Initial Strategy for the Future of *DSM*

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The *Diagnostic and Statistical Manual of Mental Disorders* first took its current form and format in 1980 when *DSM-III* was published (1). Subsequently and periodically, APA's Board of Trustees would entrust a task force with producing an updated edition. Thus, 1994 saw the publication of *DSM-IV* (2) and 2013 saw the publication of *DSM-5* (3). In 2024, the Board of Trustees established the Future DSM Strategic Committee and tasked it with developing a roadmap for *DSM*'s next iteration. The committee has been working on the roadmap since May 2024, and this report provides a summary of progress to date.

DSM: POINTS AND COUNTERPOINTS

In the 45 years since the publication of *DSM-III*, knowledge about psychiatric disorders, the psychosocial and cultural impact on them, their treatment, and their biology has evolved tremendously. *DSM* has evolved with the field, making significant and valuable adjustments and adaptations along the way. Nonetheless, there have been some important critiques of *DSM* that need to be addressed.

One criticism is that despite the progress in advancing our understanding of the root causes of psychiatric disorders or at least the contributors to them, *DSM* is positioned as an atheoretical manual for diagnosis (1). There is no attribution to biological, psychological, environmental, sociocultural, or other factors as causal, and no disease mechanisms are proposed (4). However, *DSM* recognizes the role of these factors with the inclusion of the "Risk and Prognostic Factors" section added to each disorder in *DSM-5* and *DSM-5-TR*. The reasons for this atheoretical stance are largely historical. *DSM-III*, precursor to the current *DSM*, was developed at a time when there were several conflicting hypotheses about causal mechanisms of mental illness, with limited empirical data and divergent views about the path for scientific research toward elucidating them. Thus, taking an atheoretical approach at that time allowed APA to sidestep these limitations and focus on the description of the diagnoses that are now included in *DSM*. The idea behind providing criteria for diagnoses was that it would provide a robust method for ensuring that clinicians, educators, and researchers had a common language to more clearly communicate about what disorder was being treated or studied. For many of the major disorders, the *DSM* criteria were based on the Research Diagnostic Criteria (RDC) that had been developed for research, including epidemiologic studies to overcome the differing diagnostic practices in the United States and Europe (5, 6). For disorders not covered by the RDC, RDC-style criteria were developed.

One could, of course, defend the decision to make *DSM* atheoretical even today. Although there is broad agreement in the field that disorders arise from the interplay of neurobiological, developmental, experiential, socioeconomic, cultural, and environmental factors, knowledge about precisely how these factors interact is still evolving. Given that we still do not fully understand the etiology of disorders, can we claim that we know enough to embrace a particular theoretical framework today? This is one of the issues with which the committee has grappled, as was the case during the *DSM-5* revision process.

Another critique of *DSM* is that it is categorical. Decisions about the occurrence of a disorder are binary: the disorder is either present or not. However, we know that many clinical presentations manifest symptoms that occur along a spectrum of severity and that some symptoms, such as anxiety and anhedonia, are transdiagnostic, occurring across several disorders. Indeed, the somewhat arbitrary nature of categorical boundaries is one contributor to the extensive overlap in symptoms that we observe in many disorders, the considerable heterogeneity within a given disorder, and the high frequency of comorbidity, which indeed, rather than being the exception, is common in psychiatry (7, 8).

While it is true that symptoms occur along a spectrum of severity, clinical decision making involves categorical choices among a set of finite options. Clinicians must decide whether the person before them has a given diagnosis or treatable condition, and if so, determine whether to intervene and, whenever clinically feasible, reach consensus with the person about what treatment to prescribe or intervention to implement.

Moreover, given the state of the science, were one to choose a transdiagnostic approach to symptoms, viewing them as existing along a spectrum of severity, how would cutpoints be identified? This is a critical determination because with transdiagnostic approaches, it is still the case that reaching that threshold may determine the point at which a decision will be required about whether and how to intervene.

