



## Statistics — What Can You Believe? If You Care About DSM-V, Read This

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First, let me say how proud I am that this last issue of *Psychiatric Annals* for 2008 is featuring a series of articles on behavioral statistics, guest edited by Robert Gibbons, PhD, a national resource. Dr. Gibbons has enlisted some of the best statistical minds in this country to write about modern issues in behavioral statistics. The material is well worth digesting. For research investigators, this issue should be a collector's item. For clinicians who have been bombarded by conclusions in textbooks in their development, and are currently flooded with "new findings" from many sources, it is a key to informed skepticism — a much better position than no-nothing nihilism. Was that result you claim obtained from a last observation carried forward (LOCF) analysis? How did your handling of missing data affect your result? Much is not what it seems, and this series is a partial guide for the rabbit hole. My thanks to the authors for the informative challenge they have brought us.

What about *Diagnostic and Statistical Manual of Mental Disorders* (DSM), fifth edition? The committees are at work poring over

DSM-IV, reviewing the past 15 to 20 years of literature, rooting out design flaws based on their clinical

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cal experience, doing reanalyses focused on specific questions, and trying to keep their day jobs going while volunteering for a slew of conference calls and face-to-face debates. My job is to chair the Mood Disorders Work Group.

Meta-questions have arisen. Since it is known that behavioral dimensions convey more information and transcend diagnostic categories, how could clinically valuable behavioral dimensions (eg, affect anxiety severity which predicts outcome and suicidal behavior in mood disorders) be added, even though medicine traditionally uses categories (dimensional cut points) to make decisions? How can psychosis severity be scaled across diagnostic categories? What determines caseness? Is a diagnosis enough or should impairment (and what kind?) (eg, patient distress)

reach a certain threshold or cut-off for treatment to be justifiable?

To get some feedback from you out there in the trenches, trying to vanquish mental disorders despite the second guessing and limitations imposed by managed care, formulary coverage rules, and liability issues, I have a few questions. I'd love to get enough responses emailed to jan.fawcett@att.net to be able to quote your overall opinions. Here's your chance to express your opinion and have some input. I can assure you that if I get a substantial response (more than a few lengthy diatribes), your collective opinions will be conveyed to the volunteers trying to create a diagnostic system with the most utility, reliability, and validity that our current state of knowledge allows.

**1. What do you think of the multi-axial system currently in place for psychiatric disorders? (Circle/choose as many as you agree with.)**

- A. I never use it.
- B. It conveys useful information.
- C. It could convey more useful clinical information than it does currently.
- D. Get rid of it.
- E. I would use it if it conveyed information significant for treatment/management.

**2. When it comes to recording diagnosis (Circle/choose as many as you agree with):**

- A. Simpler is better.
- B. A diagnosis should convey information relevant to treatment/management/outcome.
- C. I pay serious attention to specifier numbers (digits after the decimal point -296.xxx).
- D. I ignore specifier numbers.
- E. I would use clinically relevant dimensions (eg, distress, psychosis severity, anxiety severity) on a separate axis if they were relevant to the individual patient's treatment/management/outcome.

F. I would use a suicide risk severity dimension because it would provide evidence that I fully assessed the patient and used my assessment in the treatment plan (standard of care).

G. A suicide risk severity dimension would imply that suicide is predictable and encourage more law suits.

**3. Would you favor an interrelated system of different levels of complexity for DSM-V (eg, one for psychiatric specialists, one for primary care, and one for psychiatric researchers)?**

- A. Yes.
- B. No.

**4. What would you like to see changed in DSM-V?**

- A. Something (please specify what).
- B. Nothing.

Thank you for your thoughtful responses. Please forward responses to [jan.fawcett@att.net](mailto:jan.fawcett@att.net).

May 2009 be a happy and meaningful year for you and your family.