

# Residents' Journal

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*The following is an interview with Jan Fawcett, M.D., on "Mood Disorders and DSM-V," conducted by Todd Young, M.D. Dr. Fawcett served as the Stanley Harris, Sr., Chairman of the Department of Psychiatry at Rush Medical College in Chicago for 30 years and currently is Professor of Psychiatry at the University of New Mexico in Albuquerque. He is a member of the DSM-V Task Force and Chair of the Mood Disorders Work Group. Dr. Young is a second year psychiatry resident at the University of New Mexico in Albuquerque and the Resident Editor for this issue.*

**Dr. Young: How have you approached assembling the DSM-V Mood Disorders Work Group? What goals do you have for the work group?**

*Dr. Fawcett:* My goal is to involve people who can contribute expertise in the fundamentals, from descriptive nosology and the natural course of illness to genetics and functional neuroimaging. We also have the opportunity to appoint consultants and advisers from various disciplines to our committee. These consultants are made available to the committee so we can decide whether our advice is valid or not. The primary committee is now assembled and we're currently in the phase of appointing consultants.

I would like the members of my committee to come up with assertions. For instance, if I want to assert that there is a spectrum of anxiety and depression, from very mild to severe, and that different treatment is needed for the different ends of the spectrum—well, what evidence can I come up with to support that? What if someone else says there is no evidence for that assertion—well, what evidence do *they* have to support that? Our committee will review available datasets for the next few years. Then, the evidence we have collected will be laid out (such as we can gather it, since you can collect a lot of data that do not inform the questions you are asking). In the end, a decision will have to be made about the weight of it all.

**Dr. Young: What themes have driven the development of DSM?**

*Dr. Fawcett:* Prior to the development of DSM-III, psychiatric nosology was essentially based on psychoanalytic theory. With the publication of DSM-III in 1980, there was a historic paradigm shift to a far more descriptive approach to nosology. DSM-II was built on many different theoretical assumptions. For example, Adolf Meyer advanced the notion that symptoms and

illnesses are reactions to events, rather than purely endogenous conditions. As a trainee, a supervisor once told me that my patient's diagnosis was depression, despite the fact the patient had no signs or symptoms to suggest it, simply because he had sustained a loss! Things were very vague then, but they have changed.

DSM-III was really born from the Feighner criteria out of Washington University in St. Louis. The group there was very empirically oriented, at a time when nearly everyone else was relying on psychoanalytic theory. They were very scientific about nosology and interested in diagnostic validity.

Eventually, these criteria were adopted as the Research Diagnostic Criteria for the Collaborative Depression Study. In time, the research criteria evolved into DSM-III through the work of Eli Robbins and Robert Spitzer. Robbins represented St. Louis and the Feighner Criteria. Spitzer was a young, energetic academic from Columbia who was interested in computerized diagnosis and the refinement of nosology. Together they oversaw the evolution of the Research Diagnostic Criteria into DSM-III. DSM-IV saw some adjustments (e.g., the course and timeline of illness), but the essence has remained the same.

**Dr. Young: What major changes would you like to see incorporated into the mood disorder criteria of DSM-V?**

*Dr. Fawcett:* I would like to see symptom severity brought back into DSM. Practically speaking, there is a problem with getting multiple providers to report symptom severity reliably when they are not trained to do so. So severity has effectively been left out in the interest of clinical utility, while symptom presence and number of symptoms were translated into DSM-III. Admittedly, it was a very good thing for psychiatry to become more descriptive, but it bothers me that a person can have major depression and can be either working as an executive or in restraints in an inpatient unit and have the same diagnosis. DSM does not discriminate enough for me without the notion of severity. Residents lose something in their training because they are not really encouraged to consider symptom severity. Unfortunately, the focus remains simply on symptom presence or absence.

Anxiety severity is also a special interest of mine, since I think it predicts a lot. During the development of DSM-IV, a diagnosis of "mixed anxiety-depression" was considered. This diagnosis was a subsyndromal combination of depression and anxiety often seen in general practice. Studies



showed it to be associated with considerable disability, so it deserved to be diagnosed. Unfortunately, it was not put in as an official diagnosis, but was instead adopted as a DSM-IV research diagnosis. In recent years a lot of data have shown us that full major depression with comorbid anxiety has a rather poor outcome, including high rates of suicidal behavior. However, we are still trying to figure this thing out—is it subsyndromal or is it a very serious form of depression? Or could it be both, depending on the dimensions?

During early work on DSM-V, I attended a meeting in London to explore these very questions. Some very interesting studies were presented which examined the overlap between anxiety and depression and their shared genetic risk. Still, I am not convinced that generalized anxiety disorder and depression are the same. I see that they are closely related, with a lot of overlap, but either may still exist alone.