A third critique leveled at *DSM* is the emphasis on reliability rather than validity. Several thought leaders we interviewed assert that the *DSM* disorders are not "natural kinds" of categories, as *DSM* does not "carve nature at its joints" (9). Indeed, some scientists hold that the lack of progress in identifying biomarkers in psychiatry is due in no small part to the likelihood that the boundaries between diagnoses for which biomarkers have been sought are not correct. Although the criticism that *DSM* does not carve nature at its joints is understandable, one could argue that the locations of such joints between diagnoses are yet to be identified. Nonetheless, clinicians and researchers still need a pragmatic approach to provide care and advance the field, including the work to identify such "joints." While humbling to hear this valid concern, the committee concluded that the field has not yet identified any solutions ready for adoption, short of abandoning the whole effort or eschewing improving current nosology.

Some critics further worry that an emphasis on reliability may actually lead to reduced validity of the nosological system. That said, it is worth remembering that historically, diagnostic reliability among practitioners was not robust, and this needed to be addressed to facilitate better patient care. Most experts agreed that establishing reliability of disorders was an important first task and positioned *DSM* as a consensus document, or a sort of dictionary.

Another important limitation of *DSM* is the lack of inclusion of candidate or actual biomarkers or biological processes. Despite the tremendous progress in our understanding of brain structure and function, this knowledge base is rapidly evolving and remains decidedly incomplete. Another key barrier to such integration is that the majority of biological measures, especially biomarkers, are not yet ready to be deployed clinically, other than for Alzheimer's disease (10, 11). This has led the committee to consider alternative ways to introduce emerging information on biological factors or candidate biomarkers in psychopathology into the future *DSM* (for more details, see [12]).

An important challenge related to neurobiology became evident during the development of *DSM-5*. Rett syndrome, previously listed in *DSM*'s autism section, was removed from *DSM* when the genetic basis underlying its syndromic pathophysiology was elucidated. The decision had important repercussions because in the United States, some payers started denying coverage for the treatment of psychiatric symptoms associated with Rett syndrome. This precedent for removing a diagnosis from *DSM* and de facto from the purview of psychiatry once biological underpinnings become known is concerning, as it might lead to an erosion, if not erasure, of the field as neuroscience advances (13). For example, as the pathophysiology of Alzheimer's disease, Lewy body disease, and other late-life neurocognitive illnesses becomes better elucidated, will they be considered strictly in the domain of neurology going forward? And what are the potential implications for patients who would not have access to much-needed psychiatric, psychosocial, or cultural interventions to improve mental health care (14, 15)? If biological factors are incorporated into psychiatric classification, psychiatry and the rest of medicine need to avoid a misplaced dualism in which only those disorders for which the underlying pathophysiology has not yet been defined are considered psychiatric (14).

Another critique is that *DSM* is not based on empirical science, but rather has been developed through expert consensus (16). While strictly speaking this is true, this expert consensus does not occur in a vacuum. Rather, the experts base their consensus on empirical data that is reviewed and debated. Some advocate for the use of systematic reviews to drive decision making about changes to *DSM*, and observers note that the creation of the Scientific Review Committee during the development of *DSM-5* was a strong step toward implementing this method (17). Given the state of the science and absent well-defined boundaries between disorders, expert interpretation of empirical data is likely a reasonable approach until the evidence is better developed. Of note, such reliance on expert interpretation is consistent with how clinical practice guidelines are commonly developed across medicine, including oncology and genetics.

Additional critiques are related to the history and roots of psychiatry, which developed in a Western context that rarely acknowledged non-Western epistemologies of mind, body, health, and well-being—including mental health (18). Naturally, these perspectives have had significant influence on *DSM*, an issue that the committee seeks to address. Similarly, entrenched responses to racial characteristics and social class have an impact on psychiatric assessment. As is the case in many branches of medicine, these can lead to misdiagnosis, overdiagnosis, or underdiagnosis and negatively impact management and treatment, especially among persons from racial minority groups (19, 20). As expert consensus about interpretation of available data is the guiding model of *DSM*, raising questions as to who are designated as experts to drive the direction of *DSM* is also key. This is an essential element to ensure that more global and inclusive epistemologies and scientific approaches are integrated into the future of *DSM*. It is also critical to include people with lived experience as experts (see the Engaging Stakeholders and Diverse Perspectives section, below), in addition to psychiatrists and other clinicians.

