Women-specific mental disorders in DSM-V: are we failing again?

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Abstract

Despite a wealth of studies on differences regarding the biobehavioral and social–psychological bases of mental disorders in men and women and repeated calls for increased attention, women-specific issues have so far not been comprehensively addressed in past diagnostic classification systems of mental disorders. There is also increasing evidence that this situation will not change significantly in the upcoming revisions of ICD-11 and DSM-V. This paper explores reasons for this continued failure, highlighting three major barriers: the fragmentation of the field of women's mental health research, lack of emphasis on diagnostic classificatory issues beyond a few selected clinical conditions, and finally, the “current rules of game” used by the current DSM-V Task Forces in the revision process of DSM-V. The paper calls for concerted efforts of researchers, clinicians, and other stakeholders within a more coherent and comprehensive framework aiming at broader coverage of women-specific diagnostic classificatory issues in future diagnostic systems.

Keywords Diagnostic classification, Mental health, Women, Gender, DSM-V

Introduction: the evidence

Over the past two decades, solid research findings have been presented highlighting the core relevance of female-specific factors in mental health. The evidence covers virtually all areas of interest ranging from biological and developmental factors, gender-specific differences on risk, protective and resilience factors, social stress, trauma and violence, the pathogenesis and natural course of specific mental disorders, as well as issues of identification, treatment and intervention, and public health. This evidence has also been repeatedly summarized and translated into a comprehensive agenda for action, for example, in the Surgeon General's Workshop on Women's Mental Health (2005) or the World Health Organization's mission statement on “Gender and Women's Mental Health” (2009). Thus, there is no doubt that gender is not only a critical determinant of mental health and mental disorders, including the existence of female-specific disorders with associated specific pathogenetic mechanisms, and there is also little doubt about the existence of gender-specific determinants and mechanisms promoting and protecting mental health. There is also clear evidence of a substantial public health impact, revealing that the disease burden resulting from mental disorders and neuropsychiatric condition is disproportionally higher in females compared to males. Depressive disorders in females alone account for 42% of all the disability burden from all neuropsychiatric disorders as opposed to 29.3% in males; even higher estimates for females of up to 65% have been estimated if the disease burden is measured for all mental disorders among subjects in the reproductive years (16–55; Wittchen and Jacobi 2005). Yet – despite this convergent evidence – it remains puzzling for many of us to find out that this evidence is not more comprehensively and specifically addressed in our manual definitions of specific mental disorders in the DSMIVTR (APA 1987) or ICD-10 (WHO 1993). Of course, it could be seen as a certain progress that, in the more recent DSM versions, core gender issues are now addressed within the text descriptions (chapters on “Specific culture and gender features”). However, female-specific diagnostic features are generally not specified as diagnostic criteria for specific disorders and, if they are, they are only mentioned as a specifier (as for mood disorders “with postpartum onset”) or removed to the appendix chapter on “Criteria sets and axes provided for further study” (as for premenstrual dysphoric disorder [PMDD]; American Psychiatric Association (APA) 2000). More importantly, there is little

hope that this situation will change significantly in the upcoming revisions of ICD-11 and DSM-V. Despite the publication of a DSM-V mission book on age and gender considerations (Narrow et al. 2007) that highlights again the critical importance of gender in how mental disorders develop and present, there are up to now no signals of a systematic approach in the background documents for the DSM-V revision process to deal with female-specific disorders and syndromes more comprehensively and in greater detail. For example, neither the DSM-V mission book “A research agenda for DSM-V” (Kupfer et al. 2002) nor its follow-up publication “Advancing DSM – dilemmas in psychiatric diagnosis” (Phillips et al. 2003) do discuss this topic as a priority area and not even one chapter discusses specifically the challenges involved in gender issues and female-specific definitions of mental disorders. This leads us to the question of why do we seem to fail again to ensure a broader consideration of female-specific issues in our diagnostic classification system?

Incorporating female-specific issues in DSM-V: why we might fail again

Revising diagnostic classification systems: “the rules of the game”

