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In Review

Diagnostic Criteria as Dysfunction Indicators: Bridging the Chasm Between the Definition of Mental Disorder and Diagnostic Criteria for Specific Disorders

Michael B First, MD[1]; Jerome C Wakefield, PhD, DSW[2]

[1] Professor of Clinical Psychiatry, Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York, New York; Research Psychiatrist, Division of Clinical Phenomenology, New York State Psychiatric Institute, New York, New York.
Correspondence: New York State Psychiatric Institute, 1051 Riverside Drive—Unit 60, New York, NY 10032; mbf2@columbia.edu.

[2] Professor of Social Work, Silver School of Social Work, New York University, New York, New York; Professor of Psychiatry, Department of Psychiatry, School of Medicine, New York University, New York, New York.

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According to the introduction to the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition, each disorder must satisfy the definition of mental disorder, which requires the presence of both harm and dysfunction. Constructing criteria sets to require harm is relatively straightforward. However, establishing the presence of dysfunction is necessarily inferential because of the lack of knowledge of internal psychological and biological processes and their functions and dysfunctions. Given that virtually every psychiatric symptom characteristic of a DSM disorder can occur under some circumstances in a normally functioning person, diagnostic criteria based on symptoms must be constructed so that the symptoms indicate an internal dysfunction, and are thus inherently pathosuggestive.

In this paper, we review strategies used in DSM criteria sets for increasing the pathosuggestiveness of symptoms to ensure that the disorder meets the requirements of the definition of mental disorder. Strategies include the following: requiring a minimum duration and persistence; requiring that the frequency or intensity of a symptom exceed that seen in normal people; requiring disproportionality of symptoms, given the context; requiring pervasiveness of symptom expression across contexts; adding specific exclusions for contextual scenarios in which symptoms are best understood as normal reactions; combining symptoms to increase cumulative pathosuggestiveness; and requiring enough symptoms from an overall syndrome to meet a minimum threshold of pathosuggestiveness. We propose that future revisions of the DSM consider systematic implementation of these strategies in the construction and revision of criteria sets, with the goal of maximizing the pathosuggestiveness of diagnostic criteria to reduce the potential for diagnostic false positives.

Critères diagnostiques comme indicateurs de dysfonctionnement : combler l'écart entre la définition d'un trouble mental et les critères diagnostiques pour des troubles spécifiques

Selon l'introduction du Manuel diagnostique et statistique des troubles mentaux (DSM), 5e édition, chaque trouble doit satisfaire à la définition d'un trouble mental, qui exige la présence de préjudice et de dysfonctionnement. Construire des ensembles de critères requérant un dommage est relativement simple. Cependant, établir la présence d'une dysfonction est nécessairement inférentiel en raison du manque de connaissances des processus psychologique et biologique internes ainsi que de leurs fonctions et dysfonctions. Étant donné qu'à peu près chaque caractéristique d'un symptôme psychiatrique d'un trouble du DSM peut se manifester dans certaines circonstances chez une personne fonctionnant normalement, les critères diagnostiques basés sur les symptômes doivent être construits de manière à ce que les symptômes indiquent une dysfonction interne, et qu'ils soient donc intrinsèquement pathosuggestifs.

Dans cet article, nous avons révisés les stratégies utilisées dans les groupements de critères en vue d'accroître la pathosuggestivité des symptômes pour faire en sorte que le trouble satisfasse aux exigences de la définition du trouble mental. Les stratégies sont notamment: exigence d'une durée et d'une persistance minimales; exigence que

la fréquence ou l'intensité d'un symptôme excèdent celles observées chez une personne normale; exigence de la disproportion des symptômes, dans un contexte donné; exigence de l'omniprésence de l'expression des symptômes dans tout contexte; ajout d'exclusions spécifiques pour des scénarios contextuels dans lesquels les symptômes doivent être compris comme des réactions normales; combinaison des symptômes pour accroître la pathosuggestivité cumulative; et exigence d'un nombre suffisant de symptômes pour atteindre un seuil minimum de pathosuggestivité. Nous proposons que les futures révisions du DSM envisagent la mise en œuvre systématique de ces stratégies dans la construction et la révision des ensembles de critères, dans le but de maximiser la pathosuggestivité des critères diagnostiques et de réduire le potentiel de diagnostics faux positifs.