**Dr. Young: How will you approach incorporating genetic and imaging data into DSM-V?**

*Dr. Fawcett:* Geneticists are finding interesting things, but there is the current problem of genes coding across several diagnostic categories. For example, there are at least four genes that code for both schizophrenia and bipolar depression. Some genes have been identified that code for psychosis, but there is a lot of data showing how difficult it is to clinically discriminate psychosis across diagnoses. In factor analysis, they appear the same in different illnesses. There's so much overlap and the genes seem to go across spectrums rather than categories, which challenges the categories themselves.

Some in biological research believe that the functional imaging of individuals is still very variable. Although certain trends emerge from groups, the numbers are small. Some circuits are being identified for depression and certain anxious conditions, but the genes seem nonspecific. How much of this is ready to use? It will be exciting to go through the data and see.

Many are likely to say that we will have answers to these questions in the next 10 to 20 years. The lifespan of a DSM edition is about 15 years, so should we be looking ahead and adjusting this

edition so that we have a document that is not dead on arrival? Or should we find a way to make it a more dynamic document that can incorporate findings as they occur? I don't know what will happen, but this is one of the issues that make the working climate so interesting.

**Dr. Young: Do you think DSM will continue to evolve on a 15-year cycle, or would more frequent revisions allow a more dynamic document?**

*Dr. Fawcett:* I think we'll stay on the current schedule. Some wonder if we can find a way to incorporate new findings into the document in an ongoing fashion, without it being too complicated for clinical utility. One approach might be to publish a relatively simple clinician's edition with a separate, much more elaborate research edition. No decision has been made yet.

**Dr. Young: Is there any interest in simplifying DSM by reducing the number of diagnoses included in the text?**

*Dr. Fawcett:* It is true that some feel we have elaborated too many diagnoses and split them up so much that it is too easy to receive a diagnosis

**What's Your Opinion?** Send us your opinion about whether DSM has been helpful to your clinical training and practice. Send your brief comments to [ldevine@psych.org](mailto:ldevine@psych.org) by April 24, 2008. A selection of comments will be published in the next issue in the "Second Opinion" section.

today. When does a person become a "case," such that treatment is justified? Jules Angst has raised the issue of people who are chronically hypomanic who have neither impairment nor distress. Just because you have some diagnosable features in your behavior does not mean you are a "case." Just because you are unhappy, or demoralized with your life, does not necessarily mean you have a pathological illness. It raises the question, what is the right balance? How do you not miss the people who need treatment and deserve to have treatment supported, without including the people that may not require treatment for something that may be a natural part of the course of life?

**Dr. Young: What do you make of the ongoing explosion in the diagnosis of bipolar disorders?**

*Dr. Fawcett:* More people in need of treatment are being noticed, but at the same time, many who do not are being exposed to treatments that are not

benign. Nowhere else has this issue become more contentious than in the issue of pediatric bipolarity. We don't know what effects these medications might have at various stages of neurobiological development, because they haven't been around very long. It is a major concern that comes down to false negatives, false positives, and risk.

**Dr. Young: What challenges do you foresee?**

*Dr. Fawcett:* A diagnostic system needs utility. It must serve the clinician to allow effective treatment of patients. It should also be reliable, so that two different clinicians will tend to come up with the same diagnosis. We're trying to come up with the most reliable and useful way to approach patients and get them into the right treatment, while making these choices as valid as we know how in an era in which we are just beginning to see some of the other factors that may contribute to these illness.

One approach to this issue is to become more categorical in our classifications in anticipation of what is coming out of research studies. We look at symptoms and cutoff points for severity and allow the diagnostic categories to emerge. On the other hand, we also need to consider a dimensional approach. For instance, you could argue that suicide risk is a dimension that should be coded for every category, across all major illnesses. This is especially true now that there are putative genes for suicidal behavior. This affects patient management, so why should it not be coded diagnostically?

It is going to be an interesting process sorting all of this out over the next couple of years. We must try to improve on what we have, while trying to avoid too many future unintended consequences. It is an exciting process, because of all the opinions coming from very bright people who feel very passionately about these issues, yet at some point a decision will have to be made about which way to proceed. The climate as I see it is one in which innovation is highly encouraged. The question is, are there sufficient data available that will support innovation? It will be an interesting journey.

