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Citation


Abstract

This paper describes some of the most common criticisms of the diagnostic system used in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*), and a description of some of its benefits and limitations. While there are many legitimate criticisms that can be made about the *DSM-5*, it remains the only manual that counselors, psychologists, and psychiatrists are expected to use to diagnose their clients’ mental disorders. These professionals should have an understanding of both the advantages and the limitations of the manual so they can use it responsibly.
The *DSM-5* (American Psychiatric Association, 2013) replaced the *DSM-IV-TR* (American Psychiatric Association, 2000), and is the diagnostic manual used by counselors, psychologists, and psychiatrists to guide their diagnostic decision-making. Counselors have the responsibility to learn the *DSM-5* and use it responsibly (American Counseling Association, 2013; Dailey, Gill, Karl, & Barrio Minton, 2014). The *DSM-5* has been the object of much criticism regarding its validity, its clinical utility, and its influence on society (Frances, 2013a; Greenberg, 2013; Kirk, Gomory, & Cohen, 2013). Past editions of the manual have also been the subject of intense analysis and evaluation (Caplan, 1995; Eriksen & Kress, 2005; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997; Shelton, 1993).

The purpose of this article is to address some of the common criticisms of the *DSM-5* and the biomedical model upon which the manual is based. An objective appraisal reveals both advantages and disadvantages of its use by counselors. While the manual certainly has deficiencies and limitations, it is the only classification system addressing mental disorders in current widespread use, and in most professional settings counselors are expected to use it (Dailey, Gill, Karl, & Barrio Minton, 2014). The format of this article is to state a common criticism or question about the manual followed by the author’s analysis. The abbreviation *DSM* will be used to refer to the basic nosology used in *DSM-III, III-R, IV, IV-TR, and 5*, and specific editions will be referred to by edition number.

Criticism: The diagnosis of mental disorders is too subjective (Greenberg, 2013). How valid are the disorders and their diagnoses? Do mental disorders really exist?

There are no biomarkers for psychopathology, even for schizophrenia; there are no lab tests, blood tests, brain scans, or other such tests to determine the presence of a mental disorder (Paris, 2013). So some subjectivity in diagnosis is inevitable and unavoidable. In their diagnosis of mental disorders clinicians rely to a great extent on patients’ self-reports of their symptoms, which are themselves subjective and may be unreliable (Morrison, 2014a).

When defining mental disorders the experts are trying to define conditions
that may not exist in nature in pure forms, and there is no clear line between normal and abnormal (Eriksen & Kress, 2005). It is true that the diagnosis of mental disorders is somewhat subjective, but that is the state of the art and the science of psychodiagnosis at the current time (Morrison, 2014b). As more scientific research is conducted on the etiology and physiological correlates of mental disorders, diagnosis will no doubt become more objective. However, since some mental disorders are characterized by functional rather than organic impairment, the diagnosis of some mental disorders will most likely remain subjective for the foreseeable future (Friedman, 2013).

Criticism: The diagnosis of mental disorders in the DSM-5 is based on symptoms, not causes. The manual provides checklists of the features of the various disorders, but little information on what causes the disorders (American Psychiatric Association, 2013). If you do not know what causes a disorder, how do you know how to treat it?

It is true that diagnosis is based on symptoms, not causes. That is simply because, in most cases, the specific causes of mental disorders are unknown (Dziegielewski, 2015). So treatment, including both medications and psychotherapy, is an attempt to address the known symptoms and the unknown causes.

It is not always necessary to know the cause of a problem in order to solve it. Psychological treatments have been shown to help people with many mental disorders, even though we do not always know the cause of the disorder (Lebow, 2008). Medications help many people with mental disorders, even though we often do not know how or why they work, just as we do not know why aspirin helps with headaches (Maxmen, Ward, & Kilgus, 2009). Should we stop treating people with mental disorders until we know the exact causes of the disorders?

This situation in psychology and counseling is no different from the medical treatment of many physical disorders. Since the cause of many physical disorders is unknown, physicians sometimes simply try different medications, or other treatments, one after the other, hoping one of them will help, and they often do help. Likewise, counselors and psychologists cannot be faulted for trying a new approach after their initial treatment has failed to produce the desired results. Knowing the cause of a mental disorder is not always essential to helping the person who has the condition.
Criticism: The diagnosis of mental disorders is not scientific enough.

