Chapter 3

Classification and Diagnosis

Jean Dubuffet, *People*

Diagnosis is a critical aspect of the field of abnormal psychology. It is essential for professionals to be able to communicate accurately with one another about the types of cases they are treating or studying. Furthermore, to find the causes or best treatments for a disorder, it must first be classified correctly. For example, if one research group has found a successful treatment for depression but has defined it in a manner not followed by other researchers, the finding is not likely to be replicated by another group of investigators. Only in recent years, however, has diagnosis been accorded the attention it deserves. To beginning students of abnormal psychology, diagnosis can seem tedious because it sometimes relies on fine distinctions. For example, anxiety in social situations—being extremely tense around others—is a symptom of both schizotypal and avoidant personality disorders. In a person with schizotypal personality disorder, however, the anxiety does not decrease as the individual becomes more familiar with people, whereas in a person with avoidant personality disorder exposure does tend to reduce social anxiety. This fine distinction could certainly be viewed as hairsplitting. However, as we will discuss thoroughly later in the chapter, the decisive factor is whether the distinction is useful in differentiating the two diagnoses.

In this chapter we focus on the official diagnostic system widely employed by mental health professionals, the ***Diagnostic and Statistical Manual of Mental Disorders***, now in its fourth edition, commonly referred to as **DSM-IV**. The DSM is published by the American Psychiatric Association and has an interesting history. ◆

◆ A BRIEF HISTORY OF CLASSIFICATION

By the end of the nineteenth century medicine had progressed far beyond its practice during the Middle Ages, when bloodletting was at least part of the treatment of virtually all physical problems. Gradually people recognized that different illnesses required different treatments. Diagnostic procedures were improved, diseases classified, and applicable remedies administered. Impressed by the successes that new diagnostic procedures had achieved in the field of medicine, investigators of abnormal behavior also sought to develop classification schemes. Advances in other sciences, such as botany and chemistry, had followed the development of classification systems, reinforcing hope that similar efforts in the field of abnormal behavior might bring progress. Unfortunately, progress in classifying mental disorders was not to be easily gained.

EARLY EFFORTS AT CLASSIFICATION

During the nineteenth century and into the twentieth as well, there was great inconsistency in the classification of abnormal behavior. By the end of the nineteenth century the diversity of classifications was recognized as a serious problem that impeded communication among people in the field, and several attempts were made to produce a system of classification that would be widely adopted. For example, in the United Kingdom in 1882 the Statistical Committee of the Royal Medico-Psychological Association produced a classification scheme. Even though it was revised several times, however, it was never adopted by its members. In Paris in 1889 the Congress of Mental Science adopted a single classification system, but it was never widely used. In the United States the Association of Medical Superintendents of American Institutions for the Insane, a forerunner of the American Psychiatric Association, adopted a somewhat revised version of the British system in 1886. Then, in 1913, this group accepted a new classification, which incorporated some of Emil Kraepelin's ideas (p. 12). Again, consistency was lacking. The New York State Commission on Lunacy, for example, insisted on retaining its own system (Kendell, 1975).

DEVELOPMENT OF THE WHO AND DSM SYSTEMS

More recent efforts at achieving uniformity of classification have not been totally successful either. In 1939 the World Health Organization (WHO) added mental disorders to the *International List of Causes of Death*. In 1948 the list was expanded to become the *International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD)*, a comprehensive listing of all diseases, including a classification of abnormal behavior. Although this nomenclature was unanimously adopted at a WHO conference, the mental disorders section was not widely accepted. Even though American psychiatrists had played a prominent role in the WHO effort, the American Psychiatric Association published its own *Diagnostic and Statistical Manual* (DSM) in 1952.

In 1969 the WHO published a new classification system, which was more widely accepted. A second version of the American Psychiatric Association's DSM, DSM-II (1968), was similar to the WHO system, and in the United Kingdom a glossary of definitions was produced to accompany it (General Register Office, 1968). But true consensus still eluded the field. The WHO classifications were simply a listing of diagnostic categories; the actual behavior or symptoms that were the bases for the diagnoses were not specified. DSM-II and the British *Glossary of Mental Disorders* provided some of this crucial information but did not specify the same symptoms for a given disorder. Thus actual diagnostic practices still varied widely. In 1980 the American Psychiatric Association published an

extensively revised diagnostic manual, DSM-III. A somewhat revised version, DSM-III-R, appeared in 1987.

In 1988 the American Psychiatric Association appointed a task force, chaired by psychiatrist Allen Frances, to begin work on DSM-IV. Working groups, which included many psychologists, were established to review sections of DSM-III-R, prepare literature reviews, analyze previously collected data, and collect new data if needed. An important change in the process for this edition of the DSM was the adoption of a conservative approach to making changes in the diagnostic criteria—the reasons for changes in diagnoses would be explicitly stated and clearly supported by data. In previous versions of the DSM the reasons for diagnostic changes had not always been explicit.

DSM-IV was published in 1994. In June 2000, a "text revision" was published. No changes were made in the categories and criteria. What was changed were some discussions bearing on such issues as prevalence rates, course, and etiology, based on recently published research. As in our previous editions, our examination of these factors is based on our own analysis of the literature and not on the DSM. In this chapter we present the major DSM-IV-TR categories in brief summary. We then evaluate classification in general and the DSM in particular.

◆ THE DIAGNOSTIC SYSTEM OF THE AMERICAN PSYCHIATRIC ASSOCIATION (DSM-IV-TR)

Several major innovations distinguish the third edition and subsequent versions of the DSM. Perhaps the most sweeping change is the use of **multiaxial classification**, whereby each individual is rated on five separate dimensions, or axes (Table 3.1). In this section we briefly discuss these five axes and then describe the major diagnostic categories.

FIVE DIMENSIONS OF CLASSIFICATION

The five axes of DSM-IV-TR are:

Axis I. All diagnostic categories except personality disorders and mental retardation.

Axis II. Personality disorders and mental retardation.

Axis III. General medical conditions.

Axis IV. Psychosocial and environmental problems.

Axis V. Current level of functioning.

The multiaxial system, by requiring judgments on each of the five axes, forces the diagnostician to consider a broad range of information.

Axis I includes all diagnostic categories except the personality disorders and mental retardation, which make up Axis II. Thus Axes I and II comprise the classification of abnormal behavior. A detailed presentation of Axes I and II appears inside the front cover of the book. Axes I and II are separated to ensure that the presence of long-term disturbances is not overlooked. Most people consult a mental health professional for an Axis I condition, such as depression or an anxiety disorder. But prior to the onset of their Axis I condition, they may have had an Axis II condition, such as dependent personality disorder. The separation of Axes I and II is meant to encourage clinicians to be attentive to this possibility. The presence of an Axis II disorder along with an Axis I disorder generally means that the person's problems will be more difficult to treat.

Although the remaining three axes are not needed to make the actual diagnosis, their inclusion in the DSM indicates that factors other than a person's symptoms should be considered in an assessment so that the person's overall life situation can be better understood. On Axis III the clinician indicates any general medical conditions believed to be relevant to the mental disorder in question. For example, the existence of a heart condition in a person who was also diagnosed with depression would have important implications for treatment; some antidepressant drugs could worsen the heart condition. Axis IV codes psychosocial and environmental problems that the person has been experiencing and that may be contributing to the disorder. These include occupational problems, economic problems, interpersonal difficulties with family members, and a variety of problems in other life areas, which may influence psychological functioning. Finally, on Axis V, the clinician indicates the person's current level of adaptive functioning. Life areas considered are social relationships, occupational functioning, and use of leisure time. Ratings of current functioning are supposed to give information about the need for treatment.