Despite its limitations, *DSM* has made important contributions to the diagnosis of mental disorders. It provides a common language for clinicians, patients, and researchers across clinical settings and disciplines, which aids in communication. The availability of criteria and detailed descriptions of psychiatric disorders ensures that when a patient is receiving team-based care, there is the opportunity for shared understanding

of the targets for intervention. The standardized operational approach to categorizing psychiatric disorders based on observable symptoms and behaviors also enhances the ability of scientists to collaborate across institutions and countries. *DSM* has also included considerations of culture, which both has an important impact on the expression of psychopathology and provides context for understanding the emergence and trajectory of psychopathology. Similarly, the integration of suicide assessment across diagnoses was a key improvement with significant public health implications. A key task ahead is to preserve and build on *DSM*'s strengths and gains to date while continuing to advance its nosological framework.

DSM AND OTHER NOSOLOGICAL SYSTEMS

DSM is but one of several existing psychiatric nosological systems (21, 22). As part of its work, the committee devoted significant effort to reviewing these to glean insights from other approaches to nosology and find opportunities for harmonization.

The committee reviewed the *International Classification of Diseases* (*ICD*), which is published by the World Health Organization (WHO) and used across the globe. Of note, this nosological system is not restricted to psychiatry; it covers the whole of medicine. In the United States, billing public and private insurance for clinical services of all types, not just psychiatric services, relies on the diagnostic codes in the clinically modified version of the 10th edition of *ICD* (*ICD-10-CM*) (23). *ICD* is now in its 11th edition (24), but these latest codes have not been adopted across all countries in the world, including the United States (25). A point of interest is that unlike previous *ICD* editions, *ICD-11* now includes symptoms listed for psychiatric conditions, and these are well aligned with the symptoms in *DSM-5* (26, 27).

The Research Domain Criteria (RDoC) (28), developed by the National Institute of Mental Health (NIMH) (29), is a framework for research, rather than a nosological system. It was never intended as a diagnostic tool. Rather, it was devised to identify and describe candidate systems that might shed light on the mechanisms underpinning dimensions of psychopathology. The purpose was to provide a cohesive approach for scientists examining the biological contributors to pathology and health that could be interrogated and tested across different levels of analysis as well as in animal models and humans.

The Hierarchical Taxonomy of Psychopathology (HiTOP) is an empirically generated classification system (30, 31). It organizes symptoms into groups based on covariation and organizes syndromes into spectra based on comorbidity. Importantly, it describes symptoms and syndromes dimensionally, with the goal of enabling better measurement of symptom severity and overlaps, akin to some of the efforts made in the *DSM-5* revision process.

Some of the hierarchical and dimensional aspects of the proposed new structure for *DSM* are informed by the deliberations during the *DSM-5* revision process and the strengths of RDoC and HiTOP and similar endeavors (for more details, see 32).

DIMENSIONALITY IN *DSM*

DSM-5 attempted to move psychiatric nosology toward a dimensional perspective by incorporating dimensional measures such as the Cross-Cutting Dimensional Symptom measures and the Clinician-Rated Dimensions of Psychosis Symptom Severity scale (33). This served as a psychiatric review of symptoms that identified items to be further queried with more detailed (level 2) measures (34, 35).

The level 2 measures provided specific, detailed assessments of each of the Cross-Cutting Dimensional Symptom measures rated as positive. So, for example, if the patient endorsed depression, the Patient Health Questionnaire–9 could be administered to obtain further details. These severity dimensional measures allowed the clinician to assess the domains in more detail, enhancing the ability to assess subsyndromal conditions, emerging conditions, and residual symptoms. This permitted more refined assessments of treatment responses and prognosis. For example, anxiety can range from none to normal angst to severe pathology. The items from the self-rated level 1 Cross-Cutting Dimensional Symptom measure for adults and the review of symptoms are listed in Table 1.

Dimensionality is also seen in *DSM-5*'s alternative model for personality disorders (AMPD), which focuses on two dimensions: maladaptive personality functioning and traits. The AMPD stands in contrast to the discrete personality disorders included in *DSM-III* and *DSM-IV*, although it does include six discrete personality disorders (borderline, narcissistic, antisocial, avoidant, schizotypal, and obsessive-compulsive), as opposed to 10.

Thus, dimensionality was integrated during the development of *DSM-5*. However, its salience was diminished by its placement in Section III, often deemed by readers to be optional, as well as by limited efforts to educate the field about them. The Future DSM Strategic Committee aims to address these gaps.