While it would be desirable for the DSM nosology to be more data-based than it is, the counterargument is that the diagnosis of mental disorders is as scientific as it is possible to be, based on the current research (Belluck & Carey, 2013). Most of the changes in the DSM-5 compared to the DSM-IV-TR were based on the scientific research that was done between 2000, when the DSM-IV-TR was published, and 2013, when the DSM-5 was published (American Psychiatric Association, 2013). No doubt research will continue, requiring future revisions in the manual as our knowledge of mental disorders increases.

The process of determining whether conditions are mental disorders is not based only on scientific research. Diagnoses and their criteria are decided by committees of experts (Paris, 2013). The committee members are presumed to base their input on scientific research and their clinical wisdom, but, inevitably, opinions get mixed in. Given the lack of specific biomarkers for mental disorders, as mentioned earlier, some subjectivity is unavoidable, and there is always room for legitimate disagreement about the validity of mental disorders and the criteria used for their diagnosis.

Criticism: There are several examples of diagnoses being added to or removed from the diagnostic manual based on social pressure from special interest groups and other factors that should not affect the supposedly scientific process of writing the manual.

It is true that the inclusion or exclusion of disorders from the manual has been influenced by extraneous factors, and inclusion of a disorder in the manual can have significant social consequences (Frances, 2013a). For example, at one time homosexuality was considered a mental disorder. Due in part to social pressure and public protests, in 1973 the American Psychiatric Association voted to remove homosexuality from the manual; the vote was fairly close (Kutchins & Kirk, 1997). The change influenced social legislation and cultural norms. The point is that this change was based on a vote of the opinions of psychiatrists rather than on scientific research. This shows the extent to which the definition of “disorder” can depend on the social climate of opinion.
Another example is the inclusion of Attention-Deficit/Hyperactivity Disorder (ADHD) in the manual. There is a lot of debate about whether this disorder is over-diagnosed (Frances, 2013a). Of course, to know whether it is over-diagnosed we would have to know the real prevalence of ADHD in the population, but that is extremely difficult to determine. Nevertheless, the inclusion of ADHD in the manual has resulted in millions of prescriptions for medications to treat it. Medication does appear to help some children, but of course it should be prescribed only based on a thorough evaluation of the child (Maxmen, Kilgus, & Ward, 2009). Parents who prefer to refuse medications for their children are free to do so.

It is inevitable that the DSM diagnostic system will be influenced by social factors, and that it will have social consequences. It is probably not possible to solve this problem, since every time the manual is changed there are both intentional and unintentional consequences. It could be argued that abolishing the DSM because it has an influence on society would be like throwing the baby out with the bathwater, resulting in chaos regarding the diagnosis of mental disorders, and making it more difficult for clients to obtain needed psychological services.

Criticism: Diagnostic labels are powerful and may hurt people.

It is true that diagnostic labels have the potential of being stigmatizing, and efforts should be made to minimize such stigma (Byrne, 2000). However, diagnostic labeling does not necessarily have a negative effect (Ruscio, 2004). Some people feel better when their condition is diagnosed. Imagine that you had severe, distressing psychological symptoms and sought help from a counselor or clinician. It would probably be a big relief to hear that your condition has a name, that you are not the only person who has it, and that there is a treatment that can help. The potential stigma from being diagnosed with a disorder might be outweighed by the positive outcomes resulting from receiving diagnosis and treatment (Pies, 2013).

On the other hand, it is true that labels are powerful and can have negative effects (Gray, 2002). If someone knew you had a mental disorder, they might treat you differently. Each individual has to decide whether getting help for a problem is worth the risk that they may receive a diagnosis that could be stigmatizing. It should be noted that
since medical and psychological diagnoses are confidential, few people would know someone had a diagnosis unless they were told by the person. One exception would be insurance companies, which require diagnostic codes in order to pay for treatment. Even here, some people have the option to self-pay for their evaluation and treatment, so that the diagnosis would remain confidential.

There is a fair amount of research that suggests that when people who have a mental disorder experience stigma it is not because they have a diagnostic label, but because their behavior appears unusual or bizarre to the people around them (Ruscio, 2004). The fact that their behavior has a diagnostic label is a small contributor to their stigmatization.