DIAGNOSTIC CATEGORIES

In this section we provide a brief description of the major diagnostic categories of Axes I and II. Before presenting the diagnoses we should note that the extensive descriptions of the diagnoses in subsequent chapters will focus on instances when the cause of the disorder is not completely known. For many of these diagnoses, the DSM also includes a provision for indicating that the disorder is due to a medical condition or substance abuse. For example, depression resulting from an endocrine gland dysfunction would be diagnosed in the depression section of the DSM but listed as caused by a medical problem. Clinicians must therefore be sensitive not only to the symptoms of their patients, but also to the possible medical causes of their patients' conditions.

Finally, it should be noted that beginning with DSM-III there has been a dramatic expansion of the number of diagnostic categories. Eating disorders, some anxiety disorders (for example, posttraumatic stress disorder), several personality disorders (for example, schizotypal

personality disorder), and many of the disorders of childhood were all added in DSM-III or subsequent editions.

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence Within this broad-ranging category are the intellectual, emotional, and physical disorders that usually begin in infancy, childhood, or adolescence.

- The child with *separation anxiety disorder* has excessive anxiety about being away from home or parents.
- Children with *conduct disorder* repeatedly violate social norms and rules.
- Individuals with *attention-deficit/hyperactivity disorder* have difficulty sustaining attention and are unable to control their activity when the situation calls for it.
- Individuals with *mental retardation* (listed on Axis II) show subnormal intellectual functioning and deficits in adaptive functioning.
- The *pervasive developmental disorders* include *autistic disorder*, a severe condition in which the individual has problems in acquiring communication skills and deficits in relating to other people.
- *Learning disorders* refer to delays in the acquisition of speech, reading, arithmetic, and writing skills.

These disorders are discussed in Chapter 15.

Substance-Related Disorders A *substance-related disorder* is diagnosed when the ingestion of some substance—alcohol, opiates, cocaine, amphetamines, and so on—has changed behavior enough to impair social or occupational functioning. The individual may become unable to control or discontinue ingestion of the substance and may develop withdrawal symptoms if he or she stops using it. These substances may also cause or contribute to the development of other Axis I disorders, such as those of mood or anxiety. These disorders are examined in Chapter 12.

Schizophrenia For individuals with *schizophrenia* contact with reality is faulty. Their language and communication are disordered, and they may shift from one subject to another in ways that make them difficult to understand. They commonly experience delusions, such as believing that thoughts that are not their own have been placed in their heads. In addition, they are sometimes plagued by hallucinations, in particular, hearing voices that come from outside themselves. Their emotions are blunted, flattened, or inappropriate, and their social relationships and ability to work have markedly deteriorated. This serious mental disorder is discussed in Chapter 11.

Mood Disorders As the name implies, these diagnoses are applied to people whose moods are extremely high or low.

- In *major depressive disorder* the person is deeply sad and discouraged and is also likely to lose weight and energy and to have suicidal thoughts and feelings of self-reproach.
- The person with *mania* may be described as exceedingly euphoric, irritable, more active than usual, distractible, and possessed of unrealistically high self-esteem.
- *Bipolar disorder* is diagnosed if the person experiences episodes of mania or of both mania and depression.

The mood disorders are surveyed in Chapter 10.

Anxiety Disorders Anxiety disorders have some form of irrational or overblown fear as the central disturbance.

- Individuals with a *phobia* fear an object or situation so intensely that they must avoid it, even though they know that their fear is unwarranted and unreasonable and disrupts their lives.
- In *panic disorder* the person is subject to sudden but brief attacks of intense apprehension, so upsetting that he or she is likely to tremble and shake, feel dizzy, and have trouble breathing. Panic disorder may be accompanied by *agoraphobia*, when the person is also fearful of leaving familiar surroundings.

Alcohol is the most frequently abused substance.

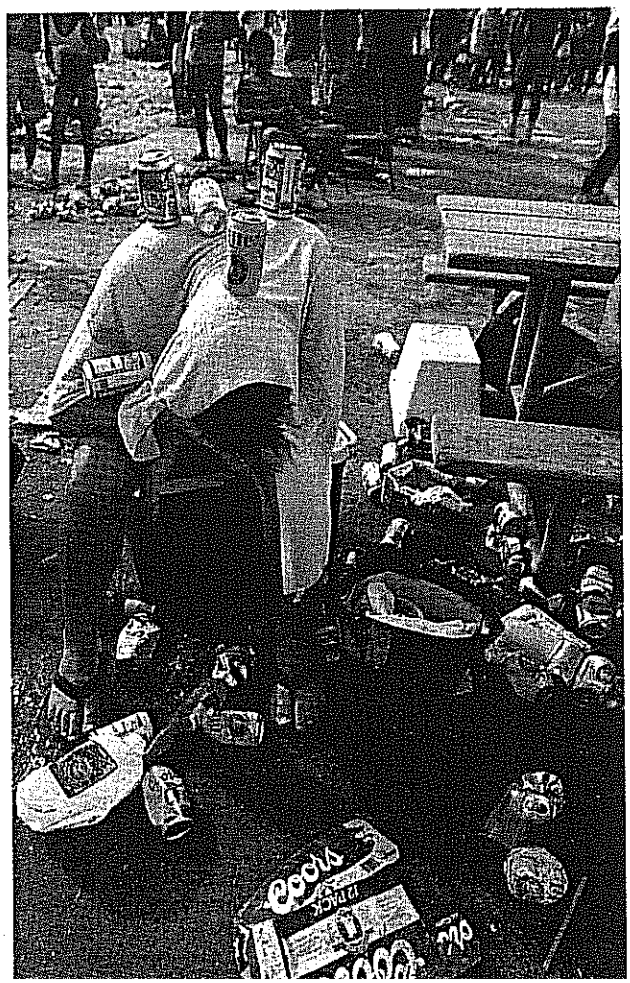

Table 3.1 DSM-IV-TR Multiaxial Classification System

Axis I	Axis II	Axis III
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	Mental Retardation	General Medical Conditions
Delirium, Dementia, Amnestic and Other Cognitive Disorders	Personality Disorders	
Substance-related Disorders		
Schizophrenia and Other Psychotic Disorders		
Mood Disorders		
Anxiety Disorders		
Somatoform Disorders		
Factitious Disorders		
Dissociative Disorders		
Sexual and Gender Identity Disorders		
Eating Disorders		
Sleep Disorders		
Impulse Control Disorders Not Elsewhere Classified		
Adjustment Disorders		

Axis IV
Psychosocial and Environmental Problems

Check:

____ Problems with primary support group. Specify:
____ Problems related to the social environment. Specify:
____ Educational problem. Specify:
____ Occupational problem. Specify:
____ Housing problem. Specify:
____ Economic problem. Specify:
____ Problems with access to health care services. Specify:
____ Problems related to interaction with the legal system/crime. Specify:
____ Other psychosocial and environmental problems. Specify:

Axis V
Global Assessment of Functioning Scale (GAF Scale)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health/illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	
100 | 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his many positive qualities. No symptoms.
90 | 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 | 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
70 | 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

Table 3.1 (continued)

