Response to Bessel van der Kolk's Criticisms About the *DSM-5* From His Book *The Body Keeps the Score*

van der Kolk's DSM-5 claim & criticism	DSM-5's reality & rebuttal
"*When DSM-5 was published in May 2013 it included some three hundred disorders in its 945 pages*" (p. 166)	• Despite adding 12 new disorder classifications, DSM-5 has a 14 fewer disorders (265 total) compared to DSM-IV-TR (297 total). This is because many disorders were either removed (e.g., polysubstance dependence), changed to specifiers to a core disorder (e.g., reading disorder, mathematics disorder, and disorder of written expression for specific learning disorder), or consolidated (e.g., or autistic disorder, Rett's disorder, childhood disintegrative disorder, and Asperger's disorder into autism spectrum disorder) • DSM-IV-TR – *in which Bessel van der Kolk was an Anxiety Disorders Advisor and the PTSD Field Trial Site Coordinator* – had 943 pages; DSM-5 has 947 pages, not 945 pages.
"*It offers a veritable smorgasbord of possible labels for the problems associated with severe early life trauma, including some new ones such as Disruptive Mood Regulation Disorder, Non-suicidal Self Injury, Intermittent Explosive Disorder, Dysregulated Social Engagement Disorder, and Disruptive Impulse Control Disorders*." (p. 166)	• If the DSM is so "flawed", then why did van der Kolk and his colleagues submit a 33-page document titled "PROPOSAL TO INCLUDE A DEVELOPMENTAL TRAUMA DISORDER DIAGNOSIS FOR CHILDREN AND ADOLESCENTS IN DSM-V?" • *Disruptive Mood Regulation Disorder*: the correct titled used in the DSM-5 is *Disruptive Mood Dysregulation Disorder (DMDD)*. Criterion "J" prohibits this diagnosis if there is a posttraumatic stress response and it cannot coexist with *Intermittent Explosive Disorder*. DMDD is not a new disorder to label children with severe early life trauma, "In fact, disruptive mood dysregulation disorder was added to DSM-5 to address the considerable concern about the appropriate classification and treatment of children who present with chronic, persistent irritability relative to children who present with classic (i.e., episodic) bipolar disorder." • *Non-suicidal Self Injury*: this proposed disorder is listed in *Section III: Conditions for Further Study*, therefore, "***These proposed criteria sets are not intended for clinical use; only the criteria sets and disorders in Section II of DSM-5 are officially recognized and can be used for clinical purposes.***" (p. 783). • *Intermittent Explosive Disorder*: this condition is not "new" to DSM-5, it was first listed in DSM-III (published in 1980, pp. 295-297), then again in DSM-III-R (published in 1987, pp. 321-322), then again in DSM-IV (published in 1994, pp. 609-612), and finally in DSM-IV-TR (published in 2000, pp. 663-667). "A diagnosis of intermittent explosive disorder should not be given to individuals younger than 6 years, or the equivalent developmental level (Criterion E), or to individuals whose aggressive outbursts are better explained by another mental disorder (Criterion F)…In addition,

	children ages 6–18 years should not receive this diagnosis when impulsive aggressive outbursts occur in the context of an adjustment disorder (Criterion F)." (p. 467) • *Dysregulated Social Engagement Disorder*: the correct titled used in the DSM-5 is *Disinhibited Social Engagement Disorder (DSED)*. Van der Kolk is correct, this is a new disorder. "Serious social neglect is a diagnostic requirement…and is also the only known risk factor for the disorder." (p. 270). • *Disruptive Impulse Control Disorders*: the correct titled used in the DSM-5 is *Disruptive, Impulse-Control, and Conduct Disorders*. This is not a trauma-related disorder but rather a chapter title or broad nosological classification. There is no such disorder in the DSM-5.
"*With DSM-5 psychiatry firmly regressed to early-nineteenth-century medical practice…its 'diagnoses' describe surface phenomena that completely ignore the underlying causes*" (p. 166)	• "These findings mean that DSM, like other medical disease classifications, should accommodate ways to introduce dimensional approaches to mental disorders, including dimensions that cut across current categories. Such an approach should permit a more accurate description of patient presentations and increase the validity of a diagnosis (i.e., the degree to which diagnostic criteria reflect the comprehensive manifestation of an underlying psychopathological disorder)." (p. 5) • "DSM is a medical classification of disorders and as such serves as a historically determined cognitive schema imposed on clinical and scientific information to increase its comprehensibility and utility." (p. 10) • "The symptoms contained in the respective diagnostic criteria sets do not constitute comprehensive definitions of underlying disorders, which encompass cognitive, emotional, behavioral, and physiological processes that are far more complex than can be described in these brief summaries. Rather, they are intended to summarize characteristic syndromes of signs and symptoms that point to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course." (p. 19) • "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." (p. 20) • "Sex and gender differences as they relate to the causes and expression of medical conditions are established for a number of diseases, including selected mental disorders. Revisions to DSM-5 included review of potential differences between men and women in the expression of mental illness" (p. 15)