Stigmatizing people who have a mental disorder is wrong. Having a mental disorder should not be any more stigmatizing than having a physical disorder such as diabetes or heart disease. Educating the public about this fact will do more to eliminate stigma that doing away with the diagnosis of mental disorders.

Criticism: The pharmaceutical industry has had too much influence on the psychiatrists who work on the DSMs (Greenberg, 2013). Pharmaceutical companies want more disorders to be added to the DSM so they will make more money selling medications.

It is true that the more disorders there are in the DSM, the more psychiatric medications will probably be sold. The large pharmaceutical companies had too much influence on the American Psychiatric Association (APA) in the development of the DSM-IV (Frances, 2013a). The APA instituted new policies to minimize the influence of the pharmaceutical industry on the development of the DSM-5 (American Psychiatric Association, 2013). Much of the work of psychiatrists involves prescribing medications, which is the most common treatment for mental disorders. As the DSM is revised in future years, policies should be implemented to separate the scientific process of defining mental disorders from the makers of pharmaceutical treatments for mental disorders. The goal would be to have no conflicts of interest.

Criticism: The DSM pathologizes too many people.
Some people complain that according to the criteria in the *DSM*, as many as one-quarter of the population has a mental disorder in any one year (Greenberg, 2013). That seems like a lot of people. It is in psychiatrists’ self-interest to create new disorders so there are more people who need treatment (Kirk, Gomory, & Cohen, 2013).

This criticism refers to the validity of the existence of the mental disorders described in the *DSM-5*. If the disorders actually exist, then they should be diagnosed so that people can get treatment for them. If the disorders do not exist, they should not be in the *DSM* in the first place. Only valid disorders (those that actually exist according to scientific research) should be included in the *DSM*. But of course, as mentioned above, determining the reality of mental disorders is not yet a strictly objective process.

It should also be noted that the list of mental disorders in the *DSM-5* includes some conditions that the general public may not realize are mental disorders. For example, insomnia is a mental disorder, sexual dysfunctions are mental disorders, and adjustment disorders are mental disorders (American Psychiatric Association, 2013). The substance use disorders (tobacco, alcohol, caffeine, cannabis, etc.) account for many millions of people in the U.S. who technically have a “mental disorder.” When these people are included, the fact that one-quarter of the population has a mental disorder at some time may not seem so extreme.

As evidence that the creators of the *DSM* do not simply invent new disorders in order to increase business for psychiatrists, consider the fact that many disorders that were suggested for inclusion in *DSM-5* were not included. Examples include internet addiction, sex addiction, shopping addiction, and other so-called behavioral addictions, which were not defined as mental disorders in the *DSM-5* because the research on these conditions is not sufficient to establish the diagnostic criteria. In addition, some of the disorders in *DSM-IV* were not included in *DSM-5* (American Psychiatric Association, 2013).

Criticism: The *DSM* makes it too easy to over-diagnose normal people; the *DSM* medicalizes problems in living. Adding so many disorders to the *DSM* has led to the pathologizing of everyday life.
Disorders that are not valid should not be included in the manual. However, counselors and clinicians are not usually in a position to judge the validity of the disorders, although they can access the original research to help them make such a judgment (American Psychiatric Association, 2013). Counselors and psychologists are typically in the position of using the manual based on the assumption that the disorders are valid. Given the fact that the DSM nosology is widely accepted and no other system has established itself as any more valid than the DSM, clinicians are expected to learn it and use it. Clients should not be given a diagnosis if their symptoms do not substantially meet the DSM criteria for the disorder. Clinicians should be careful not to over-diagnose or under-diagnose mental disorders. This is, admittedly, not always easy, and honest mistakes will sometimes be made. Only good quality clinical training and experience can help prevent such mistakes.

It is true that there is a danger that common human concerns and problems will be defined as mental disorders. Conditions should only be defined as mental disorders if they meet accepted standards for validity and cause the person significant distress or impairment. These two factors are currently part of the criteria for almost all mental disorders in the DSM-5 (American Psychiatric Association, 2013).

Criticism: The DSM-5 is based on the medical model, and it assumes that mental disorders are medical disorders. Why should psychologists and counselors use a manual designed mainly by and for psychiatrists?