60 | 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
50 | 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 | 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 | 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
20 | 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 | 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

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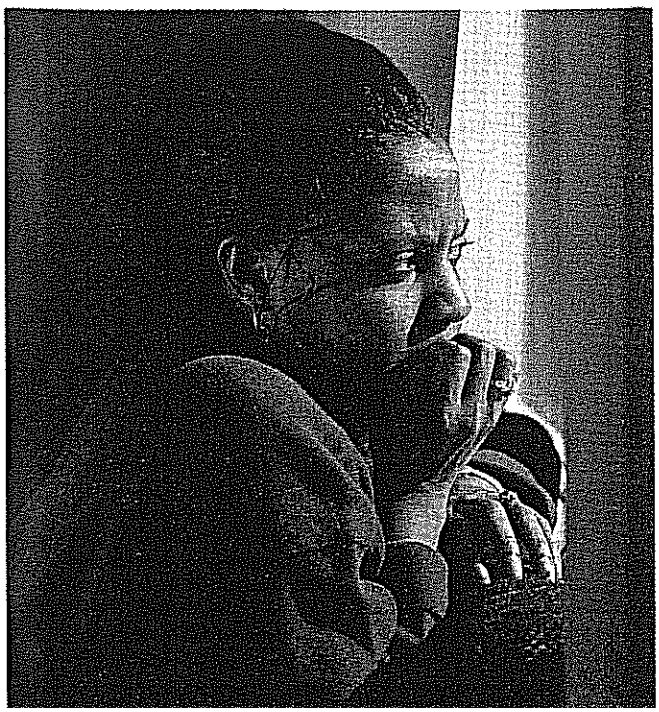
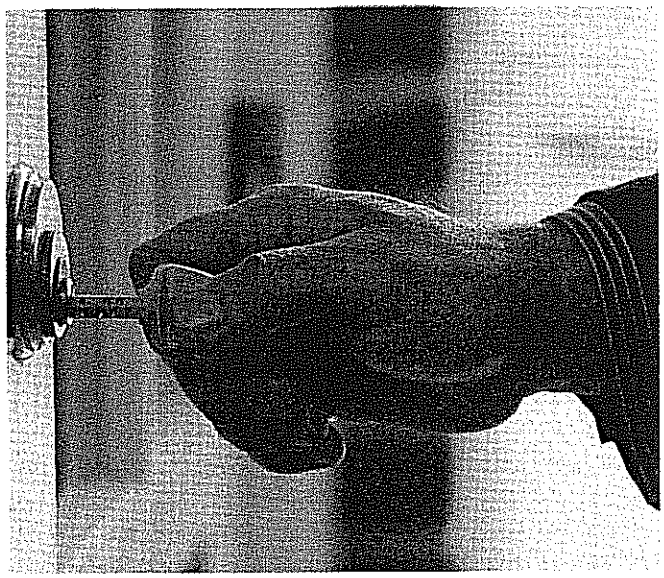
- In people diagnosed with *generalized anxiety disorder*, fear and apprehension are pervasive, persistent, and uncontrollable. They worry constantly, feel generally on edge, and are easily tired.
- A person with *obsessive-compulsive disorder* is subject to persistent obsessions or compulsions. An obsession is a recurrent thought, idea, or image that uncontrollably dominates a person's consciousness. A compulsion is an urge to perform a stereotyped act with the usually impossible purpose of warding off an impending feared situation. Attempts to resist a compulsion create so much tension that the individual usually yields to it.
- Experiencing anxiety and emotional numbness in the aftermath of a very traumatic event is called *posttrau-*

Agoraphobia, a fear of leaving familiar surroundings, is one of the anxiety disorders and is often associated with panic attacks.



Constant checking, for example, to see if doors are locked, is a common compulsion in obsessive-compulsive disorder.



matic stress disorder. Individuals have painful, intrusive recollections by day and bad dreams at night. They find it difficult to concentrate and feel detached from others and from ongoing affairs.

- *Acute stress disorder* is similar to posttraumatic stress disorder, but the symptoms do not last as long.

The anxiety disorders are reviewed in Chapter 6.

Somatoform Disorders The physical symptoms of somatoform disorders have no known physiological cause but seem to serve a psychological purpose.

- Persons with *somatization disorder* have a long history of multiple physical complaints for which they have taken medicine or consulted doctors.
- In *conversion disorder* the person reports the loss of motor or sensory function, such as a paralysis, an anesthesia (loss of sensation), or blindness.
- Individuals with *pain disorder* suffer from severe and prolonged pain.
- *Hypochondriasis* is the misinterpretation of minor physical sensations as serious illness.
- People with *body dysmorphic disorder* are preoccupied with an imagined defect in their appearance.

These disorders are covered in Chapter 7.

Dissociative Disorders Psychological dissociation is a sudden alteration in consciousness that affects memory and identity.

- Persons with *dissociative amnesia* may forget their entire past or lose memory for a particular time period.
- With *dissociative fugue* the individual suddenly and unexpectedly travels to a new locale, starts a new life, and is amnesic for his or her previous identity.
- The person with *dissociative identity disorder* (formerly called multiple personality disorder) possesses two or more distinct personalities, each complex and dominant one at a time.
- *Depersonalization disorder* is a severe and disruptive feeling of self-estrangement or unreality.

These rare disorders are examined in Chapter 7.

Sexual and Gender Identity Disorders The sexual disorders section of the DSM lists three principal subcategories.

- In *paraphilias* the sources of sexual gratification—as in exhibitionism, voyeurism, sadism, and masochism—are unconventional.
- Persons with *sexual dysfunctions* are unable to complete the usual sexual response cycle. Inability to maintain an erection, premature ejaculation, and inhibition of orgasms are examples of their problems.
- People with *gender identity disorder* feel extreme discomfort with their anatomical sex and identify themselves as members of the opposite sex.

These disorders are studied in Chapter 14.

Sleep Disorders Two major subcategories of sleep disorders are distinguished in DSM-IV-TR.

- In the *dyssomnias*, sleep is disturbed in amount (e.g., the person is not able to maintain sleep or sleeps too much), quality (the person does not feel rested after sleep), or timing (e.g., the person experiences inability to sleep during conventional sleep times).
- In the *parasomnias*, an unusual event occurs during sleep (e.g., nightmares, sleepwalking). These disorders are discussed in Chapter 16.

Eating Disorders Eating disorders fall into two major categories.

- In *anorexia nervosa* the person avoids eating and becomes emaciated, usually because of an intense fear of becoming fat.
- In *bulimia nervosa* there are frequent episodes of binge eating coupled with compensatory activities such as self-induced vomiting and heavy use of laxatives.

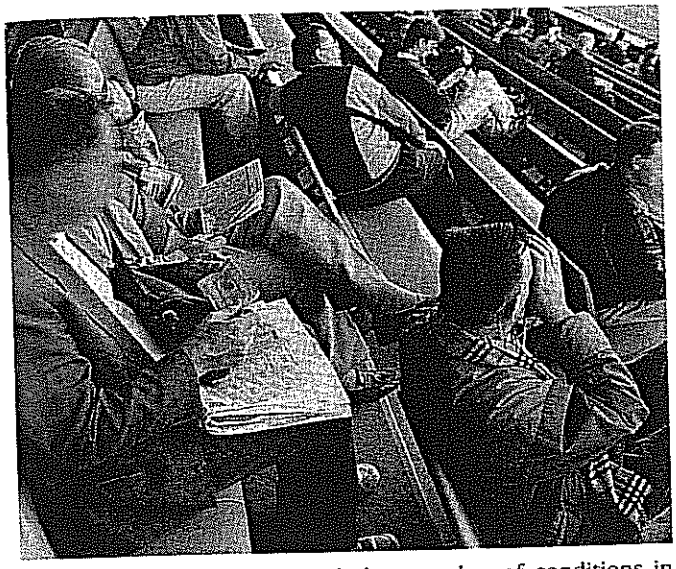
These disorders are discussed in Chapter 9.