## Nosology, Diagnostic Validity, and DSM: A Primer for Residents

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As psychiatrists, we care a great deal about nosology, in short because the accuracy of diagnosis influences prognosis. A strong relationship exists between the validity of our diagnostic system and the success of the mental health care we provide, and this relationship merits continual refinement of our system (1). In addition, clinical

practice demands a tool of maximum utility and reliability. In American psychiatry, our answer to these needs is the Diagnostic and Statistical Manual of Mental Disorders (DSM). Now that revision of the fourth edition is under way, the question of diagnostic validity has come back into focus. Residency is an important time to begin

thinking critically about this issue, because based on the current schedule, we will likely practice under the guidance of more than one revision of this "Bible of Psychiatry" (2). Although mental disorders will not change empirically over a 15-year cycle, the degree of validity that we may achieve with our nosologic system should, and we must

maintain both an open mind and a critical eye toward this refinement in the interest of patient care.

Since the publication of DSM-III, psychiatric nosology has approached the classification of mental disorders categorically, by organizing diagnoses into types based on criteria sets with defining features. These criteria sets delineate prototypical versions of proposed disorders, rather than describing how a given individual is likely to present in the clinical setting. For many disorders, the authors attempt to circumvent this dilemma by including a polythetic, or “x of y” qualifier (e.g., a minimum of five of nine listed symptoms must be present in order to diagnose a major depressive episode). Certain consequences of the shift to a categorical approach were deliberate, such as drastic improvement in the interrater reliability of clinicians making psychiatric diagnoses. But a categorical and polythetic approach to nosology lends itself to poor validity in many instances, by allowing quite different combinations of symptoms to be classified as the same disorder, with little empirical evidence that the disorder is valid in the first place, thus generating the possibility of two distinct clinical entities being misidentified as one and the same (3). Furthermore, if one does not approach the clinical interview carefully, even subtle presentations of borderline personality disorder may be misconstrued as major depressive disorder due to irritability, suicidality, anxiety, poor self-image, and psychotic symptoms.

An alternative approach to the current categorical one is to diagnose mental disorders in terms of symptom dimensions. This approach is based on quantitative assessment of attributes, rather than simply assigning them to categories without regard to severity. The benefit of a dimensional approach is a more tailored description of an individual patient’s clinical presentation. But this approach too has its limitations, as it does not lend itself readily to research, nor does it facilitate ease of clinical practice, because it lacks the recognizable quality of named diagnoses in favor of quantitative descriptions of dimensions (3, 4).

In the introduction to DSM-IV-TR, the authors state: “The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study and treat people with various mental disorders.” Indeed, DSM has become the basis of psychiatric teaching in the United States, and furthermore it forms much of the justification for managed care decisions on reimbursement of mental health care services provided. It structures our approach to patient assessment, treatment, and pretty much everything in between. It is heavily relied on to organize and facilitate psychiatric research and it provides structure to the way our legal system manages mental disorders (3, 4).

But where in the process of development did DSM earn the reputation as the “ultimate authority on psychopathology and illness” (4)? Perhaps this is due to its intended quality of utility, which

in part stems from the fact that categorical data are more readily utilized in research and in communication between clinicians than dimensional descriptions of patients. As it has become more clinically useful, DSM has been more universally adopted. But there are consequences to using such a pragmatic categorical system to organize our approach to such complex, emotional, and social creatures as human beings. Although likely an unintended consequence, DSM can be a constrictive tool by virtue of its deliberately categorical nature. Allowing symptom presence and number to dictate assignment of diagnoses (and therefore treatment selection) overlooks the realities of symptom dimensions, severity, and etiology.

Interestingly, etiology has been conspicuously lacking from DSM since the shift to a categorical approach. Although relatively little is known to date about the etiology of major mental disorders, with the exceptions of adjustment and trauma disorders, the decision to leave out a discussion of etiology was deliberate. We tabulate the presence or absence of symptoms and, with the exception of the modifier “not otherwise specified,” draw an arbitrary line between normality and mental disorder, assigning patients to one side or the other. Despite technologies such as functional neuroimaging and sophisticated genetic analyses, the reality of how little we understand of etiology continues to be a barrier to real adherence to a medical model of psychiatry, in which confirmation of etiology is the final test of diagnostic accuracy.

Leaving etiology out of DSM produces interesting consequences. For example, where does DSM intersect with responsibility for individual behavior? The authors caution: “The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.” In a forensic setting, this system of nosology must be used with caution, because with little acknowledgment of etiology, there is the possibility of its misuse to explain criminal behavior as a mental disorder.

Despite the limitations described, how do we test the validity of our diagnostic system? In 1970, Drs. Eli Robins and Samuel Guze of Washington University in St. Louis published a method consisting of five phases for establishing diagnostic validity in psychiatric illness (5). This method remains relevant today and continues to provide a framework for testing the validity of a proposed diagnostic category.