THE FUTURE DSM STRATEGIC COMMITTEE'S RESPONSIBILITIES AND STRUCTURE

The central goal of the committee is to determine the strategic direction for *DSM*'s future. Specifically, it was tasked with conceptualizing how scientific developments can inform the structure, definition, and criteria of *DSM* disorders and harmonizing as much as possible with *ICD-11*, with RDoC and HiTOP, and with other nosological developments. Additional goals included integrating biomarkers and biological factors; functioning; quality of life; severity; socioeconomic, cultural and environmental determinants of mental health; developmental factors; and suicide risk assessment into diagnostic assessments to permit more holistic formulations. Many of these foci are being addressed through four subcommittees.

TABLE 1. ***DSM-5*** **self-rated level 1 Cross-Cutting Symptom Measure: review of mental systems**[a]

Domain	Question
I.	1. Little interest or pleasure in doing things?
	2. Feeling down, depressed, or hopeless?
II.	3. Feeling more irritated, grouchy, or angry than usual?
III.	4. Sleeping less than usual, but still have a lot of energy?
	5. Starting lots more projects than usual or doing more risky things than usual?
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?
	7. Feeling panic or being frightened?
	8. Avoiding situations that make you anxious?
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?
	10. Feeling that your illnesses are not being taken seriously enough?
VI.	11. Thoughts of actually hurting yourself?
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?
VIII.	14. Problems with sleep that affected your sleep quality overall?
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?
	17. Feeling driven to perform certain behaviors or mental acts over and over again?
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?
XII.	19. Not knowing who you really are or what you want out of life?
	20. Not feeling close to other people or enjoying your relationships with them?
XIII.	21. Drinking at least four drinks of any kind of alcohol in a single day?
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or drugs like marijuana, cocaine or crack, club drugs [like ecstasy], hallucinogens [like LSD], heroin, inhalants or solvents [like glue], or methamphetamine [like speed])?

[a] Questions are rated on a 5-point scale from 0 (none or not at all) to 4 (severe or nearly every day).

The Future DSM Strategic Committee is led by a chair (María A. Oquendo, M.D., Ph.D.) and two vice chairs (Jonathan E. Alpert, M.D., Ph.D., and Nitin Gogtay, M.D.). It has 14 voting members, as well as nonvoting members, consultants, and invited speakers. More nonvoting ex officio members will be integrated going forward from within APA (Board of Trustees, Assembly, and the *DSM-5-TR* steering committee), from external organizations (NIMH, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Services Administration), and early career fellows, as well as people with lived experience. The ultimate structure of the membership of the committee is shown in Figure 1.

After the launch of *DSM-5*, an open online system for submitting proposals for changes to *DSM* was created. The portal is available to the community to suggest additions of diagnoses, changes in symptoms, deletions of diagnoses, and other changes (36). The DSM-5 Task Force developed specific criteria that must be met for proposed changes to be considered. Also, there was an expectation that proposals be scholarly, including a thorough and scholarly review of literature to support the proposal. Going forward, the Future DSM Strategic Committee aims to continue to develop *DSM* as a living document, wherein changes can happen synchronously with scientific advances and updates can be produced, likely on an annual basis. Similar to the process developed by the DSM-5 Task Force, the plan is to develop criteria for proposals as well as a method for submitting them and disseminating requests for proposals for changes to *DSM* periodically. In addition to evaluating submissions with proposed changes to *DSM*, the committee aims to set up a process for regularly reviewing content in the context of evolving knowledge.