Factitious Disorder A diagnosis of *factitious disorder* is applied to people who intentionally produce or complain of physical or psychological symptoms, apparently because of a psychological need to assume the role of a sick person. This disorder is discussed in Chapter 7.

Adjustment Disorders An *adjustment disorder* involves the development of emotional or behavioral symptoms following the occurrence of a major life stressor. However, the symptoms that ensue do not meet diagnostic criteria for any other Axis I diagnosis.

Impulse Control Disorder Impulse control disorders include a number of conditions in which the person's behavior is inappropriate and seemingly out of control.

- In *intermittent explosive disorder* the person has episodes of violent behavior that result in destruction of property or injury to another person.
- In *kleptomania* the person steals repeatedly, but not for the monetary value of the object or for the use of the object.
- In *pyromania* the person purposefully sets fires and derives pleasure from doing so.
- In *pathological gambling* the person is preoccupied with gambling, is unable to stop, and gambles as a way to escape from problems.
- *Trichotillomania* is diagnosed when the person cannot resist the urge to pluck out his or her hair, often resulting in significant hair loss.



Impulse control disorders include a number of conditions in which the person's behavior is out of control. Pathological gambling is an example.

Personality Disorders Personality disorders are defined as enduring, inflexible, and maladaptive patterns of behavior and inner experience. They are listed on Axis II of the DSM.

- In *schizoid personality disorder* the person is aloof, has few friends, and is indifferent to praise and criticism.
- The individual with a *narcissistic personality disorder* has an overblown sense of self-importance, fantasizes about great successes, requires constant attention, and is likely to exploit others.
- *Antisocial personality disorder* surfaces as conduct disorder before the person reaches age fifteen and is manifested in truancy, running away from home, delinquency, and general belligerence. In adulthood the person is indifferent about holding a job, being a responsible partner or parent, planning for the future or even for tomorrow, and staying on the right side of the law. People with antisocial personality disorder—also called psychopathy—do not feel guilt or shame for transgressing social mores.

Chapter 13 covers the personality disorders.

Other Conditions That May Be a Focus of Clinical Attention This all-encompassing category comprises conditions that are not regarded as mental disorders per se but still may be a focus of attention or treatment. This category seems to exist so that anyone entering the mental health system can be categorized, even in the absence of a formally designated mental disorder.

If an individual's medical illness appears to be caused in part or exacerbated by a psychological condition, the diagnosis is *psychological factors affecting physical condition*. Referred to previously as a psychophysiological or psychosomatic disorder, this condition is reviewed in detail in Chapter 8. Among the other diagnoses in this category are the following:

- Academic problem (e.g., underachievement)
- Antisocial behavior (e.g., in professional thieves)
- Malingering (faking physical or psychological symptoms to achieve a goal, such as avoiding work)
- Relational problem (e.g., poor relationship with sibling or spouse)
- Occupational problem (e.g., dissatisfaction with work)
- Physical or sexual abuse
- Bereavement
- Noncompliance with treatment (e.g., refusing medication)
- Religious or spiritual problem (e.g., questioning one's faith)
- Phase-of-life problem (difficulties created by a life transition, such as beginning school)

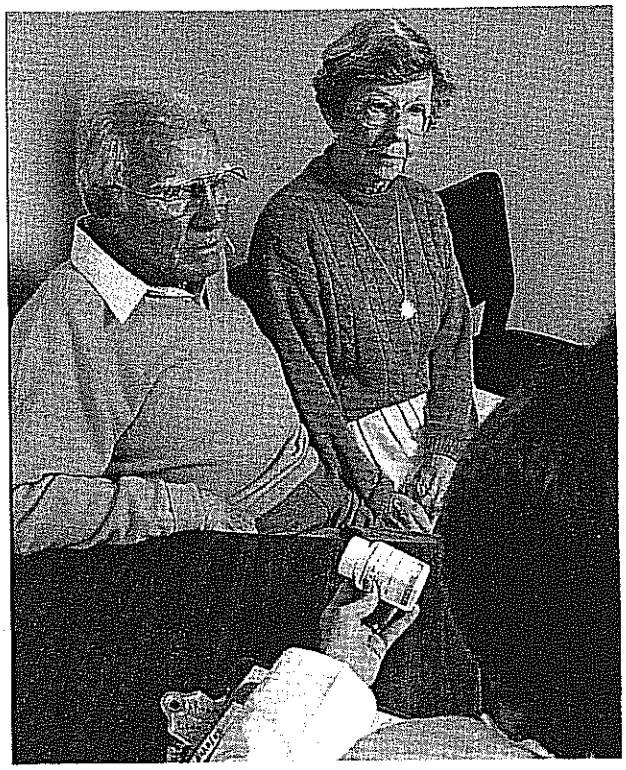
In this context it is interesting to recall our discussion of the difficulties of defining mental disorder (p. 3). Should these life difficulties really be included in a listing of mental disorders? Are mental health professionals qualified, for example, to "treat" religious doubt? Many of these conditions will not be covered in this book, although malingering is discussed in Chapter 7, therapy for marital problems in Chapters 10 and 17, and physical and sexual abuse in Chapters 7 and 14.

Delirium, Dementia, Amnestic, and Other Cognitive Disorders This category covers disorders in which cognition is seriously disturbed.

- *Delirium* is a clouding of consciousness, wandering attention, and an incoherent stream of thought. It may be caused by several medical conditions such as malnutrition as well as by substance abuse.
- *Dementia*, a deterioration of mental capacities, especially memory, is associated with Alzheimer's disease, stroke, and several other medical conditions as well as with substance abuse.
- *Amnestic syndrome* is an impairment in memory when there is no delirium or dementia.

Delirium and dementia are discussed in detail in Chapter 16 because they are often associated with aging. Amnestic syndrome is considered in Chapter 12 because it is often linked to alcohol abuse.

Now that we have briefly described the DSM's diagnostic categories and its axes, we return to the case of Ernest H. with which the book began. Table 3.2 shows how Ernest's diagnosis would look. On Axis I, Ernest is diagnosed with alcohol dependence, which has also created a problem with sexual arousal. His current problems with his marriage are noted, as is his prior history of bipolar disorder. In addition, Ernest is diagnosed on



The frequency of Alzheimer's disease, which severely impairs cognitive functioning, increases with advanced age.

Axis II as having avoidant personality disorder. His feelings of inferiority, his self-consciousness when around others, and his avoidance of activities because of fear of criticism are the basis of this diagnosis. He has no general medical condition relevant to his problems, so he has no diagnosis on Axis III. His problems with his marriage are noted on Axis IV, and his current level of functioning is rated at 55 on the GAF (indicating a moderate level of impairment). Though alcohol may be Ernest's most immediate problem, the multiaxial diagnosis gives clinicians a fairly full picture of the complex of problems that will need to be addressed in treatment. Focus on Discovery 3.1 describes some diagnoses and axes that are not regarded as well-enough established to be included in DSM-IV, but are in need of further study.