Revising a diagnostic classification system is a highly complex and largely political process. The “players” are not only the researchers and clinicians, but also the public and stakeholders. On this more general level, one major political barrier and obstacle might be seen in the fact that many advocacy groups oppose female-specific criteria, syndromes, and disorders because they fear that psychiatric stigma and associated adverse effects might be attached to the role of women and the problems they experience. Although since DSM-III this indeed quite critical issue has been moderated by introducing the more neutral and descriptive term of “mental disorders,” thus avoiding the highly problematic term “psychiatric illness,” this obviously did not moderate the sometimes fierce rejection of diagnostic categories like “premenstrual dysphoric disorder,” as an example. Beyond this more political issue, there are numerous other barriers, such as the constitution of revision task forces, rarely including experts on female-specific issues, and the removal of gender issues of diagnosis-specific task forces into a separate task force together with culture issues. Although such an organization seems to make a lot of sense because gender issues clearly represent a general concern that cut across all diagnoses, such separation makes it more difficult to reach agreement in the diagnostic task forces about gender-specific suggestions, simply because the linkages between task forces imply substantial logistical challenges. Another barrier might be that there are too many specific critical topics that are being addressed (e.g., improving the wording of criteria of specific disorders, increase consistency across disorders, implementing new principles like stronger emphasis on dimensional measures) Helzer et al. 2008; Wittchen et al. 1999. Unfortunately, gender issues are not always on the work agenda of DSM-V task forces. It should be mentioned that this dilemma is not unique to gender issues, but is equally shared, for example, by the age and developmental work groups. A particular challenging barrier might also be seen in the specific DSM-V rules for making revisions: For suggesting and introducing new disorders or major revisions the bar for successful adoption of a proposal is quite high. To mention a few: (a) There must be consensus in the task force and among advisors and experts for the change, (b) there must be substantial experimental and empirical evidence across all domains of the validation process (familial aggregation/ co-aggregation, genetics, neurobiological factors, sociodemographic and cultural factors, environmental risk factors, prior psychiatric history, cognitive emotional, temperament and personality, comorbidity, diagnostic stability, course of illness, response to treatment), and (c) among these causal neurobiologic factors are emphasized, consistent with DSM-V's mission to be a system that is stronger related to core pathogenetic processes rather than being simply

descriptive and reliable. Clearly, providing such comprehensive validation evidence is sometimes even difficult for established diagnoses, even more so for new diagnostic categories or new diagnostic criteria proposed. The situation is even more challenging if one considers that there are considerable pressures to simplify the forthcoming DSM-V, for example, by reducing the number and the heterogeneity of diagnostic groups Helzer et al. 2008. This incomplete description of the DSM-V revision process makes it evident how difficult it is and will always be to justify new syndromes and disorders as independent diagnoses or to achieve major modifications in the criteria. Accepting these standards more or less willingly means that, if we want a more comprehensive and specific consideration of female-specific criteria and disorders in the future classification, concerted action from researchers, clinicians, and stakeholders is mandatory. Furthermore, from a science perspective, there must be clear experimental and empirical evidence for all the changes proposed, presented in a way that makes it easy for the revision task forces to translate the evidence into explicit criteria.

Heterogeneity and fragmentation of the women's mental health field – a barrier?

Given that the women's mental health field is in fact well-organized with a broad consensus-based agenda, one might be surprised to see fragmentation listed here as a barrier. It is certainly true – as displayed in the Conceptual Framework (Surgeon General's Workshop on Women's Mental Health, Workshop Report 2005) – that this interdisciplinary field is much more organized than other fields. However, when it comes to revising a diagnostic system for mental disorders, the broad coverage of interdisciplinary topics ranging from lifestyle issues to social forces can also become an obstacle. Particularly, if many interdisciplinary fields with different concepts, definitions, and agendas are involved, the coherent work on a few selected issues in the field of diagnostic classifications and the elaboration of scientific evidence may become difficult. This seems to be especially true with regard to meeting the formal and content requirements of an empirically based pathogenetic classification system as outlined above as the core mission for DSM-V. For example, the term “women's mental health” covers an extremely broad spectrum of issues that go much beyond the core aspects of immediate relevance to diagnostic classification and criteria for disorders. The lack of a coherent framework of “women-specific diagnostic and classificatory issues” and the lack of a consensus-based “diagnostic classificatory proposal” from the women's mental health field that could provide guidance to DSM-V is clearly one core barrier. This lack becomes easily evident, if we would simply do a literature search in web of science or PubMed using the search terms “diagnostic classification and gender” as an example. Although one would expect that these search terms lead to hundreds of hits, one is surprised to find mostly references that deal with “gender identity disorders.” The reason for this is evident; the relevant literature is simply fragmented and listed under a range of other keywords, that rarely specifically used keywords like diagnostic classification, diagnosis, etc. Greater coherence, coordination, and emphasis on diagnostic issues and the derivation of a coordinated proposal as to how the women's mental health field would like to see female-specific issues considered in DSM-V would be a major step forward. Providing such a proposal, either in form of diagnostically cross-cutting or diagnosis-specific proposals, would make it easier for the DSM-V task forces to consider such changes seriously and more systematically. The collections of excellent papers in this issue highlight – with a few exceptions – this problem clearly. Most of the contributions focus on selected areas such as postnatal and perinatal depression or psychosis, trauma and posttraumatic stress disorder, and PMDD, making well-substantiated suggestions for changes in various forms and formats. Yet, beyond postnatal mood disorder, there seems to be little consistency and agreement even among this specialist group about how such changes can be effectively translated and justified within the content of

the ongoing DSM-V revision process. This failure might be due to the differences in traditions and procedures used in the interdisciplinary women's mental health field. As an example, one could highlight that, at this point, there is no consensus about the use of a comprehensive diagnostic assessment platform for female-specific issues in diagnostic classification that could help to build up over time a coherent symptom, syndrome, and diagnostic platform of evidence needed for a more successful translation of evidence into diagnostic classification systems.