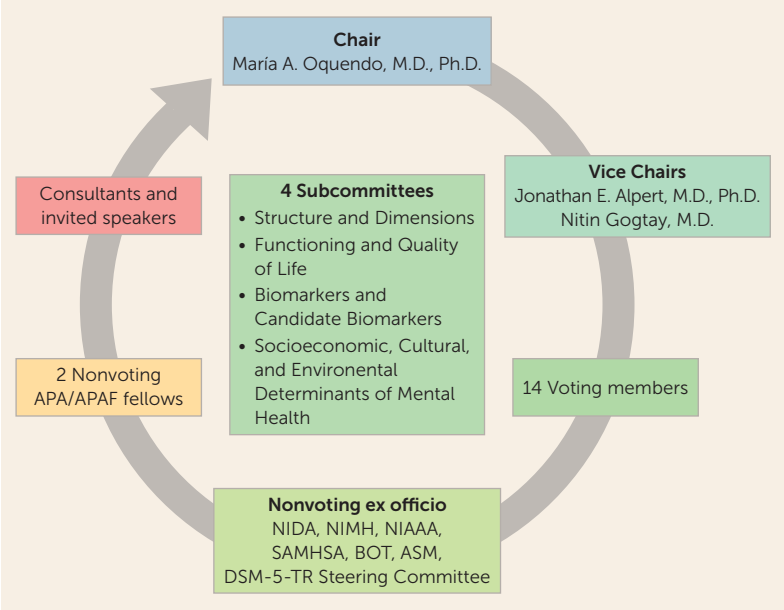
Structure and Dimensions Subcommittee

Chaired by Dost Öngür, M.D., Ph.D., the Structure and Dimensions Subcommittee is charged with evaluating the organization of *DSM* and considering whether a redesign and/or reorganization would be of utility. This subcommittee will evaluate approaches to capturing the continuum of severity in psychiatric symptoms, improving diagnostic validity, enhancing personalized treatment, facilitating research, accommodating new discoveries, and considering a neurodevelopmental focus, all while maintaining *DSM* clinical utility. Importantly, the committee will develop a framework for integrating transdiagnostic dimensions into the *DSM* nosology. Such dimensions are likely to be key to identifying constructs for which pathophysiology can be more tractably defined. This subcommittee, in collaboration with the Research and Methodology Documentation Subcommittee, will also decide on the criterion framework needed for change and incorporate other subcommittees' work into the nosological structure. The subcommittee's charge is outlined in Box 1, and further information may be found in another article in this series (32).

Functioning and Quality of Life Subcommittee

Chaired by Karen Drexler, M.D., the Functioning and Quality of Life Subcommittee is charged with identifying the best way to weave assessment of functioning and quality of life into *DSM*. The aim is to correct the unintended consequences of putting the assessment of functioning (i.e., the WHO Disability Assessment Schedule 2.0) (37) in the latter chapters of *DSM-5* (Section III)

FIGURE 1. Future DSM Strategic Committee[a]



[a]APAF, American Psychiatric Association Foundation; ASM, Assembly of the American Psychiatric Association; BOT, Board of Trustees; NIAAA, National Institute on Alcohol Abuse and Alcoholism; NIDA, National Institute on Drug Abuse; NIMH, National Institute of Mental Health; SAMHSA, Substance Abuse and Mental Health Services Administration.

BOX 1. Charge for the Structure and Dimensions Subcommittee

- Need to redesign or reorganize *DSM*
- Capture the continuum (dimensionality) of mental health
- Improve diagnostic validity, enhance personalized treatment
- Facilitate research, accommodate new discoveries, consider a neurodevelopmental focus
- Maintain *DSM* clinical utility
- Decide on the criteria and framework needed for change
- Incorporate other subcommittees' work into the nosological structure

despite understanding its importance in prompting treatment seeking, in predicting remission, and in understanding the burden of mental illness. The subcommittee will evaluate potential instruments that have been tested and validated, ideally in multiple populations, to recommend a more comprehensive patient assessment. This work aims to align with recovery-oriented assessment and care and to promote preventive and long-term care strategies. The subcommittee's charge is outlined in Box 2, and further information may be found in another article in this series (38).

Biomarkers and Biological Factors Subcommittee

Initially chaired by Bruce Cuthbert, Ph.D., and now by Anissa Abi-Dargham, M.D., the Biomarkers and Biological Factors Subcommittee is charged with identifying the best way to incorporate measures of biomarkers and biological factors into *DSM* and bridging the gap between clinical psychiatry and neuroscience. The subcommittee will assess the potential contribution of both laboratory tests and data from wearable devices and other technologies to *DSM*. A challenge is that not only are there many subtypes of biomarkers (risk prediction, diagnostic monitoring, prognosticating treatment response, predicting relapse, etc.), it is also clear that with the exception of biomarkers for Alzheimer's disease, none are currently ready for integration. A key task for this subcommittee is to develop a rubric to define the parameters that biological factors must meet to be included in *DSM*—that is, what constitutes "enough evidence" to warrant integration into *DSM* as candidate biomarkers, even if they are not yet at the rigorous level of a biomarker, while being clear about any limitations. The subcommittee's charge is outlined in Box 3, and further information may be found in another article in this series (12).