Table 3.2 DSM-IV-TR Multiaxial Diagnosis of Ernest H.

Axis I	Alcohol Dependence
	Alcohol-Induced Sexual Problem, with Impaired Arousal
	Bipolar I Disorder, Most Recent Episode Manic, in Full Remission
	Partner Relational Problem
Axis II	Avoidant Personality Disorder
Axis III	None
Axis IV	Problem with Primary Support Group
Axis V	GAF = 55

◈ ISSUES IN THE CLASSIFICATION OF ABNORMAL BEHAVIOR

Our review of the major diagnostic categories of abnormal behavior was brief because the diagnoses will be examined in more detail throughout this text. On the basis of this overview, however, we will examine here the usefulness of the current diagnostic system. Among those who are critical of the DSM, one group asserts that classification per se is irrelevant to the field of abnormal behavior, and a second group finds specific deficiencies in the manner in which diagnoses are made in the DSM.

GENERAL CRITICISMS OF CLASSIFICATION

Some critics of diagnosis argue that to classify someone as depressed or anxious results in a loss of information about that person, thereby reducing some of the uniqueness of the individual being studied. In evaluating this claim, recall our earlier discussions of paradigms and their effect on how we glean information about our world. It appears to be in the nature of humankind to categorize whenever we perceive and think about anything. Those who argue against classification per se therefore overlook the inevitability of classification and categorization in human thought.

Consider the simple example of casting dice. Any of the numbers one through six may come up on a given toss of a single die. Let us suppose, however, that we classify each outcome as odd or even. Whenever a one, three, or five comes up on a roll, we call out "odd," and whenever a two, four, or six appears, we say "even." A person listening to our calls will not know whether the call "odd" refers to a one, three, or five or whether "even" refers to a two, four, or six. In classification, some information must inevitably be lost.

What matters is whether the information lost is *relevant*, which in turn depends on the purposes of the classification system. Any classification is designed to group together objects sharing a common property and to ignore differences in the objects that are not relevant to the purposes at hand. If our intention is merely to count odd and even rolls, it is irrelevant whether a die comes up one, three, or five, or two, four, or six. In judging abnormal behavior, however, we cannot so easily decide what is wheat and what is chaff, for the relevant and irrelevant dimensions of abnormal behavior are uncertain. Thus when we do classify, we may be grouping people together on rather trivial bases while ignoring their extremely important differences.

Classification may also have negative effects on a person. Consider how your life might be changed after being diagnosed as having schizophrenia. You might be-

come guarded and suspicious lest someone recognize your disorder. Or you might be chronically on edge, fearing the onset of another episode. The fact that you are a "former mental patient" could have a stigmatizing effect. Friends and loved ones might treat you differently, and employment might be difficult to obtain.

There is little doubt that diagnosis can have such negative consequences. It is clear from the existing research that the general public holds a very negative view of mental patients and that patients and their families believe that such stigmatizing effects are common (Rabkin, 1974; Wahl & Harrman, 1989). We must recognize and be on guard against the possible social stigma of a diagnosis.

THE VALUE OF CLASSIFICATION AND DIAGNOSIS

Assuming that various types of abnormal behavior do differ from one another, classifying them is essential, for these differences may constitute keys to the causes and treatments of various deviant behaviors. For example, mental retardation is sometimes caused by phenylketonuria. A deficiency in the metabolism of the protein phenylalanine results in the release of incomplete metabolites that injure the brain (see p. 440). A diet drastically reduced in phenylalanine prevents some of this injury. As Mendels (1970) noted, however, "had we taken 100, or even 1,000, people with mental deficiency and placed them all on the phenylalanine-free diet, the response would have been insignificant and the diet would have been discarded as a treatment. It was first necessary to recognize a subtype of mental deficiency [retardation], phenylketonuria, and then subject the value of a phenylalanine-free diet to investigation in this specific population, for whom it has been shown to have value in preventing the development of mental deficiency" (p. 35).

Forming categories may thus further knowledge, for once a category is formed, additional information may be ascertained about it. Even though the category is only an asserted, and not a proved, entity, it may still be heuristically[1] useful in that it facilitates the acquisition of new information. Only after a diagnostic category has been formed can people who fit its definition be studied in the hope of uncovering factors responsible for the development of their problems and of devising treatments that may help them. For example, only a few decades ago, bipolar disorder (episodes of both mania and depression) was not typically distinguished from depression. If this distinction had not subsequently been made, it is unlikely that lithium would have been recognized as an effective treatment, as it is today.

SPECIFIC CRITICISMS OF DIAGNOSIS

In addition to the general criticisms just described, more specific criticisms are commonly made of psychiatric classification. The principal ones concern whether discrete diagnostic categories are justifiable and whether the diagnostic categories are reliable and valid. These criticisms were frequently leveled at DSM-I and DSM-II. At the close of this section we will see how subsequent editions of the DSM have come to grips with them.

Discrete Entity versus Continuum The DSM represents a **categorical classification**, a yes–no approach to classification. Does the patient have schizophrenia or not? It may be argued that this type of classification, because it postulates discrete diagnostic entities, does not allow continuity between normal and abnormal behavior to be taken into consideration. Those who advance the continuity argument hold that abnormal and normal behavior differ only in intensity or degree, not in kind; therefore, discrete diagnostic categories foster a false impression of discontinuity.

In contrast, in **dimensional classification** the entities or objects being classified must be ranked on a quantitative dimension (e.g., a 1-to-10 scale of anxiety, where 1 represents minimal and 10 extreme). Classification would be accomplished by assessing patients on the relevant dimensions and perhaps plotting the location of the patient in a system of coordinates defined by his or her score on each dimension. (See Figure 3.1 for an illustration of the difference between dimensional and categorical classification.) A dimensional system can subsume a categorical system by specifying a cutting point, or threshold, on one of the quantitative dimensions. This capability is a potential advantage of the dimensional approach.

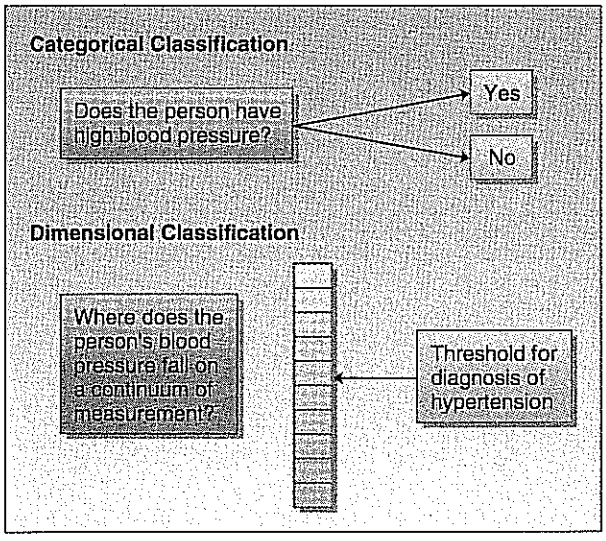


Figure 3.1 Categorical versus dimensional classification.

[1] *Heuristic* is a central word and concept in science. It comes from the Greek *heuriskein*, "to discover," or "to find," and is defined in *Webster's* as serving to guide, discover, or reveal, and more specifically as valuable for stimulating or conducting empirical research. The frequent use of this word and its derivatives underlines the importance scientists place on ideas in generating new knowledge.

