DSM-5's Validity: Non Sumus Angeli!
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Non Sumus Angeli

Whenever some reporter makes the fatuous claim, "The DSM is psychiatry's bible!" I am reminded of a story concerning the Vatican, during the years of Pope John XXIII. It seems that a new building had to be constructed on Vatican grounds, and the architect submitted his plans directly to the Pope. Soon the plans were returned to the architect with the words "Non sumus angeli" written in the margin: "We are not angels." The architect and his staff were baffled as to what the Pope meant, until finally someone noticed the plans did not include bathrooms.

No, psychiatrists are not gods or angels, and the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)[1] is not our "bible." It is a useful but incomplete text; an informative but fallible guide. Many of us respect the time and effort that went into developing the DSM-5, while also hoping that DSM-5.1 or -5.2 will provide substantially more. Of course, we would all like more neuroscience, and many of us would like to see more psychodynamic explication of the major disorders. Although symptom checklists lend themselves to the goals of research -- for example, establishing cut-offs and inclusion criteria for a particular study -- they rarely answer the needs of clinicians for a comprehensive understanding of the patient.[2] I believe that the framers of the DSMs have always acknowledged this limitation.

That said, I bristle when I hear some in the mental health field -- and many in the mass media -- argue that the DSM-5 is "not valid" because it lacks definitive biological tests or biomarkers. This sort of claim reflects a profound misunderstanding on the part of both the general public and, alas, many clinicians: namely, the identification of "scientific" with "laboratory test" or "radiologic image." This amounts to a kind of scientism, not science, and the public has been sold a bill of goods on this subject.

Many Measures of Validity

Dr. Bernard Carroll's description[3] of convergent validity should be required reading for all psychiatry residents. He explains that our disease constructs take shape through a process of "convergent validation." This entails "...iterative attention to signs, symptoms, course of illness, response to treatments, family history, and laboratory data." He adds that "laboratory tests are not the automatic gold standard of evidence for validity." Indeed, as Dr. Carroll[3] pointedly observes,

We need to be clear that the existence of disease is not predicated on having a biological test. It's nice when we do have one, but there are many areas in medicine where there is no conclusive diagnostic test. Think migraine. Think multiple sclerosis. Think chronic pain. Indeed, clinical science correctly recognized many diseases long before lab tests came along for confirmatory diagnostic application. Think Parkinson's disease, Huntington's disease, epilepsy...it's a long list.

Furthermore, validity is not a single or simple construct. Thus, discriminant validity refers to the ability of a set of diagnostic criteria to distinguish one condition from another: for example, how well does our construct of schizophrenia allow us to distinguish this condition from autistic spectrum disorders or bipolar disorder? Predictive validity is a measure of how well a diagnostic category allows us to make accurate predictions of course of illness, episode recurrence, degree of impairment, morbidity and mortality, and response to treatment.

More Than a Lab Test

It is probably too early to know how the modifications in the DSM-5 will affect these validity measures compared with DSM-III and DSM-IV criteria. And, it could be argued that more time should have been taken to find out. Nonetheless, historically, several of the major diagnostic categories in the DSMs have shown both good reliability (kappa values, or interrater agreement) and reasonably good predictive validity. For example, Mason and colleagues\[4\] found that both DSM-III-R and ICD-10 diagnoses of schizophrenia had high predictive validity for long-term outcome, and that both provided relatively stable diagnoses over time.

Similarly, in an 8-year, prospective study of bipolar I disorder in children,\[5\] there was strong evidence of stability and continuity of the diagnosis, into adulthood. For example, in adult individuals with childhood bipolar I disorder, the 44.4% frequency of manic episodes was 13-44 times higher than in the general population -- an indicator of good predictive validity of the bipolar I diagnosis.\[*\]

Dr. Carroll believes that many other psychiatric disorders have achieved good convergent validity, including mania, melancholia, panic disorder, obsessive-compulsive disorder, and catatonia.\[3\] Nonetheless, the next update of the DSM-5 needs to include more convergent validity data for its diagnostic categories, including how well they predict course of illness, morbidity and mortality, comorbid illness, and response to treatment.

We can do better than the DSM-5, and we must strive for ever-increasing levels of validity -- but this is much more than a matter of fixating on laboratory tests. Psychiatry is, and will remain, a clinical science, unlike physics or thermodynamics. And regardless of whether laboratory are available, there is no substitute for listening carefully to the patient's narrative, getting a comprehensive family history, ruling out pertinent medical and neurologic confounders, and using sound clinical judgment in making the diagnosis.

The bottom line belongs to Dr. Carroll: "Laboratory measures are the servants of clinical science, not the other way around."\[3\]

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\[*\]The Geller study used a more conservative criterion for manic episodes than the DSM-IV does: 2 weeks of manic symptoms were required, rather than 1, along with at least 1 "cardinal symptom" of mania (elation and/or grandiosity). Furthermore, the study's rigorous evaluation of the children and their parents is hardly representative of everyday outpatient practice, where increasing prescription of antipsychotic medication in children and adolescents is a serious concern.\[6\] Nevertheless, the Geller study is a good example of predictive validity in psychiatric diagnosis.

**Suggested Reading**


**References**


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