Some psychologists and counselors object to the domination of the medical model in American psychiatry, which is the foundation of the DSM (Beutler & Malik, 2002). They would like to be able to get payment for providing counseling and psychotherapy to clients who have problems in living, such as marital problems, vocational problems, uncomplicated grief, etc. The DSM-5 calls these “V-code” problems “conditions that may be a focus of clinical attention “ but specifically states that these conditions “are not mental disorders” (American Psychiatric Association, 2013, p. 715). Most third-party payers only pay for the treatment of mental disorders that are listed in the DSM, not the treatment of the “V-code” conditions.
The DSM has become the diagnostic reference book for various political, economic, scientific, and professional reasons. The American Medical Association and the American Psychiatric Association has much more power than the American Psychological Association or the American Counseling Association. Although some psychologists have proposed diagnostic systems that are not based on the medical model, their work has not gained much attention (Beutler & Malik, 2002). Counselors and psychologists who truly believe that the DSM is invalid and harmful to clients should not use it, since doing so would be unethical (American Counseling Association, 2014; American Psychological Association, 2002). Of course there would be consequences to opting out of the use of the DSM-5, including being unable to provide treatment to many clients who prefer to pay for their therapy via their health insurance policy.

Organizations such as the World Health Organization and third-party payers, including insurance companies, need a standardized system to collect data, and the DSM became that system. It is highly influential at present, but maybe in the future other, better diagnostic systems will be created and replace the DSM. Until then, psychologists and counselors need to know the DSM and be able to make diagnoses based on it.

Most psychologists and counselors probably agree with the psychiatrists that mental disorders do exist and that the manual does a pretty good job of naming and describing them (Caplan, 2013; Ginter, 2013; McElfresh, 1998). They just wish that insurance companies would be more liberal in paying for the treatment of conditions that are not defined as mental disorders, such as marital distress (Greenberg, 2013). It would be odd for counselors to complain, on the one hand, that the addition of new disorders to the DSM is “diagnostic inflation” (Frances, 2013c), while on the other hand they complain that they cannot get payment for treating clients for problems of daily living.

It would be nice if third-party payers would fund counseling and psychotherapy for everyone who wanted it, whether they had a mental disorder or a problem in living. However, given the lack of financial resources to provide unlimited assistance to everyone for every concern, it is likely that insurance companies will continue to restrict payment to people who need treatment for the more severe conditions designated as mental disorders in the DSM-5. Often they do cover treatment for mental disorders that
are considered relatively less serious, such as adjustment disorders, sexual dysfunction, and sleep disorders (Dziegielewski, 2015).

Criticism: The makers of the DSM-5 pretend that the diagnostic manual is much more valid than it really is.

Perhaps surprisingly, the developers of the DSM-5 (American Psychiatric Association, 2013) were careful not to overstate the validity of the disorders described in the manual. For example, consider these excerpts from the preface: The DSM-5 “is a classification of mental disorders . . . to facilitate more reliable diagnoses of these disorders” (p. xii). “Past science was not mature enough to yield fully validated diagnoses . . . . However, the last two decades . . . have seen real and durable progress . . . . The science of mental disorders continues to evolve.” (p. 5). The reliability of diagnosis has seen some progress, and research on validity has improved but still has a long way to go (Morrison, 2014a, 2014b).

The DSM-5 preface also states “A complete description of the underlying pathological processes is not possible for most mental disorders” (p. xii). This statement is a candid admission that the cause of most mental disorder is unknown. “Mental disorders do not always fit completely within the boundaries of a single disorder” (p. xii) and “the boundaries between many disorder ‘categories’ are more fluid over the life course than DSM-IV recognized” (p. 5). This explains why it is so challenging to establish the validity of mental disorders.

The manual states that “Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders, the most important standard for the DSM-5 disorder criteria will be their clinical utility . . . . “ (p. 20). In other words, until we know the cause of mental disorders, we will be severely limited in establishing their validity. So an important function of the manual is to ensure that when different clinicians refer to specific mental disorders they are all talking about the same thing (Dailey, Gill, Karl, & Barrio Minton, 2014).

The DSM-5 argues against the use of the manual as a “cookbook;” it states that use of the manual requires “clinical training” and “clinical judgment;” “it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder
diagnosis” (p. 19). A diagnosis should only be made “on the basis of the clinical interview, text descriptions, criteria, and clinician judgment” (p. 21). These cautionary statements should reduce the misuse of the diagnostic criteria, and thus increase reliability.