In the context of making a psychiatric diagnosis, the diagnostic criteria for a disorder have 2 functions: to help the clinician differentiate the disorder from other disorders that share clinical features (for example, distinguishing MDD from dysthymia or bipolar disorder) and to help differentiate disorder from nondisordered normal presentations (for example, distinguishing MDD from normal sadness or normal grief). It is the second of these 2 functions that has been the focus of most of the criticism of the latest edition of the manual, DSM-5.[1] The claim has been that the DSM-5 definitions for numerous disorders fail to validly differentiate disordered symptomatic presentations from nondisordered symptomatic presentations, thus creating a risk of wholesale false-positive diagnoses.[2]

The DSM's definition of mental disorder and how it is applied to the various specific disorders is key to approaching the false-positives problem systematically. Discrepancies between the definition's requirements and the diagnostic criteria for a specific category are often at the root of problems of false-positive diagnosies.[3] The DSM-5 definition of mental disorder, which is a minor modification of the definition that has appeared in all DSMs since DSM-III, states that

> a mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.[1, p 20]

Moreover, the definition specifies that even such potentially problematic conditions as socially deviant behaviour and conflicts between the individual and society "are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."[1, p 20]

According to DSM-5's definition, there are 2 requirements for a syndrome to be considered indicative of a mental disorder. First, there must be sufficient evidence to infer that the syndromal symptoms represent a dysfunction in the processes underlying mental functioning. Second, this dysfunction must cause harm to the person in the form of a disturbance in psychological functioning that is "clinically significant,"[1, p 20] which, as the definition further specifies, generally translates into distress or social role impairment that is sufficiently serious to warrant clinical attention. The argument for accepting these central aspects of the DSM's approach to the concept of mental disorder, and for understanding the definition's reference to dysfunction as meaning failure of biologically designed functioning of psychological mechanisms or processes, has been persuasively elaborated in Wakefield's harmful dysfunction analysis of the concept of mental disorder (see Wakefield[4–9] and Wakefield and First[10]), and will not be reiterated here.

Logically, each diagnostic category in the DSM that is claimed to be a mental disorder must satisfy the conditions set forth in the definition of mental disorder. The DSM-5 is the first edition of the manual to make this principle fully explicit when introducing the definition: "Each disorder

Highlights

- The DSM-5 definition of mental disorder requires that, in addition to being harmful, the symptoms of each category of disorder must represent an internal dysfunction.
- Although the introduction to DSM-5 states that each disorder included in the manual must meet its definition of mental disorder, including the dysfunction requirement, the definition was not systematically applied in the construction of diagnostic criteria sets in this or any earlier DSMs.
- Given that most psychiatric symptoms can occur in normal people, and given our lack of knowledge of psychological and biological mechanisms underlying symptoms, various strategies must be used to ensure that symptom-based criteria are pathosuggestive and imply the presence of dysfunction, such as requiring an extended symptom duration that is greater than expected in a normal person or excluding diagnosis when the context is one in which symptoms are more likely to represent normal-range responses.
- Such strategies should be systematically elaborated and applied to current and future DSM criteria sets with the goal of reducing the risk of false positives and responding to public concerns about the pathologization of problems of living.