The first phase involves describing the clinical picture of a disorder, but it is not merely a list of symptoms. It may also include race, sex, age at onset, and precipitating factors in the interest of defining a clinical picture more precisely. This level of validity is also referred to as “content validity.” The second phase, considered a higher level of validity, utilizes laboratory studies such as chemical, physiological, radiological, and anatomical

research to refine classification. This phase is analogous to “internal validity,” which is to say that it allows us to evaluate whether the diagnostic classification truly describes what it is intended to describe. Although some progress has been made since their method was described, we still have relatively few consistent and reliable assays to apply to this phase. Ironically, rigorous application of diagnostic validity criteria to our current nosologic system would allow us to identify valid categories that could subsequently narrow our focus in the search for objective evidence (such as laboratory evidence) of discrete diagnoses. As Robins and Guze point out, using this method to identify which current diagnoses have validity suggests which diagnoses identify discrete illnesses, whether or not we have a strong foundation of assays available to assess internal validity (5).

The third phase, consistent with the concept of external validity, evaluates whether a diagnostic category truly differentiates itself from other discrete categories. This acknowledges the reality of overlapping symptoms and the confounding nature of using a purely categorical approach to diagnosis. The fourth phase provides retrospective verification of a diagnosis by using follow-up study to determine whether or not patients continue to suffer from the same disorder they were diagnosed with originally or from some other disorder that would account for the original presentation. As the authors of DSM acknowledge, the discovery that patients are actually suffering from a different disorder than originally diagnosed suggests poor homogeneity of the original diagnostic category and therefore the need for refinement.

The final phase uses family study to assess diagnostic validity. While it is true that many psychiatric illnesses appear to have a heritable transmission, family study can also assess the effects of environment on the prevalence of a mental disorder among close relatives. Thus, regardless of etiology, the finding of a disorder among family members across generations strengthens the degree of validity of the diagnosis.

So how should we make use of the many diagnoses in DSM-IV that do not strongly meet validity criteria? In the case of personality disorders, which are notoriously problematic in terms of validity, a diagnosis may serve to predict certain behavior patterns and personal coping styles. Regardless of their validity, diagnoses still offer clinical utility, because they can predict the way a patient may engage our therapeutic efforts. The caveat is to maintain awareness of these proposed disorders of personality but not prejudice. In lieu of a dimensional nosologic system, we must use a de facto dimensional approach to treatment at the individual level. This intuitive component of clinical acumen must be generalized to much of DSM, regardless of the degree of established validity of any given diagnosis.

One final factor to consider is the nomenclature used to refer to morbidity. Currently, psychiatry is conceptualized in terms of mental disorders rather than mental illnesses. Although the terms “dis-

ease,” “illness,” and “disorder” are often used interchangeably, there is a purpose behind our selection of nomenclature. Specifically, by using the term “mental disorder,” we imply that there are limitations to the way we identify and diagnose clinical impairment. We use impairment as our compass for identifying what symptom, or combination of symptoms, merit treatment. But impairment due to psychiatric disease is analogous to hypertensive end-organ damage. If as physicians we were to wait until the development of end-organ damage to begin treatment of hypertension, the vast majority of morbidity would occur well before treatment began. Perhaps staging of psychiatric disorders should also be adopted into our nosologic system, as has been done in other

disciplines of medicine, in order to improve outcomes.

Despite its flaws, if used with an awareness of its limitations, DSM can be an indispensable guide to the assessment, diagnosis, and treatment of our patients. As we gather data and improve our understanding of the etiology, course, staging, and validity of our diagnostic system, patient care must necessarily improve.

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## Is DSM Negatively Impacting Resident Growth?

Pat Rabjohn, M.D., Ph.D.

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I hope the answer is no. However, after almost 4 years of residency training, I’m having my doubts. Part of me believes DSM has enhanced my training as a clinician by providing a framework from which I can establish a diagnosis for a patient, yet part of me worries that DSM has diminished my interviewing skills, reducing me to a “checklist” psychiatrist.

A few weeks ago an intern asked me to help interview a potential admission in our emergency department. During our walk there, the intern stated he was “way behind on his notes” and that he “needed to rush” if he was going to start call at 5 p.m. I told him I would be happy to do the interview, knowing it would save time. Twenty minutes later we were headed back to the inpatient unit with all the information needed to write a history and physical. The intern commented on how quickly I moved from past psychiatric history to the history of present illness, and how impressed he was with the “speed” of the interview. Specifically, he said, “you screened him for depression, mania, psychosis, and substance abuse without missing a beat.” While the admission was justified and the appropriate information was collected to make the initial treatment plan and decisions about medication, the interview lacked empathy and understanding, and a real doctor-patient relationship was not established. Symptom severity was never really assessed, nor was there an attempt to use the interview as a basis to develop a differential diagnosis. As I drove home that evening, I asked myself, *was that the right model for an intern?* And, perhaps more importantly, *is this the type of psychiatrist I want to be?*

About a week afterwards I was in the emergency department with the same intern and I came across a videotape of myself interviewing an inpatient from my PGY-1 year. It was a 30-minute mock oral interview of a new admission with psychotic

depression. Here was an excellent opportunity to compare my recent interview as Chief Resident to an admission interview I performed as an intern.

