinicians. *Categories*, *dimensions*, and *prototypes* all were proposed for conceptualising the *DSM-5* PDs. As discussed under *Controversies Related to Proposed Disorders*, opinions as to how clinicians think are quite mixed. Cognitive psychologists have the expertise to confirm whether clinicians think best in categories, dimensions, or prototypes, and to inform the APA on how to create a diagnostic system that balances validity and clinical utility.

The *DSM-5* Task Force intended to move toward an etiologically based system of classification with a focus on biology (Kupfer & Regier, 2011). Even the definition of a mental disorder proposed by Stein et al. (2010) was alleged to reflect a commitment to biological reductionism (McLaren, 2010). Others argued that it would be decades before research on the pathophysiology of mental disorders has any impact on clinical practice (e.g., Frances, 2009b). Biopsychologists have the expertise to review the literature and to offer an opinion as to whether its paradigm-shifting plan is timely or premature.

Steven S. Sharfstein, MD (2005), past president of the APA, stated that, "as a profession, we have allowed the biopsychosocial model to become the bio-bio-bio model" (p. 3). Given the intention to develop a classification system based on a presumed biological etiology of mental disorder, clinical and counselling psychologists who believe that the data support a biopsychosocial etiology should contribute to the debate.

The Task Force considered the introduction of dimensional measures to be a defining feature of *DSM-5* (Regier et al., 2009). However, Phillips (2010b) predicted that working clinicians would not consider the instruments proposed for use in the *DSM-5* to be

worth the time involved in administering them. Frances (2010d) and Jones (2012b) suggested that the Task Force did not have the time or psychometric expertise required to construct the proposed measurement scales, which are now in Section III for further study. Psychologists with expertise in psychometrics should examine these measures and, if warranted, inform the APA on how to construct measures of the constructs of interest that are reliable, valid, and possess clinical utility. Clinical and counselling psychologists should examine the contention by Frances (2010d) that well-developed rating scales already exist and inform the APA about any instruments that might have good reliability and validity, and possess greater clinical utility.

It is arguable that many of the controversies regarding the new disorders and revised diagnostic criteria arose in large part because of the inadequate definition of a mental disorder. The controversy regarding *DSM-5* medicalizing normative variation and increasing false-positives might not have arisen if a definition existed that clearly distinguished normality from psychopathology (Frances & Widiger, 2012). The concerns of First and Wakefield (2010) and McLaren (2010), discussed earlier, regarding the definition proposed by Stein et al. (2010), are but one illustration of the difficulty mental health professionals have had with the elusive definition. As a second illustration, First (2008) observed: "It is important to clarify from the outset that the criteria for determining whether a behavior is a 'vice' (i.e., whether it is illegal or immoral) is not equivalent to the criteria for determining whether a behavior is indicative of a mental disorder" (p. 36). However, this issue arose repeatedly in our discussion of hypersexual disorder, PCD, pedohebephilic disorder, and the behavioural addictions, where Work Groups argued that these are mental disorders and opponents argued that they are vices. As a third illustration, Frances and Widiger (2012) argued that, "Historically, conditions have become mental disorders by accretion and practical necessity, not because they met some independent set of abstract and operationalized criteria" (p. 111). Mental disorders are social constructs, they argued, and consequently must be defined pragmatically according to the useful purposes they serve. The real challenge is not to create a definition, but rather to hold the line against diagnostic inflation by resisting the addition of conditions that have fuzzy boundaries with normality and that fail the test of *primum non nocere* (first, do no harm) (Frances & Widiger, 2012). The task would be challenging, but if clinical and counselling psychologists could construct a definition that better distinguishes mental disorder from normality, this would be a momentous contribution to *DSM-5* and to the field. Alternatively, if Frances and Widiger (2012) are correct, clinical and counselling psychologists should direct their efforts to finding the line that separates practical necessity from diagnostic inflation (Batstra & Frances, 2012).

Many authors expressed concerns about the Task Force's methodology (e.g., Frances, 2009a, 2011a). It was alleged that the Task Force had placed no constraints on the amount of change that could occur during the revision of *DSM-5*, and that the Work Groups had been encouraged to think innovatively, with little guidance. Skodol (2012), a member of the Task Force, confirmed these allegations: "For the first year or so, everything was on the table, and Work Groups were encouraged to think outside the box. . . . For the first year or so of Work Group meetings, there were no guidelines for change for DSM-5" (p. 324). Social and industrial−organisational psychologists with expertise in leadership are well suited to suggest ways to promote good leadership and adherence to methodological processes in a way that inspires confidence in concerned observers. Additionally, the manner in which the field trials were conducted and data analysed were controversial. Under *Controversies Related to the Task Force*, we summarised Jones's (2012a) critique of the field trials. The problems with the settings, attrition rate, missed deadlines, and the failure to evaluate validity and prevalence rates cannot be excused. The decision to change the customary way of conducting diagnostic reliability tests and interpreting kappa values might have merit, but there is no evidence that the Task Force acquired any external opinion as to whether the problems solved by the change would outweigh the problems caused by the discontinuity with the method used in *DSM–III* and *DSM–IV*. Psychologists with expertise in medical research design and statistics should evaluate the field trials and inform the field as to whether the new or old field trial methodology has 1 greatest value.