Abbreviations

ADHD	attention-deficit hyperactivity disorder
DSM	Diagnostic and Statistical Manual of Mental Disorders
MDD	major depressive disorder
MDE	major depressive episode

identified in Section II of the manual . . . must meet the definition of a mental disorder. . . . [T]he following elements are required . . ."[1, p 20]

To ensure that each DSM disorder meets the requirements for being a mental disorder, diagnostic criteria must include elements indicative of both harm and dysfunction. In general, operationalizing the harm requirement is much more straightforward than establishing the presence of dysfunction. The harm requirement can be explicitly stated as a criterion. For example, the clinical significance criterion (that is, "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning"[1, p 21]) is included in most diagnostic criteria sets specifically to establish that the harm threshold for diagnosis of a disorder has been met. Often the symptoms listed in the diagnostic criteria and the features of the symptoms used to support the inference to dysfunction (for example, long duration and association with other symptoms) are manifestly harmful and any further specification of the harm requirement is redundant. For example, the MDD clinical significance criterion has been shown to be redundant and unnecessary in this way; if you have sufficient symptoms to qualify for MDD, you will almost certainly report significant distress or impairment in your role functioning.[11–13]

However, rarely a DSM-5 category's symptoms are mild enough that the harm requirement is not clearly satisfied. For example, diagnosis of the new DSM-5 category of mild neurocognitive disorder requires only modest decline from previous performance in any cognitive domain, and limits their impact on the individual by also requiring that the declines "do not interfere with capacity for independence in everyday activities."[1, p 605] Clinical significance is not required. Such nonimpairing decline, either ignored or easily addressed by modest compensatory strategies, is common in normal aging and does not seem to rise to harm levels warranting disorder diagnosis.

In contrast, formulating criteria that establish the presence of an internal dysfunction is much more challenging. This is primarily because of the necessarily inferential nature of identifying dysfunction, given our current lack of knowledge of internal psychological and biological processes and their functions and dysfunctions. Objective laboratory evidence that a brain dysfunction exists and underlies a psychological disturbance, such as diagnostically specific abnormal brain imaging findings known to be the result of brain pathology, would obviate the need for inference, but such tests are unavailable at this time.

Because of the absence of such explicit biomarkers, dysfunction must instead be inferred from the symptomatic presentation together with the contextual circumstances plausibly implying the breakdown of a normally operating psychological or biological function. This was the same situation that existed in physical medicine before knowledge of etiology, when the presence of disorder was inferred from symptomatic presentations that were concluded to be inconsistent with normal functioning. The challenge is greater with mental disorders because of the greater overlap of psychological symptoms indicative of disorder with normal reactions.

In practical terms, given that virtually every psychiatric symptom characteristic of a DSM disorder can occur in some form or in some context in a normally functioning person, criteria based on symptoms must be constructed in such a way as to indicate that the symptom cannot reasonably be considered normal (that is, within the range of normal functioning). For example, even though it is normal for a person to experience transient periods of depressed mood from time to time, when that depressed mood is persistent and part of a syndrome of co-occurring symptoms, such as sleep and appetite disturbance, fatigue, suicidality, and cognitive distortions regarding self-worth, one can plausibly infer an underlying dysfunction.

Consequently, the main challenge in creating valid diagnostic criteria for a DSM category is to show that dysfunction can be inferred from the symptom criteria, possibly taking into account the context in which the symptoms occur.[3,14] To our knowledge, there has been no systematic exploration of how this is accomplished. In this paper, we perform an initial reconnaissance of the various strategies that are used in formulating DSM diagnostic criteria to indicate that a symptomatic presentation meets the dysfunction requirement, and the challenges each strategy faces. It should be noted that by validity of diagnostic criteria we refer here to conceptual validity,[4,15] the degree to which criteria identify disorders and not nondisorders, thus avoiding false-positive diagnoses.

Varying Pathosuggestiveness of Individual Symptoms

Symptoms differ in the degree to which they lend support to an inference to underlying dysfunction and thus suggest disorder (that is, are pathosuggestive). A few psychiatric symptoms, typically those that indicate a major deficit in functioning, are highly pathosuggestive and almost invariably indicate a dysfunction (for example, severe intellectual disability with an IQ of less than 50). However, most psychiatric symptoms, such as anxiety, fear, depression, and irritability, are ubiquitous in normal people and occur under some circumstances as part of the normal range of emotional expression, thus are not particularly pathosuggestive in themselves. When symptoms with low inherent pathosuggestiveness—for example, sadness or insomnia—appear in diagnostic criteria, their usefulness in adding to the support for the dysfunction hypothesis will depend on their interaction with a wide range of modifiers and other criteria, such as those requiring persistence, chronicity, being part of a syndrome, and being disproportionate to the environmental context.