Criticism: The *DSM-5* is so flawed that psychologists and counselors should not use it. They should use the *International Classification of Diseases (ICD)* codes instead (World Health Organization, 2014). These codes are the same as those used in the *DSM-5*, and can be found on the internet for free.

The *ICD* codes are, indeed, the same as the codes in the *DSM-5*. One of the innovations in the *DSM-5* was the harmonization of its codes with the *ICD*. However, the *ICD* does not include any information other than the codes, such as diagnostic criteria, diagnostic features, prevalence, risk factors, etc. It is not really feasible to use the *ICD* codes without knowing the diagnostic criteria and features that are included in the *DSM-5*. Only a clinician who understands psychopathology and already knows how to diagnose mental disorders according to the *DSM-5* could go directly to the *ICD* codes. Thus, the *ICD* is not a substitute for the *DSM-5*.

Criticism: The *DSM-5* is not an improvement on the *DSM-IV*.

It would be very difficult to support this criticism. The *DSM-5* draws on many years of research that was not available to the writers of *DSM-IV*, which was published in 2000. Some of the improvements include the following (American Psychiatric Association, 2013). The manual was re-organized to reflect the developmental and lifespan approach, which should appeal to counselors. Gender and cultural issues were integrated in the descriptions of the disorders more fully. The latest scientific research in genetics and neuroimaging was used to improve the disorder descriptions. Asperger’s disorder and pervasive developmental disorder were consolidated into autism spectrum disorder, since there was little evidence to support their separation. The diagnostic criteria for bipolar and depressive disorders were streamlined. The substance use disorders were restructured for consistency and clarity.
The multiaxial system in *DSM-IV*, which many clinicians did not use, was eliminated from *DSM-5*. The Global Assessment of Functioning (GAF) scale, which had poor reliability and validity, was replaced with the Disability Assessment Schedule. *DSM-5* includes helpful new cross-cutting symptom measures, new guidelines for cultural formulation interviews, and an optional alternative model for the diagnosis of personality disorders (American Psychiatric Association, 2013).

In contrast to the *DSM-IV*, the *DSM-5* introduced a dimensional approach to diagnosis. This was a great advance, since many disorders are now thought to exist on a continuum, rather than as distinct categories. “Like most common human ills, mental disorders are heterogeneous at many levels” (p. 12). Many other improvements are described in the *DSM-5* itself (American Psychiatric Association, 2013).

Criticism: The *DSM-5* is not as good as it should be.

It is true that the *DSM-5* is not anywhere near perfect, but no one has said it is, and it is the only diagnostic system we have that has gained general acceptance. Although there are many valid criticisms of the *DSM* nosology and the *DSM-5* specifically, many experts believe that the criticism has been exaggerated and based on misunderstandings about what the manual is designed to do (Caplan, 2013; Dailey, Gill, Karl, & Barrio Minton, 2014; Gintner, 2013; McElfresh, 1998; NHS Choices, 2013). Even the criticisms of the *DSM-5* by the American Counseling Association were minor and relatively inconsequential (Locke, 2012). While there was intense criticism of the proposed *DSM-5* prior to its appearance, since its publication much of the criticism has evaporated, suggesting that the critics’ catastrophic expectations were not fulfilled.

All counselors and psychologists should learn how to use the *DSM-5* ethically and intelligently, without exaggerating its faults or its benefits. Several good guides on how to use the *DSM-5* responsibly and with an understanding of its advantages, disadvantages, and limitations are available (Daily, Gill, Karl, & Barrio Minton, 2014; Dziegielewski, 2015; First, 2013; Frances, 2013b; Morrison, 2014a, 2014b; Paris, 2013; Paris & Phillips, 2013). Both the American Counseling Association and the American Psychological Association have sponsored continuing education workshops on the use of the *DSM-5*. 
Most Americans pay for their counseling and psychotherapy via their health insurance policy, and insurance companies typically require the use of standardized diagnostic codes. Counselors will be expected to use the DSM-5 until something better comes along (American Counseling Association, 2013). It should be used cautiously and humbly, with full awareness that our diagnostic decisions can have a significant effect on clients’ lives. Our clients have a right to expect that we will use the diagnostic system accurately, ethically, and responsibly for their benefit.

References