Socioeconomic, Cultural, and Environmental Determinants of Mental Health Subcommittee

Chaired by Milton L. Wainberg, M.D., the Socioeconomic, Cultural, and Environmental Determinants of Mental Health Subcommittee fills a gap in *DSM* given that despite the influence of socioeconomic, cultural, and environmental determinants of mental health on the development, progression, and treatment of mental disorders, they are not adequately addressed in *DSM* or in other psychiatric nosologies. The focus of this subcommittee is based on the Dahlgren-Whitehead model of health determinants adopted

BOX 2. Charge for the Function and Quality of Life Subcommittee

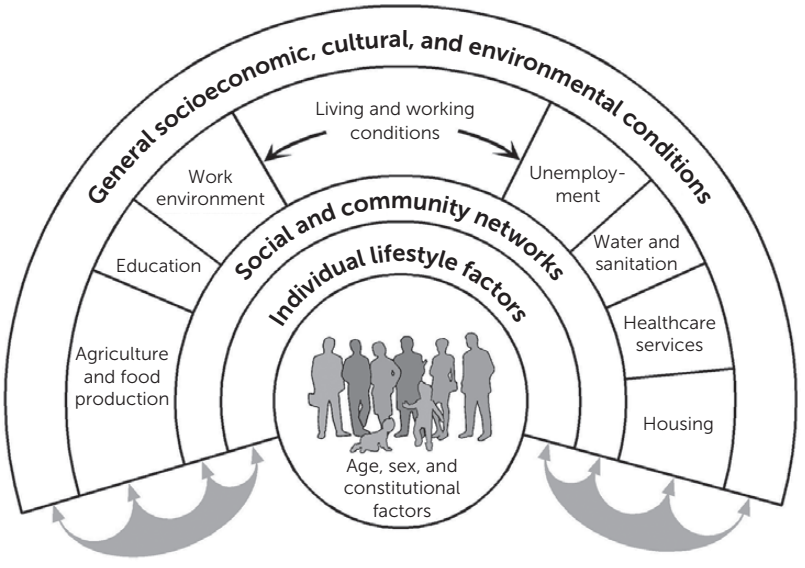
- Identify the best way to weave assessment of functioning and quality of life into *DSM*
- Begin evaluating potential instruments to recommend
- Facilitate comprehensive assessments
- Align with recovery-oriented assessment and care
- Promote preventive and long-term care strategies
- Recommend tested and validated instruments

BOX 3. Charge for the Biomarkers and Biological Factors Subcommittee

- Identify the best way to incorporate measures of biomarkers (risk, diagnostic, monitoring and prognostic, treatment response, and relapse) in *DSM*
- Assess the potential of laboratory and wearable devices use
- Bridge the gap between psychiatry and neuroscience
- A psychiatric nosology system based on objective measures with the potential to:
  - Promote tailored treatments
  - Enhance early detection and prevention and predict therapeutic response

by WHO, which recommends consideration of socioeconomic, cultural, and environmental determinants in clinical formulations and treatment planning (Figure 2). The charge is to integrate these determinants and intersectionality into psychiatric assessment to result in more holistic evaluations. Intersectionality is a framework delineating how multiple social categorizations for a given individual interact to yield distinct experiences of privilege and discrimination for that person. That is, the sociocultural categories do not exert their impact in isolation. They interact and intersect to shape the person's identities and social experiences. The subcommittee will also incorporate Indigenous and global perspectives into the *DSM* framework. Anticipated outcomes include bringing attention to disparities in mental health, enhancing prevention, promoting early intervention, and reducing stigma. The subcommittee's charge is outlined in Box 4, and further information may be found in another article in this series (39).

FIGURE 2. Dahlgren-Whitehead conceptual framework for social determinants of health[a]



[a]From reference 46; reproduced with permission. See also reference 47.

CULTURAL CONSIDERATIONS IN *DSM*

Cultural considerations are essential for the understanding and classification of mental disorders (40). Culture not only functions as a social identity and determinant of health but also profoundly influences symptom expression, illness experience, and diagnostic interpretation. A cultural lens allows for the decentering of Western epistemologies and the embrace of more inclusive and globally informed perspectives. Cultural practices interact with neurobiological, psychological, and social processes, further underscoring the complex multifactorial and multifaceted nature of mental health and illness (41). *DSM*'s inclusion of the Outline for Cultural Formulation and the Cultural Formulation Interview marked a significant step forward, and the future *DSM* will continue to build on these advances with an eye toward increasing their pragmatic utility in the clinic (3, 42). Ethnocultural considerations are integrated into the work of each subcommittee, and strategies to ensure that cultural factors are addressed in all aspects of the *DSM* evolution will be developed.