"*In other words, it lacks scientific validity*" (p. 167)	• It seems that van der Kolk's proposed Developmental Trauma Disorder lacked scientific validity, else why did he boast that "*Shortly after the APA rejected Developmental Trauma Disorder for inclusion in the DSM, thousands of clinicians from around the country sent small contributions to the Trauma Center to help us conduct a large scientific study, known as a field trial, to further study DTD*"? (p. 168) • "The Scientific Review Committee (SRC) was established to provide a scientific peer review process that was external to that of the work groups. The SRC chair, vice-chair, and six committee members were charged with reviewing the degree to which the proposed changes from DSM-IV could be supported with scientific evidence. Each proposal for diagnostic revision required a memorandum of evidence for change prepared by the work group and accompanied by a summary of supportive data organized around validators for the proposed diagnostic criteria (i.e., *antecedent* validators such as familial aggregation, *concurrent* validators such as biological markers, and *prospective* validators such as response to treatment or course of illness). The submissions were reviewed by the SRC and scored according to the strength of the supportive scientific data. To the surprise of participants in both revision processes, large sections of the content fell relatively easily into place, reflecting real strengths in some areas of the scientific literature, such as epidemiology, analyses of comorbidity, twin studies, and certain other genetically informed designs." (pp. 8-9) • "Related to recommendations about alterations in the chapter structure of DSM-5, members of the diagnostic spectra study group examined whether scientific validators could inform possible new groupings of related disorders within the existing categorical framework. Eleven such indicators were recommended for this purpose: *shared neural substrates, family traits, genetic risk factors, specific environmental risk factors, biomarkers, temperamental antecedents, abnormalities of emotional or cognitive processing, symptom similarity, course of illness, high comorbidity, and shared treatment response*. These indicators served as empirical guidelines to inform decision making by the work groups and the task force about how to cluster disorders to maximize their validity and clinical utility." (p. 12) • "Approaches to validating diagnostic criteria for discrete categorical mental disorders have included the following types of evidence: *antecedent* validators (similar genetic markers, family traits, temperament, and environmental exposure), *concurrent* validators (similar neural substrates, biomarkers, emotional and cognitive processing,

	and symptom similarity), and *predictive* validators (similar clinical course and treatment response)." (p. 20) • "Whereas the diagnostic criteria in Section II are well-established measures that have undergone extensive review, the assessment tools, a cultural formulation interview, and conditions for further study included in Section III are those for which we determined that the scientific evidence is not yet available to support widespread clinical use. These diagnostic aids and criteria are included to highlight the evolution and direction of scientific advances in these areas and to stimulate further research." (pp. 23-24)
"*…despite the near-universal consensus that it represented no improvement over the previous diagnostic system*."	• No source to support such a broad claim. What people constitute the "*universal consensus" – van der Kolk's 11 DTD colleagues?* How is "*no improvement*" measured and empirically established?
"Why are *relationships or social conditions left out?*" (p. 167)	• "Use of information from family members and other third parties (in addition to the individual) regarding the individual's performance is recommended when necessary." (p. 21) • **Developmental and Lifespan Considerations** (p. 13) • **Cultural Issues** (pp. 14-15) • **Gender Differences** (p. 15) **Depressive Disorders** examples: • "Childhood risk factors include parental loss or separation" (Blanco et al. 2010). (p. 170) • "Environmental factors associated with the expression of premenstrual dysphoric disorder include stress (Deuster et al. 1999; Girdler et al. 2004), history of interpersonal trauma (Girdler et al. 2004), seasonal changes (Maskall et al. 1997), and sociocultural aspects of female sexual behavior in general, and female gender role in particular." (p. 173) **Disruptive, Impulse-Control, and Conduct Disorders** examples: • "Social (e.g., loss of friends, relatives, marital instability), occupational (e.g., demotion, loss of employment), financial (e.g., due to value of objects destroyed), and legal (e.g., civil suits as a result of aggressive behavior against person or property; criminal charges for assault) problems often develop as a result of intermittent explosive disorder." (p. 468)