Conversely, symptoms that are more highly pathosuggestive in themselves tend to require fewer accompanying indicators of dysfunction and contextual qualifiers. Some symptoms, such as delusions and hallucinations, have a high level of pathosuggestiveness because, in their severe,

impairing form, they most commonly occur in people suffering from a mental illness. However, studies reveal that substantial percentages of people in the community report occasionally experiencing such symptoms in milder or transient form,[16–21] even apart from specific contexts in which such symptoms are known to become more frequent among people who are nondisordered, such as during substance intoxication or withdrawal, in the context of bereavement, in people under extreme stress, or as part of some culturally sanctioned practices.[22–26] Consequently, even delusions and hallucinations are not completely pathosuggestive, and some additional diagnostic criteria or contextual considerations are almost always needed to secure the inference to dysfunction. In general, the lower the pathosuggestiveness of a symptom, the greater the need to use one or more of the strategies we enumerate below for distinguishing symptoms indicative of dysfunction from normally generated symptoms.

Duration and Persistence as Indicators of Dysfunction

Perhaps the most common technique used to indicate that a symptom is indicative of a dysfunction is to add modifiers requiring a minimum duration. Many symptoms, such as transient fears and sadness, can look the same as symptoms of disorder. However, their brief occurrence generally indicates normal affective variation, so requiring lengthy duration tends to support the inference to dysfunction. For example, in DSM-5, most of the anxiety disorders (for example, separation anxiety disorder in adults, specific phobia, social anxiety disorder, and agoraphobia) now require that symptoms must be "persistent, typically lasting for 6 months or more."[1, p 203] Similarly, the persistence requirement for MDE that the symptoms be present for most of the day, nearly every day is also an attempt to distinguish MDE from normal everyday sadness, which is more likely to come and go throughout the day. The appropriate duration requirement for a given disorder will depend on background assumptions about which durations are long enough to substantially reduce the likelihood that the symptoms are not indicative of dysfunction.

However, in the case of affects such as sadness or anxiety, it is obvious that a duration or persistence requirement alone does not ensure that the symptom represents dysfunction because emotions triggered by contextual circumstances can sometimes last for similar durations, especially if the triggering circumstances themselves persist. For example, fear of going outside for 6 months or more may be reasonable and within normal range for an individual living in a city under siege during wartime where there are real dangers involved in leaving one's home, and sadness due to a sequence of ongoing serious losses may also be lengthy but normal. Consequently, other techniques, such as requiring the sadness to be part of a larger syndrome with other more pathosuggestive symptoms (see below), or requiring, as in the diagnostic criteria for specific phobia, that "the fear or anxiety is out of proportion to the actual danger . . . and to the sociocultural context,"[1, p 197] must also be employed to support the inference to dysfunction.

Frequency–Intensity Modifiers as an Indicator of Dysfunction

Another common technique is to append a modifier requiring that either the frequency or intensity of a symptom be at a level beyond what would be considered the typical frequency or intensity for such a symptom in a normal person. For example, in recognition that some symptoms of inattention, hyperactivity, and impulsivity commonly occur in normal people, each criterion for ADHD requires that the symptom occur often (for example, "often fails to give close attention to details or makes careless mistakes"[1, p 59]). Similarly, the criteria for premenstrual dysphoric disorder, in recognition that the symptoms commonly occur in normal premenstrual women and thus do not necessarily indicate dysfunction, generally preface each symptom with the modifier marked (for example, "marked affective lability"[1, p 171]) to increase the likelihood that the symptoms represent an underlying dysfunction rather than normal perimenstrual symptoms. In both of these cases, it is implied that the requirement for increased frequency and intensity is to be judged relative to the baseline of what is typically seen in normal people.