ENGAGING STAKEHOLDERS AND DIVERSE PERSPECTIVES

The committee is developing frameworks to meaningfully engage stakeholders and diverse perspectives in informing the future of *DSM* to optimize its applicability and clinical utility. This will include soliciting input from people with lived experience in the process of developing a future *DSM*. The committee also seeks to incorporate clinician perspectives and integrate feedback from other stakeholders. For example, the committee is engaged with the American College of Neuropsychopharmacology, WHO, the European College of Neuropsychopharmacology (which has recently mapped out a Precision Psychiatry Roadmap [43]), the Indian Psychiatric Association, and more (44).

PRAGMATIC ISSUES TO CONSIDER REGARDING CHANGES TO *DSM*

One key pragmatic issue is that in the United States, although not in most other countries, the description and criteria in *DSM* are used for billing and insurance reimbursement, despite using the *ICD-10-CM* codes. In any case, changes to the criteria or the diagnostic codes must be implemented in a manner that does not disrupt their clinical utility globally or have untoward consequences for patient care.

BOX 4. Charge for the Socioeconomic, Cultural, and Environmental Determinants of Mental Health Subcommittee

- Identify the impact of socioeconomic, cultural, and environmental determinants of mental health and intersectionality on *DSM*
  - Cultural and ethnoracial backgrounds, sex and gender, belief systems, education, life experiences, personality, etc.
  - Incorporate global perspectives
- How best to incorporate these into *DSM* framework so that they:
  - Help bring attention to disparities in mental health
  - Help enhance prevention and early intervention
  - Help reduce stigma

Another consideration is how best to position *DSM* so that it continues to evolve in the digital era and in the context of broad use and availability of artificial intelligence.

POSSIBLE NEW DIRECTIONS FOR THE FUTURE *DSM*

Some ideas under consideration include moving away from theoretical agnosticism and embracing biology and environment and their interactions as key determinants of mental disorders. That is, biology interacts with the contextual environment, including historical, social, and cultural experiences and their intersectionality to determine the final clinical presentation. This can be accomplished by including descriptive language but also by finding a pragmatic way to integrate biomarkers and other biological factors, recognizing that it is very early days for most of these.

The committee is also evaluating how best to ensure that the disorders in the manual, which may be close to the best we have today, not be reified. The problem of reification emerges among both clinician and patient groups as well as the public at large. Thus, the disorders come to be viewed as immutable or somehow definitive. However, clearly, as knowledge emerges about the underlying pathophysiology of disorders, including biological and environmental factors, changes to extant descriptions of disorders will be required. Moreover, the addition of transdiagnostic dimensions may aid in mitigating the risk of reification because it makes explicit that there are aspects of psychopathology that transcend diagnostic boundaries and hence categories. Educational efforts by APA to make these concepts more broadly understood will be essential.

Transdiagnostic dimensions may also assist, as mentioned above, in making inroads on determining the biological and other underpinnings of psychiatric symptoms. This is important because of significant concerns that current *DSM* categories impede progress on this front. Further, progress in elucidating pathophysiology, developing new treatments, and devising increasingly valid classification schemes will require a combination of research approaches, some that draw directly on *DSM* nosology and some agnostic to *DSM*. Applied with all due epistemic humility, *DSM* can continue to play an important role in clinical care and research.

Finally, the committee debated the risks and benefits of changing the manual's name. This arose through the observation that the presence of the word "statistical" in the manual's title was anachronistic since the goal of the manual is no longer simply to provide for the collection of psychiatric hospital and census statistics (45). At the same time, the *DSM* "brand" has tremendous recognition and visibility, which is worth retaining. The committee is proposing an adjustment to the name: *Diagnostic and Scientific Manual*. Rather than being a statement about the definitiveness of the science reflected in *DSM*, this change highlights the committee's goal to ensure that the evolution of *DSM* continues to be guided by science and the view that this value is important enough to be reflected in the title.

Other areas of focus are likely to arise, and the committee will maintain a flexible process.

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