	• "Given that the pervasiveness of symptoms is an indicator of the severity of the disorder, it is critical that the individual's behavior be assessed across multiple settings and relationships. Because these behaviors are common among siblings, they must be observed during interactions with persons other than siblings." (p. 463) • "Also, because the indicators of the specifier are characteristics that reflect the individual's typical pattern of interpersonal and emotional functioning, it is important to consider reports by others who have known the individual for extended periods of time and across relationships and settings (e.g., parents, teachers, co-workers, extended family members, peers). (p. 472)
DSM-5 ignores *"abandonment, abuse, and deprivation…"*as "*…the cause of mental problems*…" (p. 167)	**Neurodevelopmental Disorders** examples: • "Gullibility and lack of awareness of risk may result in exploitation by others and possible victimization, fraud, unintentional criminal involvement, false confessions, and risk for physical and sexual abuse." (p. 38) • "Postnatal causes include hypoxic ischemic injury, traumatic brain injury, infections, demyelinating disorders, seizure disorders (e.g., infantile spasms), severe and chronic social deprivation, and toxic metabolic syndromes and intoxications (e.g., lead, mercury) (Harris 2006)." (p. 39) • "There may be a history of child abuse, neglect, multiple foster placements, neurotoxin exposure (e.g., lead), infections (e.g., encephalitis), or alcohol exposure in utero." (p. 62) • "However, ADHD is not characterized by fear of abandonment, self-injury, extreme ambivalence, or other features of personality disorder." (p. 65) **Anxiety Disorders** examples: • "Environmental risk factors for specific phobias, such as parental overprotectiveness, parental loss and separation, and physical and sexual abuse, tend to predict other anxiety disorders as well (Kessler et al. 1997; LeBeau et al. 2010)." (p. 200) • "Reports of childhood experiences of sexual and physical abuse are more common in panic disorder than in certain other anxiety disorders (Roy-Byrne et al. 2006)." (p. 211) • "Borderline personality disorder is characterized by fear of abandonment by loved ones, but problems in identity, self-direction, interpersonal functioning, and impulsivity are additionally central to that disorder, whereas they are not central to separation anxiety disorder." (p. 195)

	Obsessive-Compulsive and Related Disorders examples: • "Physical and sexual abuse in childhood and other stressful or traumatic events have been associated with an increased risk for developing OCD (Grisham et al. 2011)." (p. 239) • "Body dysmorphic disorder has been associated with high rates of childhood neglect and abuse (Phillips et al. 2010a)." (p. 245) **Trauma- and Stressor-Related Disorders** examples: • "These include lower socioeconomic status; lower education; exposure to prior trauma (especially during childhood) (Binder et al. 2008; Cougle et al. 2009; Smith et al. 2008); childhood adversity (e.g., economic deprivation, family dysfunction, parental separation or death); cultural characteristics (e.g., fatalistic or self-blaming coping strategies); lower intelligence; minority racial/ethnic status; and a family psychiatric history." (p. 277) • *Reactive Attachment Disorder & Disinhibited Social Engagement Disorder* diagnostic criterion C.1.: "Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults." (pp. 265 & 268)
"*The most stunning rejection of the DSM-V [sic] came from the National Institute of Mental health, which funds most psychiatric research in* America" with a focus on "*what are called "Research Domain Criteria (RDoC)*" (p. 167)	• Is van der Kolk projecting his negative feelings of being stunningly rejected by the APA? • "In fact, the use of a shared framework helped to integrate the work of DSM and ICD work groups and to focus on scientific issues. The DSM-5 organization and the proposed linear structure of the ICD-11 have been endorsed by the leadership of the NIMH Research Domain Criteria (RDoC) project as consistent with the initial overall structure of that project." (p. 11)
NIMH "*would no longer support DSM's symptom-based diagnosis…to create a framework for studies that would cut across current diagnostic categories*" (p. 167)	• "DSM-5 is designed to better fill the need of clinicians, patients, families, and researchers for a clear and concise description of each mental disorder organized by explicit diagnostic criteria, supplemented, when appropriate, by dimensional measures that cross diagnostic boundaries, and a brief digest of information about the diagnosis, risk factors, associated features, research advances, and various expressions of the disorder." (p. 5) • "Despite the problem posed by categorical diagnoses, the DSM-5 Task Force recognized that it is premature scientifically to propose alternative definitions for most disorders. The organizational structure is meant to serve as a bridge to new