Focus on Discovery 3.1

Issues and Possible Categories in Need of Further Study

One of DSM-IV-TR's appendixes is entitled "Criteria Sets and Axes Provided for Further Study." It contains several proposals for new categories that the DSM-IV task force considers promising but not sufficiently established by data to merit inclusion in DSM-IV. By listing and describing these categories of disorders, the DSM task force hopes to encourage professionals to consider whether a future DSM should contain any of these syndromes or axes as official ways of classifying mental disorders.

POSSIBLE NEW SYNDROMES

Here is a sampling of the more than two dozen categories mentioned as meriting further study:

Caffeine Withdrawal As with withdrawal from other addicting substances, significant distress or impairment in occupational or social functioning must result from not drinking accustomed levels of beverages containing caffeine. Symptoms include headache, fatigue, anxiety, depression, nausea, and impaired thinking. Inclusion of caffeine withdrawal as a new category would certainly swell the ranks of the mentally disordered.

Premenstrual Dysphoric Disorder Written about a good deal in the press and assailed by feminists and sexists alike, this proposed syndrome is marked by depression, anxiety, anger, mood swings, and decreased interest in activities usually engaged in with pleasure, when occurring a week or so before menstruation for most months in a given year. The symptoms are so severe as to interfere with social or occupational functioning. This category is to be distinguished from premenstrual syndrome, which is experienced by many more women and is not nearly as debilitating.

Feminists may be pleased or displeased with this possible new category. On the plus side, inclusion might alert people to the hormonal bases of monthly mood changes linked to the menstrual cycle and thereby foster more tolerance and less blame. On the minus side, listing such mood changes in a manual of mental disorders would seem to convey the message that women who experience these psychological changes are mentally disordered.

Mixed Anxiety-Depressive Disorder For a time during the development of DSM-IV it seemed that this disorder would be formally listed, for clinicians have for many years sometimes found it difficult to decide whether to diagnose a person as having primarily a depressive disorder or primarily an anxiety disorder. Depressed mood must have lasted for at least a month and been accompanied by at least four of the following symptoms: concentration or memory problems, disturbances of sleep, fatigue or low energy, irritability, worry, crying easily, hypervigilance, anticipating the worst, pessimism about the future, or feelings of low self-esteem. The person must not be diagnosable as having a major depressive disorder, dysthymic disorder, panic disorder, or generalized anxiety disorder. We will return to this proposed category in Chapter 6.

Passive-Aggressive Personality Disorder (Negativistic Personality Disorder) This personality disorder was present in DSM-III and DSM-III-R but was moved to the appendix in DSM-IV. Not attributable to depression, symptoms include resenting, resisting, and opposing demands and expectations by means of passive activities, such as lateness, procrastination, forgetfulness, and intentional inefficiency. The inference is that the person is angry or resentful and is expressing these feelings by *not* doing certain things rather than by more direct expression, such as assertiveness or aggressiveness. Such people often feel mistreated, cheated, or underappreciated.

Depressive Personality Disorder In lay terms this personality disorder would be applied to people whose general lifestyle is characterized by gloominess, lack of cheer, and a tendency to worry a lot. This traitlike, long-term disorder may be a precursor to a full-blown major depressive disorder. The DSM admits that it is very difficult to distinguish between depressive personality disorder and the main depressive disorders. Another disorder listed in this appendix is *minor depressive disorder*, which may be distinguishable only by virtue of its not being as long-standing as depressive personality disorder.

PROPOSED AXES IN NEED OF FURTHER STUDY

Professionals are being encouraged to consider whether a future axis should include defense mechanisms (equated by DSM with coping styles), defined as "automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors" (DSM-IV-TR, 2000, p. 807). Defense mechanisms are divided into groups called defense levels and are measured by a proposed Defensive Functioning Scale. Some of these coping mechanisms derive from psychoanalytic theory.

There are seven defense levels, each with a set of defense mechanisms. The levels range from "High adaptive level" to "Level of defensive dysregulation." The following examples are among the proposed levels and mechanisms.

High Adaptive Level This most adaptive, healthy defense level contains coping efforts that are realistic ways of handling stress and are conducive to achieving a good balance among conflicting motives. Examples are:

- *anticipation*—experiencing emotional reactions before a stressful event occurs and considering realistic, alternative courses of action; for example, carefully planning for an upcoming meeting with an employer who is unhappy with your performance
- *sublimination*—dealing with a stress by channeling negative feelings into socially acceptable behaviors; for example, working out at a gym

Disavowal Level This middle level is characterized by defenses that keep troubling stressors or ideas out of conscious awareness.

denial—refusing to acknowledge a degree of discomfort or threat that is obvious to an observer; for example, maintaining that your marriage is fine despite the obvious and repeated conflicts noticed by your friends

projection—falsely attributing to another person one's own unacceptable feelings or thoughts; for example, believing that your professor is angry with you, rather than the reverse

Level of Defensive Dysregulation This lowest level is marked by a failure to deal with stress, leading to a break with reality.

psychotic denial—denial that is so extreme as to be marked by a gross impairment in reality testing; for example, maintaining that the results of three biopsies showing a cancerous growth are wrong

The reliability of the defense mechanisms axis has recently been studied. After training, two clinicians rated a series of patients. Unfortunately, reliability was not very good (Perry et al., 1998). Perhaps reliability would improve if a better assessment device were developed for the assessment of defense mechanisms, as happened when structured interviews began to be used to make DSM diagnoses.

Clearly, a dimensional system can be applied to most of the symptoms that constitute the diagnoses of the DSM. Anxiety, depression, and the many personality traits that are included in the personality disorders are found in different people to varying degrees and thus do not seem to fit well with the DSM categorical model.

The choice between a categorical and a dimensional system of classification, however, is not as simple as it might seem initially. Consider hypertension (high blood pressure), a topic discussed at length in Chapter 8. Blood-pressure measurements form a continuum, which clearly fits a dimensional approach; yet it has proved useful to categorize certain people as having high blood pressure in order to research its causes and possible treatments. A similar situation could exist for the DSM categories. Even though anxiety clearly exists in differing degrees in different people and thus is a dimensional variable, it could prove useful to create a diagnostic category for those people whose anxiety is extreme. There is a certain inevitable arbitrariness to such a categorization (where exactly should the cutoff be?), but it could be fruitful nonetheless.

It is also possible that a variable that on the surface appears dimensional actually represents an underlying categorical, or off–on, process. This is a complex argument, but some of its flavor can be appreciated by considering a hypothetical single-gene cause for hypertension. Blood pressure might result from a complex interplay between the gene (off or on) and a variety of environmental influences—diet, weight, smoking, stress, and so on. Observed blood pressure is a dimensional variable, but hypertension might result principally from the operation of the single off–on gene, which is a categorical variable. Given that we can observe only the surface variable, how can we tell whether there might be an underlying categorical process? Although well beyond the scope of this book, complex mathematical procedures have been developed to test such questions (e.g., Meehl, 1986), and they have been used to test whether a dimensional or categorical approach is most applicable to several diagnoses (Tykra et al., 1995). We will return to this issue in our discussion of personality disorders in Chapter 13.