However, symptoms normally vary in intensity owing to individual temperament and context. For example, a person satisfying ADHD criterion A.1.d, "often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace,"[1 p 59] rather than having a dysfunction, may simply not understand the instructions owing to placement in a class that is too academically challenging, a contextual factor acknowledged in DSM-5's instruction not to count the symptom if it is "solely a manifestation of . . . failure to understand tasks or instructions."[1 p 59] Such contextual factors must be considered when determining the significance of the frequency or intensity of the symptom (see below).

To contribute to validity, the frequency and duration requirements must be sufficient to indicate not merely that a symptom occurs regularly or is problematic but that it occurs often enough to suggest that it is due to dysfunction rather than being explainable in terms of normal causes. This has led to concern, for example, about the DSM-5 binge eating disorder requirement that "the binge eating occurs, on average, at least once a week for 3 months,"[1, p 350] which seems consistent with normal-range excessive eating at social events, and the DSM-5 oppositional defiant disorder requirement that in children "5 years or older, the behavior should occur at least once per week for at least 6 months,"[1, p 462] which seems consistent with normal-range behaviour at that age.

Disproportionality

In determining whether a symptom is evidence of dysfunction, the most direct way of taking context into account is to require that the intensity of the symptom be out of proportion to any environmental triggers, when the

symptom is normally a proportional response. For example, the criteria for the phobic anxiety disorders require that the anxiety symptoms be out of proportion to the actual danger posed by the situation (for example, social situations in social anxiety disorder, and the phobic stimulus in specific phobia). Similarly, the criteria for intermittent explosive disorder and disruptive mood dysregulation disorder require that aggressive outbursts be grossly out of proportion to the provoking circumstances. In other cases, the disproportionality requirement is implied by use of modifiers such as excessive, as in the generalized anxiety disorder requirement of excessive anxiety and worry about numerous events or activities.

The rationale for such criteria is that most human psychological reactions are biologically designed to vary in intensity in accordance with some features of the perceived context. For example, fear can range from mild apprehension to outright terror, depending on the degree of danger or imminence of harm. Similarly, anger can go from mild indignation to uncontrollable rage depending on the degree of perceived threat or violation. Substantial and chronic disproportionality between the nature of the environmental stimulus and the reaction suggests an underlying dysfunction in calibration of response. However, the inference to dysfunction can be influenced by further factors that influence intensity of response, such as individual temperamental variation and cultural shaping of appropriate levels of response.

Pervasiveness as an Indicator of Dysfunction

Another indicator of pathosuggestiveness is the pervasiveness of the expression of a symptom. Given that most false positives in terms of dysfunction reflect that the symptom is better understood as a normal response to an environmentally determined contextual factor, if the symptom is present across a wide variety of contextual factors, it suggests that the symptom is most likely due to an internal dysfunction. For example, ADHD diagnosis requires that

> Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).[1, p 60]

The same strategy is used in the criteria for the new DSM-5 disruptive mood dysregulation disorder, which requires that temper outbursts and irritable mood "are present in at least two of three settings (i.e., at home, at school, with peers)."[1, p 156]

Pervasiveness is also sometimes indicated by polythetic criteria sets that require a subset of multiple different specified situations in which a dysfunction may express itself. For example, the criteria set for paranoid personality disorder lists various situations—unjustified doubts about the loyalties of friends and associates, being reluctant to confide in others, reading hidden meanings into benign remarks, perceiving unjustified attacks on one's character, and unjustified suspicions regarding the fidelity of a spouse or sexual partner—in which the same dysfunction of inability to trust other people may be manifested. Requiring at least 4 of these items implies pervasiveness of mistrust across situations, supporting the hypothesis that it represents an internal dysfunction in an ability to trust rather than a normal reaction to threatening situations.