	diagnostic approaches without disrupting current clinical practice or research. With support from DSM-associated training materials, the National Institutes of Health other funding agencies, and scientific publications, the more dimensional DSM-5 approach and organizational structure can facilitate research across current diagnostic categories by encouraging broad investigations within the proposed chapters and across adjacent chapters. Such a reformulation of research goals should also keep DSM-5 central to the development of dimensional approaches to diagnosis that will likely supplement or supersede current categorical approaches in coming years." (p. 13) • "A growing body of scientific evidence favors dimensional concepts in the diagnosis of mental disorders...From both clinical and research perspectives, there is a need for a more dimensional approach that can be combined with DSM's set of categorical diagnoses…*Cross-cutting symptom* measures modeled on general medicine's review of systems can serve as an approach for reviewing critical psychopathological domains. The general medical review of systems is crucial to detecting subtle changes in different organ systems that can facilitate diagnosis and treatment. A similar review of various mental functions can aid in a more comprehensive mental status assessment by drawing attention to symptoms that may not fit neatly into the diagnostic criteria suggested by the individual's presenting symptoms, but may nonetheless be important to the individual's care. The cross-cutting measures have two levels: Level 1 questions are a brief survey of 13 symptom domains for adult patients and 12 domains for child and adolescent patients. Level 2 questions provide a more in-depth assessment of certain domains. These measures were developed to be administered both at initial interview and over time to track the patient's symptom status and response to treatment." (p. 733) ○ See https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures ○ See Jones, K. D. (2012), Dimensional and cross-cutting assessment in the DSM-5. *Journal of Counseling & Development, 90*: 481-487. doi:10.1002/j.1556-6676.2012.00059.x • "In DSM-5, we recognize that the current diagnostic criteria for any single disorder will not necessarily identify a homogeneous group of patients who can be characterized reliably with all of these validators. Available evidence shows that these

	validators cross existing diagnostic boundaries but tend to congregate more frequently within and across adjacent DSM-5 chapter groups." (p. 20)
"Could the fact that the APA had earned $100 million on the DSM-IV…be the reason we have this new diagnostic system?" (p. 167)	• DSM-5 is not a new *diagnostic system*; instead "the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives. This new structure corresponds with the organizational arrangement of disorders planned for ICD-11 scheduled for release in 2015. Other enhancements have been introduced to promote ease of use across all settings:…"
"*The DSM-5…framework conceptualizes mental illness solely as a brain disorders.*" (p. 167)	• "DSM has been used by clinicians and researchers from different orientations (biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems), all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients. The information is of value to all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals." (p. xli) • "Although no definition can capture all aspects of all disorders in the range contained in DSM-5, the following elements are required: 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. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities." (p. 20)
"*…the American Counseling Association*" has "*115,000 DSM buying members…*" (p. 395)	• The American Counseling Association has around 55,000 members – *it has never had 115,000 members*; in contrast, The American Psychological Association has approximately 117,500 members, and the American Psychiatric Association has approximately 37,800 members.
"*People with histories of abuse, neglect, or severe deprivation will remain mysterious and largely untreated unless we heed the admonition of Alan Sroufe*:" (p. 168)	• Unfounded and a hasty generalization that draws upon emotional appeal without any empirical data. • "DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders…Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide diversity of contexts." (p. xli)