RELIABILITY: THE CORNERSTONE OF A DIAGNOSTIC SYSTEM

The extent to which a classification system, or a test or measurement of any kind, produces the same scientific observation each time it is applied is the measure of its **reliability**. An example of an unreliable measure would be a flexible, elastic-like ruler whose length changed every time it was used. This flawed ruler would yield different values for the height of the same object every time the object was measured. In contrast, a reliable measure, such as a standard wooden ruler, produces consistent results.

Interrater reliability refers to the extent to which two judges agree about an event. For example, suppose you wanted to know whether a child suspected of having attention deficit/hyperactivity disorder did indeed have difficulty paying attention and staying seated in the classroom. You could decide to observe the child during a day at school. To determine whether the observational data were reliable you would want to have at least two people watch the child and make independent judgments about the level of attention and activity. The extent to which the raters agreed would be an index of interrater reliability (see Figure 3.2 for an illustration).

Reliability is a primary criterion for judging any classification system. For a classification system to be useful,

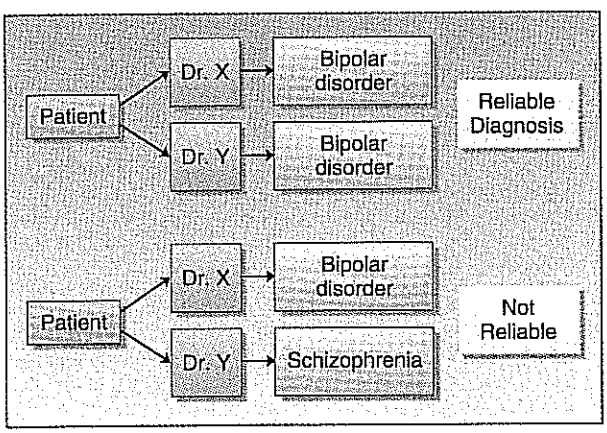


Figure 3.2 Interrater reliability.

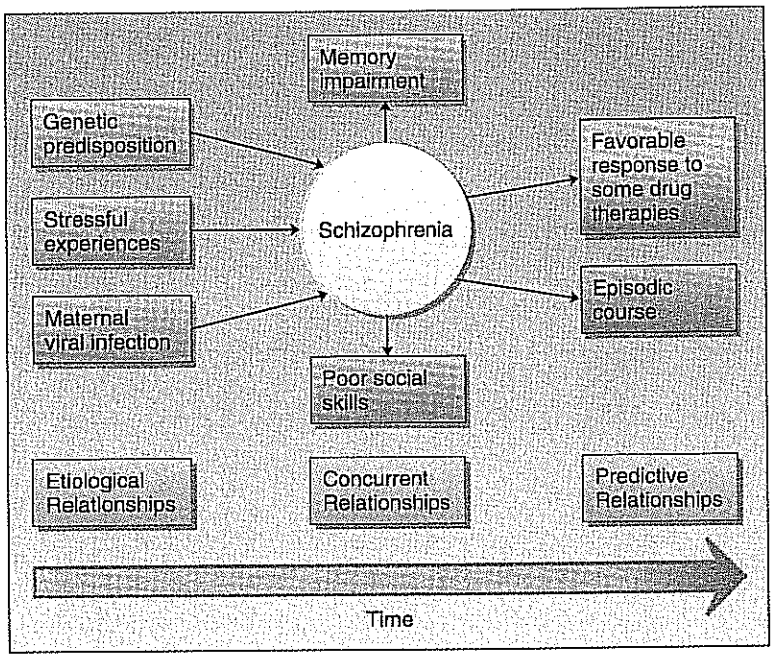


Figure 3.3 Construct validity. Some lawful relationships of the construct of schizophrenia.

those applying it must be able to agree on what is and what is not an instance of a particular category.[2] A person diagnosed as having an anxiety disorder by one clinician should be given the same diagnosis by another clinician as well. After all, if someone is not diagnosed correctly, he or she may not receive the best treatment available. Prior to DSM-III, reliability was not acceptable, mainly because the criteria for making a diagnosis were not presented clearly and methods of assessing a patient's symptoms were not standardized (Ward et al., 1962). As we will soon see, reliability for most current diagnostic categories is good.

HOW VALID ARE DIAGNOSTIC CATEGORIES?

Validity is a complex topic. There are several types of validity, which we will describe in Chapter 4. Here we discuss the type of validity that is most important for diagnosis—**construct validity**. The diagnoses of DSM are referred to as constructs because they are inferred, not proven, entities. A diagnosis of schizophrenia, for instance, does not have the same status as a diagnosis of diabetes. In the case of diabetes, we know the symptoms, the biological malfunction that produces them, and some of the causes. For schizophrenia, we have a proposed set of symptoms, but only very tentative information regarding mechanisms that may produce the symptoms.

[2] These two components of reliability—agreeing on who is a member of a class and who is not—are termed *sensitivity* and *specificity*. Sensitivity refers to agreement regarding the presence of a specific diagnosis; specificity refers to agreement concerning the absence of a diagnosis.

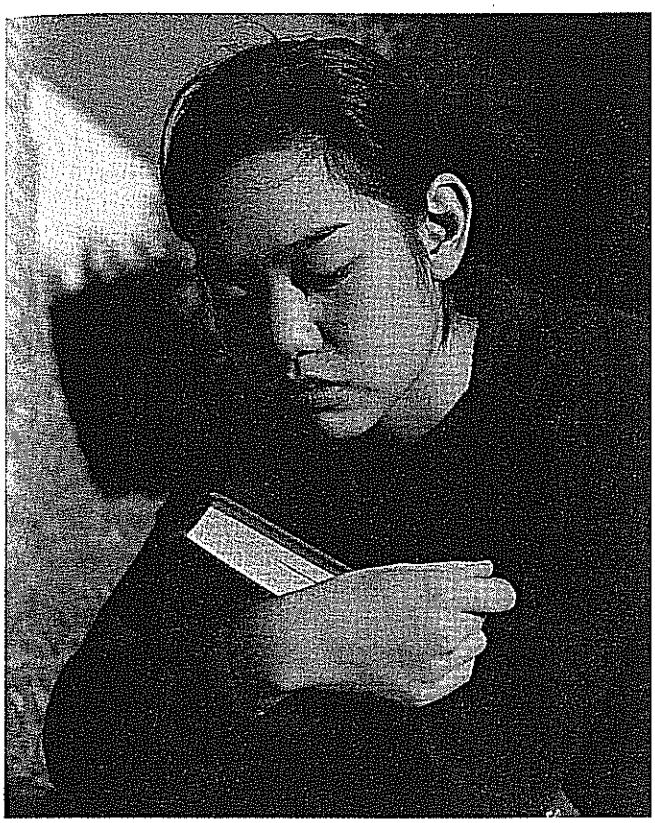
Construct validity is determined by evaluating the extent to which accurate statements and predictions can be made about a category once it has been formed. In other words, to what extent does the construct enter into a network of lawful relationships? Some of these relationships may be about possible causes of the disorder, for example, a genetic predisposition or a biochemical imbalance. Others could be about characteristics of the disorder that are not symptoms but occur frequently, for example, poor social skills in people with schizophrenia. Other relationships could refer to predictions about the course of the disorder or the probable response to particular treatments. The greater the number and strength of relationships into which a diagnosis enters, the greater the construct validity (see Figure 3.3).

We have organized this book around the major DSM diagnostic categories because we believe that they indeed possess some construct validity. Certain categories have greater validity than others, however, and we will discuss these differences in the chapters on each of the major diagnostic categories.