The Disorders and Diagnostic Criteria

Some of the new disorders proposed for *DSM-5* were accepted for inclusion. Those that were not could be diagnosed as other specified or unspecified disorders, the *DSM-5* replacements for the not otherwise specified designation (APA, 2013), or considered again during planned incremental updates (APA, 2010a). Consequently, we discuss both.

The validity of many of the new *DSM-5* disorders was intensely disputed. For example, Frances and Widiger (2012) (see *Controversies Related to the Task Force*) argued that five new disorders are defined by symptoms that are common in the population and therefore medicalize normality. They also argued that the reduced diagnostic thresholds for four established disorders have the potential to trigger epidemics of false-positives with associated problems due to medication side effects, stigma, and insurability. Clinical and counselling psychologists have the expertise to review the literature, to do the research, and to determine the veracity of these claims.

First (2010c), Frances (2010e), and Kaliski (2012) argued that the forensic risks of some disorders were not adequately considered. Frances (2010b) lamented that TDD would be used by lawyers as an excuse for misbehaviour and lead to unforeseen forensic problems. Consider PCD and pedohebephilic disorder. Although not included in *DSM-5* by name, they could be diagnosed as other specified paraphilic disorder (APA, 2013) or included in the next iteration of *DSM-5* (APA, 2010a). If so, Frances (2011b) and Frances and First (2011) alleged that they could be misused to civilly commit SVPs after their prison sentence are served, because it has not been established that either are valid diagnoses. Consequently, more research is needed to determine if PCD and hebephilia are mental disorders and how the presence of either in the *DSM* will influence the civil commitment of SVPs. Problems also arise with PTSD from a legal perspective. First (2010c) was concerned about the broadness of the range of qualifying traumatic stressors, and the increased opportunity this gives to individuals to malinger when reporting subjective symptoms in personal injury cases. Kaliski (2012) argued that many of the new *DSM-5* disorders will not satisfy the requirement of forensic utility. Forensic psychologists have the expertise to examine these

disorders and diagnostic criteria, and to evaluate their forensic risks.

School psychologists are involved in the identification and diagnosis of children with psychological problems (Wodrich, Pfeiffer, & Landau, 2008). Several controversial disorders (e.g., ADHD, ASD, disruptive mood dysregulation disorder, substance use and addictive disorders) are likely to arise in school. School psychologists are in a unique position to review these disorders and diagnostic criteria and to inform the APA as to their clinical utility.

Ethical issues. The revision of the *DSM* is replete with ethical questions that require consideration. Psychologists are users of the *DSM* and, consequently, psychological ethicists should contribute to the resolution of these issues. Psychologists might have an ethical obligation to do so. The *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2010) states in its Preamble that psychologists are committed to improving the condition of society. In doing so, they may perform the role of social interventionist. Principle IV of the *Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) states that psychologists have a responsibility to society, that psychologists should promote human welfare, and that psychologists should act when they possess expert knowledge relevant to important societal issues. Because the *DSM-5* will have a significant impact on society, these ethical principles imply that psychologists should use their expertise to address the *DSM-5* controversies.

We discussed the conflicts of interest controversy that originated with *DSM–IV* and that raised questions regarding pharmaceutical industry influence on the *DSM-5*. There is no doubt that the industry influences the prescribing habits of physicians (Katz, Caplan, & Merz, 2010). Consequently, it is likely the industry will be interested in, and support drug research on, the new mental disorders in *DSM-5* (Raven & Parry, 2012). Similarly, the industry will support a change from the current atheoretical approach to classification to one based upon the presumption of a biological etiology, because this will generate increased profits. Kupfer and Regier (2009) assured that the *DSM-5* disclosure policy was sufficient to limit industry bias, but others are less certain because a substantial number of Task Force members had industry ties (Cosgrove & Krimsky, 2012; Pilecki et al., 2011). Katz et al. (2010) reviewed research showing that even small gifts from drug companies can influence the behaviour of recipients. Psychological ethicists should examine the extent to which drug companies might have influenced the *DSM-5*, and might influence the incremental updates (APA, 2010a).

We discussed under *Controversies Related to the Task Force* the medicalization of normality controversy. Batstra and Frances (2012) espoused the need to prevent further diagnostic inflation due to *DSM-5*. The additions to the *DSM-5* of new disorders and lower diagnostic thresholds have significant implications for society. A psychiatric diagnosis can affect self-esteem, employment, insurability, parental access, adoption, and military service, among other things. Moreover, the extent to which the *DSM-5* and its future iterations might promote the unnecessary use of dangerous medication by medicalizing normative variation needs to be examined and managed. This concern is made salient by the fact that prescription drugs now cause more unintentional deaths in the United States than do street drugs (Batstra & Frances, 2012). Psychological ethicists should examine whether the APA's disclosure policy, the new *DSM-5* disorders, and the lowered diagnostic thresholds for some disorders are in the public interest as opposed to the interest of researchers and the pharmaceutical industry, and offer their conclusions to the field.