Contextual Exclusions of False-Positive Scenarios Indicative of Nondysfunction

An alternative strategy involves adding specific exclusions for contextual scenarios in which the symptoms are best understood as normal reactions.[14] For example, as in DSM-IV, in DSM-5, selective mutism is diagnosable only if "the failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation."[1, p 195] In such cases, the failure to speak, rather than representing an internal dysfunction, is understandable as a normal response to lack of familiarity with the required spoken language. Analogously, DSM-5 oppositional defiant disorder newly excludes diagnosis if the defiant behaviour is directed only toward a sibling, because sibling relations can normally include such behaviour. Likewise, DSM-5 introduces the requirement that a sexual dysfunction can be diagnosed only if the lack of sexual response in a relationship is not better explained as a consequence of severe relationship distress (for example, partner violence).

Requiring Additional Pathosuggestive Symptoms as an Indicator of Dysfunction

A standard strategy for increasing the pathosuggestiveness of a disorder definition is to require multiple features to be present so that the overall pathosuggestiveness of the criteria set reflects the cumulative pathosuggestiveness of the various required symptoms. Monothetic criteria sets, in which each individual criterion must be met to make the diagnosis, use this approach, with each successive required criterion increasing the cumulative pathosuggestiveness of the whole. For example, the social anxiety disorder definition requires that all of criteria A through J be met for the diagnosis to be made, with each criterion serving to increase the likelihood that the social anxiety and avoidance represents an internal dysfunction rather than normal variation in the trait of shyness.

Such a strategy can also be used in improving the pathosuggestiveness of individual criterion items. For example, manic episode's criterion A requires elevated, expansive, or irritable mood, but this was found to be subject to false positives owing to circumstantial reasons for, say, irritability.[27] Thus DSM-5 improved the pathosuggestiveness of this criterion by adding a requirement of increased activity or energy as well, in addition to the elevated, expansive, or irritable mood. The combined pathosuggestiveness is likely to be more than simply additive.

Using Symptom Thresholds in a Syndrome as an Indicator of Dysfunction

The DSM-5 definition of mental disorder specifies that each mental disorder is a syndrome. The identification of syndromes was a cornerstone of diagnosis in the early days of medicine and remains so for fields of medicine for which the underlying pathophysiology is largely unknown, such as headaches, rheumatological diseases, and psychiatric conditions. A syndrome may be defined as a group of symptoms that tend to occur together and tend to have an identifiable course. Although in some cases a particular symptom is defined to be a required component of the syndrome, in many cases no specific symptom is essential, reflecting the heterogeneity of the symptomatic presentations of the syndrome. In DSM, such heterogeneity is reflected in the use of polythetic criteria sets, in which a minimum number of items from a longer list are required (for example, the 3 out of 7 items required in the B criterion for a manic episode).

However, identification of syndromal, co-occurring symptoms does not necessarily imply that the underlying etiological process is a dysfunction. For example, normal grief involves a cluster of symptoms that tend to co-occur, including yearning for the deceased, intense sorrow, disbelief, emotional numbness, bitterness or anger about the loss, avoidance of reminders of the loss, feeling alone or detached from others, desire to die to be with the deceased, feeling that life is empty without the deceased, and others. These symptoms co-occur (that is, comprise a syndrome) because they are all responses to the same causative factor, that is, the death of a loved one. However, the presence of this syndrome does not imply the presence of dysfunction, because each of these symptoms, as well as any subset, can be a manifestation of a normal and expected reaction to loss.

The need for diagnostic thresholds that require a minimum number of symptoms when setting the boundary with normality (for example, the requirement for 5 out of 9 symptoms in MDD) reflects that the pathosuggestiveness of each symptom, taken on its own, is insufficient to allow inference to dysfunction. However, as more symptoms are determined to be present, the aggregate pathosuggestiveness can become sufficient for a confident inference to underlying dysfunction. For example, depressed mood and difficulty sleeping, by themselves, have relatively low pathosuggestiveness, but the presence of additional depressive symptoms, such as decreased appetite, fatigue, and feelings of worthlessness, increase the likelihood of underlying dysfunction.

