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Gender issues and DSM-V

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With each edition of the DSM, there has been greater attention paid to gender issues. The DSM-I, published in 1952, contained essentially no mention of sex differences in psychiatric illness. The DSM-II (1958) only rarely noted sex differences in disorders but did include the sex-specific disorder "Psychosis with Childbirth" as well as "Involutional Melancholia", which was commonly associated with menopause.

The DSM-III (1980) added a text section on "Sex Ratios" for each disorder but provided only minimal information such as "more common in women" or stated the information was not available; there were also sporadic comments about gender differences in course and treatment-seeking behavior. Several diagnoses in the DSM-III were sex-specific or had different diagnostic criteria for men and women, most of which were in the section on Psychosexual Disorders. The other disorder with sex-specific diagnostic criteria in DSM-III was Somatization Disorder, which had a threshold of 14 symptoms for women and 12 symptoms for men from among the 37 possible symptoms, 4 of which were categorized as "female reproductive symptoms" (painful menstruation, menstrual irregularity, excessive bleeding, and severe vomiting during pregnancy). The DSM-III-R (1987) added proposed criteria for another sex-specific diagnosis, Late Luteal Phase Dysphoric Disorder (LLPDD). Because of the tremendous controversy generated by this diagnosis and concerns voiced by women's groups that its inclusion in the DSM may stigmatize women, it was placed in the Appendix as a diagnosis for further study, to be coded as an Unspecified Mental Disorder.

In DSM-IV (1994), a text section on "Specific Culture, Age, and Gender Features" was added for each disorder, which included any known information about gender differences in prevalence, symptoms and course. LLPDD remained in the Appendix of DSM-IV, with the name changed to Premenstrual Dysphoric Disorder (PMDD) and the coding changed to Depressive Disorder Not Otherwise Specified; in the body of the DSM, PMDD was listed as an example of Depressive Disorder NOS. The criteria for Somatization Disorder were changed so that the number of categories and required symptoms were equal for men and women, although some sex-specific symptoms were still included as examples. Another important addition in DSM-IV was the modifier "With Postpartum Onset" to describe episodes of Major Depressive Disorder, Bipolar I or II Disorder, or Brief Psychotic Disorder with onset within 4 weeks after childbirth. In DSM-IV-TR (2000), the information in the text about gender differences in the prevalence, symptoms, and course of disorders was greatly expanded. "With Postpartum Onset" was retained as a specifier with the same 4-week time frame. The only disorders that are unique to men or women or have sex-specific diagnostic criteria are among the Sexual and Gender Identity Disorders (and PMDD in the Appendix).

What changes with regard to gender issues should be incorporated into DSM-V? The following options should be considered:

1. PMDD should be removed from the Appendix and included as a separate disorder in the body of the DSM.

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There are more than adequate data now to support the existence of this disorder, the burden of illness associated with it, the capacity of researchers and clinicians to diagnose it, and the efficacy of various treatment modalities (Cunningham et al. 2009). The Mood Disorders section would be the most appropriate place for this disorder.

2. The postpartum onset specifier should be modified to refer to the onset of episodes of illness within three months (instead of 4 weeks) after childbirth, to be more consistent with the state of research and expert opinion in this area (Wisner et al. 2006). In addition, the use of this specifier should be broadened to include anxiety disorders, since postpartum episodes may occur with these disorders as well.
3. In addition to the specifier for postpartum onset, other specifiers related to women's reproductive function should be strongly considered. A specifier "With Premenstrual Exacerbation" should be added to describe the common pattern seen in many women with mood, anxiety, and psychotic disorders in which symptoms tend to worsen during the luteal phase of the menstrual cycle (Kornstein et al. 2005). This issue is of tremendous importance for clinicians in that such worsening and improvement in symptoms across the cycle may otherwise be misattributed to other factors, such as medication effects or changes in the underlying illness. Identifying this pattern is also important because the treatment regimen of a given patient may need to be modified to cover these cyclic fluctuations in illness. Having this specifier would help clinicians to become more aware of the impact of the menstrual cycle on the course of psychiatric illness and to better care for their patients who experience a premenstrual exacerbation of symptoms.
4. Another specifier related to reproductive function that should be added is "With Perimenopausal Onset", to describe episodes of illness that have their onset during the perimenopausal period. A number of studies have shown the perimenopause to be a time of increased vulnerability for the onset of episodes of mood disorder, in women both with and without a prior history (Cohen et al. 2006; Freeman et al. 2006). In addition, there is evidence that these episodes respond differently to treatment compared to mood episodes at other times in a woman's life (Soares et al. 2001).
5. Consideration should be given to having a separate section on "Psychiatric Disorders Related to Reproductive Function", which would include disorders such as PMDD, postpartum depression, postpartum psychosis, and perimenopausal depression.
6. The text sections on "Specific Culture, Age, and Gender Features" should be further expanded to incorporate new knowledge on gender differences in prevalence, etiology, presentation, and course of psychiatric disorders, as well as gender differences in treatment-seeking behavior. In addition, the impact of menopausal status on these features should be included when known. Whether there should be sex-specific criteria for disorders should be a subject of ongoing debate for future editions of the DSM. While gender differences in the symptoms of many disorders have been described, such as more atypical symptoms and a greater number of symptoms in women compared to men with depression (Kornstein and Sloan 2005) and more affective symptoms and positive symptoms in women compared to men with schizophrenia (Gearon and Rachbeisel 2002), there is value in having a broad set of criteria within which gender differences can be noted, rather than having essentially two different disorders for the two sexes.
7. The specifier "With Atypical Features" for major depressive episodes should be renamed. Since women frequently present with atypical features and depression is more common in women, these features should not be considered "atypical". A related concern is that some instruments commonly used to assess depression, including the 17-item Hamilton Depression Scale and the Montgomery-Asberg Depression Scale, do not include atypical features of depression and therefore should not be used to assess depression in women.

It is of utmost importance that the DSM be updated to reflect our current state of knowledge concerning gender issues and women's mental health. Such modifications will help clinicians to better incorporate this knowledge into their practices and will enable researchers to better study the influence of gender in the etiology, phenomenology, and treatment of psychiatric disorders.

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