The need for a coherent female-specific diagnostic assessment platform

Several authors have recently highlighted the problem that there are no standard diagnostic assessment tools that provide sufficiently detailed information about female-specific disorders such as PMDD, female-specific characteristics of psychopathological presentations such as mental disorders with postpartum onset, the relationship of characteristics of the menstrual cycle with psychopathology and perimenopausal and postmenopausal manifestations of syndromes (Soares and Zitek 2008; Steiner et al. 2003b; Yonkers and McCunn 2007). Given the increased psychopathological burden of women with regard to most diagnoses (Andrade et al. 2003), the lack of such an instrument has also impeded the accumulation of better clinical–epidemiological information regarding the core factors associated with the increased incidence and prevalence of the following mental disorders in women. Epidemiological studies consistently show that, with the onset of the reproductive years at menarche, mood disorders are at least twice as common in women as in men (Kessler 2003; Lewinsohn et al. 1998; Steiner et al. 2003a; Wittchen and Jacobi 2005). A similar gender-specific pattern is also evident in anxiety, eating, and somatoform disorders as well as with regard to the type and extent of comorbid patterns (Rief et al. 2001; Wittchen and Jacobi 2005; Yonkers and McCunn 2007). There is also considerable evidence that onset, course, and prognosis of these disorders may be different for men and women (Fehm et al. 2005; Wittchen and Jacobi 2005). In spite of the existence of many syndrome-specific assessment tools, there are almost no generally agreed upon comprehensive psychopathological assessment instruments that fully address the specific characteristics of women's reproductive years. Therefore, it has been difficult to relate psychopathological syndromes and their course to core female-specific issues, such as the menstrual cycle, pregnancy, postpartum, and menopause (Steiner et al. 2003a; Yonkers and McCunn 2007). Furthermore, some disorders that are exclusively relevant to women such as PMDD and perinatal and perimenopausal disorders are not covered by the existent standard diagnostic tools at all. Despite the wide range of instruments available that specifically address some of these critical issues, these tools are typically questionnaires covering only a few domains and cannot easily be embedded into one coherent and conceptually sound diagnostic assessment instrument along the principles of DSM-IV or DSM-V. Thus, except for some recent attempts to supplement established diagnostic instruments by female-specific diagnostic modules such as PMDD (Wittchen et al. 2002), there has been no instrument in this area covering a broader spectrum of women-specific mental disorders. Most recently, we have suggested the CIDI-VENUS (CIDI-V; Martini et al. 2009; Steiner et al. 2003b; Steiner et al. 2007; Steiner et al. 2008; Wittchen et al. 2001) as such a – probably still incomplete and imperfect tool – providing a systematic and comprehensive approach to current female-specific core questions in mental disorders and psychopathological research, allowing a reliable examination of a wide range of mental disorders with embedded modular additions of women-specific conditions and factors (menstruation, pregnancy, postpartum, or menopause). The availability of a standardized and comprehensive categorical and dimensional examination of mental disorders and psychopathological syndromes during pregnancy as well as pregnancy and delivery outcomes

(e.g., gestational age, mode of delivery) is expected to provide an extensive and solidly coordinated basis for cross-sectional and longitudinal studies in epidemiological and clinical settings. Linked to the already existent family-genetic CIDI version (Lieb et al. 2000), the instrument might also enhance the efficiency and the detail of studies dealing with the familial transmission of mental disorders as well as perinatal research in general. Although the CIDI-V was primarily developed for epidemiological studies to examine women-specific disorders, it can also be used for clinical practice to study prevalence and incidence, maintenance, comorbidity patterns, and temporal relationships with the female reproductive cycle more comprehensively. The CIDI-V utility is enhanced by further covering critical issues like the impact of adverse pregnancy outcomes (e.g., stillbirth) and consequences of abdominal operations. Such approaches, if accepted more widely, might be instrumental for building up a cumulative data platform for female-specific issues in diagnostic classification, providing the basis for a more successful translation of evidence into future diagnostic classification systems.

Conclusion

A more successful translation of gender-specific issues into future diagnostic classification system requires concerted action from the women's mental health field specifically emphasizing those female-specific issues that should be considered in diagnostic classification systems. It is the responsibility of the women's mental health field to reach consensus and overcome fragmentation in order to propose specific suggestions according to the general rules of diagnostic classification systems and the specific rules used in the current DSM-V process. As long as such consensus is lacking or restricted to a few mental disorders only, it is unlikely that our vision of a broader and comprehensive recognition of female-specific criteria in DSM-V and ICD-10 will become a reality.

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