During the videotape interview, I focused on eliciting a clear history of present illness with pertinent positives and negatives so a diagnosis could be established. But there was one significant difference from my more recent interview. As an intern, it appeared that I made a genuine attempt to both connect with the patient and show empathy toward his situation. Several questions I asked him concerned his estranged wife and how he felt now that she had taken their children and moved out of the state. Once, I even replied, “that sounds tough...how are you able to cope with both the loss of your family and your chronic back pain?” In addition, I spent a fair amount of the interview trying to uncover a basis or trigger for his illness, along with a sense of how it was affecting him biologically, psychologically, and socially. I tried to explore if the severity of his distress was tied to his wife leaving him or exacerbated by his recent spinal fusion, and whether his symptoms had been less when he was working full-time or were worse now that he was living with his parents and unemployed. As an intern, I had a fair command of the biopsychosocial model, something that is promoted as important for psychiatrists to learn. We are taught that we should be knowledgeable in both psychopharmacology and psychotherapeutic interventions and aware of a way to bridge both modalities to provide patients with the best and most optimal care possible. As a PGY-4 in the emergency room with an impressionable intern, the biopsychosocial approach never crossed my mind.

What happened in the last 3 years? Was I just having an off day, or have I really become a checklist psychiatrist—someone who highlights or crosses off symptom criteria memorized from a

pocket copy of DSM-IV in order to make a diagnosis?

I began carrying around a copy of DSM-IV a few months into my intern year. Each time I screened an admission or saw someone in the outpatient clinic, I would scan the text to ensure I was meeting criteria for whichever diagnosis was in question. It seemed like a good plan at the time. As a result, I can now state the specific criteria for most of the major diagnoses, which will likely help me pass the board examination. As a bonus, I even have most of the numeric codes memorized, which will facilitate coding and billing when I enter independent practice in a few months. But the question persists: did this have a negative impact on my interviewing skills and, more importantly, did it diminish my ability to provide competent and compassionate care for patients?

If the answer is yes, I do not believe DSM is the sole culprit. I developed my own outpatient clinic for first-episode depression as a PGY-3 so I could get “faster” and “more efficient” in using various rating scales, including the Quick Inventory of Depressive Symptomatology (QIDS), the Hamilton Depression Rating Scale (HAM-D), and the nine item depression scale of the Patient Health Questionnaire (PHQ-9)—all of which encourage a checklist approach to diagnosis. I moonlight frequently in our psychiatric emergency room, which is a busy place that demands quick screening interviews and triage, reinforcing the same checklist attitude. Nevertheless, when I interview patients I find myself asking questions and considering diagnoses based on DSM criteria.

Since I believe it is difficult to treat properly if you lack a diagnosis, it makes sense to have a set of diagnostic criteria that have been agreed upon by established experts in psychiatry. But what is the cost, and are we losing something in the process? Does DSM limit resident growth by reducing

psychiatric residents to checklist physicians? Once again, I hope the answer is no. I hope psychiatry residents use the symptom criteria within DSM as

a part of their comprehensive patient evaluation, yet realize that it is only a small piece of the puzzle and that it is still important to recognize each

patient as an individual person with biological, psychological, and social issues, each of which need to be considered.

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## 2008 APA Annual Meeting



We would like to invite all residents to participate in a focus group taking place at the 2008 APA Annual Meeting in Washington, D.C. Editor-in-Chief **Robert Freedman, M.D.**, along with the **Committee on Residents and Fellows** and select Deputy Editors and editorial staff, will solicit thoughts on the Residents' Journal and how the *American Journal of Psychiatry* can be of further use to residents. The meeting is scheduled for Tuesday, May 6, 2008, from 3:00 to 5:00 p.m. in the Grand Hyatt Washington, Burnham Room, Constitution Level. For further information please

contact [ajp@psych.org](mailto:ajp@psych.org).

For information on the 2008 APA Annual Meeting, including registration and housing, please visit <http://www.psych.org/MainMenu/EducationCareerDevelopment/Meetings/AnnualMeeting.aspx>.

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