A number of proposed disorders come with their own specific ethical dilemmas. The British Psychological Society (2011) and Frances (2010b) argued that the behavioural addictions are best conceptualised as life choices, not mental disorders. These authors have suggested that medicalizing gambling disorder, and possibly other problems such as internet gaming disorder, currently in Section III for further study, could be harmful. Turning to ASD, there is consensus that this diagnosis is more stigmatizing than the diagnosis of AD (e.g., Szatmari, 2011). Even if data suggest that Asperger's is part of ASD, this finding might not justify the harm done by forcing those with Asperger's to accept a more stigmatizing diagnosis. Similarly, the evidence for considering GD a mental disorder needs to be weighed against the harm done by the stigma. Meyer-Bahlburg (2010) observed that calling transgenderism a mental disorder has been to the detriment of transgender persons in divorce proceedings, custody disputes, employment, and serving in the military. GD could be moved to the chapter for nonmental disorders (i.e., Other Conditions That May Be a Focus of Clinical Attention), or conceptualised as a medical problem, as suggested by Meyer-Bahlburg (2010). Alternatively, GD could be viewed as a normative variation and be removed from the *DSM*, as homosexuality was. If removed, a solution as to how adults with GD would obtain access to the accepted medical treatments would be required. Consider also the paraphilias. According to the *DSM-5*, a person can be ascertained as having a paraphilia without having a paraphilic disorder (APA, 2013). Labelling a person with the condition of paraphilia, in the absence of a disorder, solely for the convenience of researchers might not be ethically justifiable. Research is required to determine the possible psychological sequelae of ascertainment. Regarding the PDs, Tyrer, Crawford, Mulder, and ICD-11 Working Group for the Revision of Classification of Personality Disorders (2011) stated that *DSM–IV* PDs were underdiagnosed due to practitioners' concerns about stigmatizing patients. Skodol (2012) confirmed that the Work Group had considered changing the name of the PDs to something "more meaningful and less pejorative" (p. 321), but they were unable to agree upon an alternative. Obtaining agreement would require a herculean effort, but if it reduced stigma and thereby increased treatment availability to those who need it, the effort would be warranted. Research on the effect of a name change is needed. Regarding PTSD, a major focus in the literature has been on conceptual bracket creep and how to limit the problem of malingering. However, because the definition of a traumatic stressor is limited, some individuals who truly have been traumatized will become ineligible for a diagnosis of PTSD. Ethically, the greater error might be missing true-positives, not increasing the risk of malingering. Research is required to determine how many true-positives would be missed with the A criterion in *DSM-5*. Psychological ethicists should examine all these issues.

Conclusion

The *DSM-5* controversies indicate that successful incremental updates of *DSM-5* will require a consideration of more than just empirical research. As a human endeavour, it will require the

consideration of the many process variables that affect the revision process. Psychologists with expertise in areas reviewed above are exceptionally qualified to analyse the *DSM-5* controversies and to recommend solutions to the problems that have arisen and are likely to arise again unless they are recognised, acknowledged, and solved. We have suggested that psychologists should study the *DSM-5* controversies not only because they have the ability to do so, but also because they have an ethical duty to use their skills in a manner that will benefit society. The voices of a small number of psychologists could go unheard. However, Frances (2010a, para. 21), who is uniquely positioned to know because of his experience with *DSM–IV*, has argued that the APA will be "exquisitely sensitive" to the opinions of professional research-oriented organisations within psychiatry, psychology, and the neurosciences. Consequently, if psychologists' recommendations come from credible organisations such as the American Psychological Association, the Canadian Psychological Association - Société canadienne de psychologie, and The British Psychological Society, perhaps via their respective divisions and sections, it is likely that they will be heard.

Résumé

L'American Psychiatric Association (APA) a publié le *DSM-5* en mai 2013. Le processus de révision a suscité la controverse. Dans la première partie de cet article, nous présentons un survol des éléments controversés dans les démarches de l'APA et du groupe de travail chargé du processus de révision. Ces éléments incluent des allégations de secrets, des accusations de conflits d'intérêts, de l'appréhension à l'égard de la promesse d'un changement de paradigme, des préoccupations au sujet de la définition de trouble mental, des accusations de médicalisation de la normalité et des allégations de méthodologie déficiente. Dans la deuxième partie, nous résumons les différends au sujet de certaines des modifications apportées aux troubles et aux critères de diagnostic dans le *DSM-5*. Dans la troisième partie, nous arguons que les différends concernant l'élaboration du *DSM-5* auraient pu être prévus et évités. Étant donné qu'il y aura des mises à jour ponctuelles du *DSM-5* dans un avenir rapproché, (American Psychiatric Association, 2010. *APA modifies DSM naming convention to reflect publication changes*, Washington, É.-U. : Auteur), nous proposons que les psychologues ne participant pas au processus de révision utilisent leur expertise unique en vue de résoudre certains des différends qui ont marqué l'élaboration du *DSM-5* et, ainsi, de faciliter l'établissement de la prochaine version de cet ouvrage.

Mots-clés : *DSM-5*, controverse, psychologues.

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