Viewed in this light, rather than representing zones of rarity in a symptom-severity continuum or cut-points that are associated with a risk for a negative outcome (as is the case with blood pressure thresholds), the DSM symptom thresholds instead represent thresholds of minimum clinical confidence that a dysfunction is present. This is in accord with the expert consensus method by which most of the symptom thresholds in the DSM were established; that is, a group of experts set thresholds based on their intuitive sense regarding the minimum number of symptoms required for the diagnosis. For example, when the developer of the original MDE criteria was asked about the basis for the particular chosen threshold of 6 out of 10 symptoms, he replied "it sounded about right."[28, p 136]

One serious problem with trying to establish a threshold for the minimum number of symptoms based on an intuitive sense of cumulative pathosuggestiveness is that the pathosuggestiveness associated with each particular symptom in the syndrome is not equivalent. Some symptoms of depression (for example, psychomotor retardation) are much more pathosuggestive than others (for example, insomnia). Nevertheless, all are generally given equal weight regarding symptom count. Unfortunately, establishing appropriate differential weights to the individual symptoms comprising a syndrome would be difficult to accomplish empirically and may add a level of unwieldy complexity to the diagnostic definitions.

The differential evidential weight possessed by symptoms, combined with the fact that they are given equal weight in DSM diagnostic algorithms, leads to the potential for substantial false-positive diagnoses among conditions in which the diagnostic threshold can be reached using a subset of symptoms with relatively low cumulative pathosuggestiveness. This problem is especially likely to occur when relatively few symptoms are required to reach threshold. For example, this explains the concern about the DSM-5 diagnostic criteria for substance use disorder, which require only 2 out of a list of 11 symptoms.[29] Although there are several symptoms of high pathosuggestiveness among the substance use disorder symptoms (for example, withdrawal symptoms, inability to stop use, and craving), the low threshold allows for 2 symptoms of low pathosuggestiveness (for example, driving under the influence of alcohol, and arguing with one's spouse about alcohol use) to be sufficient for diagnosis, even though the inference to dysfunction does not seem well supported by this particular symptom combination.

Conclusion

The DSM-5, as with all other DSMs since DSM-III, has continued the process of refining descriptive syndromal diagnostic criteria to better identify dysfunctions and distinguish them from normal functioning. Many minor modifications were aimed at this goal. To take one further example, the DSM-5 criteria for insomnia disorder (formerly primary insomnia) are improved by the addition of a requirement that "The sleep difficulty occurs despite adequate opportunity for sleep"[1, p 362]; thus if you have trouble sleeping because you are being kept awake by your neighbour's late-night television watching or the circumstances of your work, that no longer satisfies criteria for a mental disorder, as it may have under DSM-IV criteria.

However, no systematic effort was made in either DSM-5 or in prior editions of the DSM to evaluate each feature of each diagnostic criteria set for the degree to which it contributed to conceptual validity in picking

out conditions due to dysfunctions, or to systematically review, critique, and reformulate criteria sets with this goal explicitly in mind. Unfortunately, a proposal for a DSM-5 conceptual review committee[30] that might have pursued these goals was rejected. The result has been a manual vulnerable to accusations of expansive criteria that are subject to substantial rates of false-positive diagnoses.

Fortunately, the DSM-5 is designed to be a living document, subject to periodic partial revision as new empirical evidence emerges. We would suggest that such revisions include a review of any proposed criteria, with the goal of maximizing the pathosuggestiveness of criterion items to reduce the potential for false positives. As the DSM-5 states, each criteria set must satisfy the requirements set by the definition of mental disorder. We believe that, given the level of criticism of the manual regarding pathologization of normal conditions, it is a good time to reinvigorate the DSM's quest for, and commitment to, achieving conceptual validity.

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