THE DSM AND CRITICISMS OF DIAGNOSIS

As we have mentioned, the diagnoses in DSM-II were not very reliable. Beginning with DSM-III and DSM-III-R an effort was made to create more reliable and valid diagnostic categories. Major improvements include the following:

1. The characteristics and symptoms of each diagnostic category in Axes I and II are now described much more extensively than they were in DSM-II. For each disorder there is a description of essential features, then of associated features, such as laboratory findings (e.g., enlarged ventricles in schizophre-



The core symptoms of depression appear to be similar cross-culturally. However, guilt is less frequent in Japan than in Western cultures.

nia), and results from physical exams (e.g., electrolyte imbalances in people who have eating disorders). Next are statements drawn from the research literature about age of onset, course, prevalence and sex ratio, familial pattern, and differential diagnosis (i.e., how to distinguish one diagnosis from another that is symptomatically similar to it).

❷ Much more attention is now paid to how the symptoms of a given disorder may differ depending on the culture in which it appears. For example, it is known that the core symptoms of both schizophrenia (e.g., delusions and hallucinations) and depression (e.g., depressed mood and loss of interest or pleasure in activities) are similar cross-culturally (Draguns, 1989). However, guilt is a frequent symptom of depression in Western society but an infrequent symptom in Japan and Iran. Similarly, depression in Latinos is more likely to involve somatic complaints, such as headaches or "nerves." (Focus on Discovery 3.2 describes further efforts by the DSM to be more sensitive to the effects of culture.)

❸ Specific *diagnostic criteria*—the symptoms and other facts that must be present to justify the diagnosis—are spelled out more precisely, and the clinical symptoms that constitute a diagnosis are defined in a glossary. Table 3.3 compares the descriptions of a manic episode given in DSM-II with the diagnostic criteria given in DSM-IV-TR. The bases for making diagnoses are decidedly more detailed and concrete in DSM-IV-TR.

Table 3.3 Description of Manic Disorder in DSM-II versus DSM-IV

DSM-II (1968, p. 36)

Manic-depressive illness, manic type. This disorder consists exclusively of manic episodes. These episodes are characterized by excessive elation, irritability, talkativeness, flight of ideas, and accelerated speech and motor activity. Brief periods of depression sometimes occur, but they are never true depressive episodes.

DSM-IV (1994, p. 332)

Diagnostic Criteria for a Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only three hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: DSM-IV-TR material reprinted with permission from the DSM-IV-TR, 2000, American Psychiatric Association.

Focus on Discovery 3.2

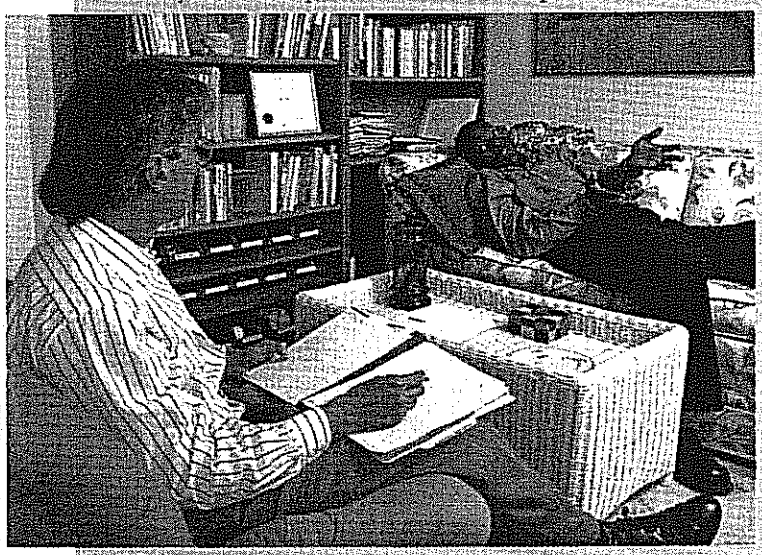
Ethnic and Cultural Considerations in DSM-IV-TR

Previous editions of the DSM were criticized for their lack of attention to cultural and ethnic variations in psychopathology. DSM-IV attempts to enhance its cultural sensitivity in three ways: (1) by including in the main body of the manual a discussion of cultural and ethnic factors for each disorder; (2) by providing in the appendix a general framework for evaluating the role of culture and ethnicity; and (3) by describing culture-bound syndromes in an appendix.

Among the cultural issues of which clinicians need to be aware are language differences between the therapist and the patient and the way in which the patient's culture talks about emotional distress. Many cultures, for example, describe grief or anxiety in physical terms—"I am sick in my heart" or "My heart is heavy"—rather than in psychological terms. Individuals also vary in the degree to which they identify with their cultural or ethnic group. Some value assimilation into the majority culture, whereas others wish to maintain close ties to their ethnic background. In general, clinicians are advised to be constantly mindful of how culture and ethnicity influence diagnosis and treatment, a topic discussed in the next chapter.

The DSM also describes "locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category" (DSM-IV, 1994, p. 844). The following are some examples that may occur in clinical practices in North America.

A therapist must be mindful of the role of cultural differences in the ways in which patients describe their problems.



amok—a dissociative episode in which there is a period of brooding followed by a violent and sometimes homicidal outburst. The episode tends to be triggered by an insult and is found primarily among men. Persecutory delusions are often present as well. The term is Malaysian and is defined by the dictionary as a murderous frenzy; the reader has probably encountered the phrase "run amok."

brain fag—originally used in West Africa, this term refers to a condition reported by high school and university students in response to academic pressures. Symptoms include fatigue, tightness in the head and neck, and blurring of vision. This syndrome resembles certain anxiety, depressive, and somatoform disorders.

dhat—a term used in India to refer to severe anxiety and hypochondriasis linked to the discharge of semen.

ghost sickness—extreme preoccupation with death and those who have died; found among certain Native American tribes.

koro—reported also in south and east Asia, an episode of intense anxiety about the possibility that the penis or nipples will recede into the body, possibly leading to death.

The improved explicitness of the DSM criteria has reduced the descriptive inadequacies that were the major source of diagnostic unreliability and thus has led to improved reliability. Another factor in improved reliability is the use of standardized, reliably scored interviews for collecting the information needed for a diagnosis. (We will describe such interviews in the next chapter.) Results of an extensive evaluation of the reliability of DSM-III-R are shown in Table 3.4. The reliabilities vary but are quite acceptable for most of the major categories. The relatively low figures for anxiety disorders are higher in other studies that used an assessment interview specifically tailored for them (DiNardo et al., 1993). Although the data are not all in yet, the reliability of DSM-IV-TR diagnoses look comparable to those shown in the table.

Thus far we have described the DSM in positive terms. The attainment of adequate diagnostic reliability is a considerable achievement, but a number of problems remain.

1. The discrete entity versus continuum issue, discussed earlier, has not been satisfactorily resolved.
2. It is unclear whether the rules for making diagnostic decisions are ideal. Examining Table 3.3, we see that for patients to be diagnosed as suffering from mania they must have three symptoms from a list of seven, or four if their mood is irritable. But why require three symptoms rather than two or five (see Finn, 1982)? Just as there is a degree of arbitrariness about the point at which a person is diagnosed as having high blood pressure, so there is an element of arbitrariness to the DSM's diagnostic rules.
3. The reliability of Axes I and II may not always be as high in everyday usage, for diagnosticians may not

Table 3.4 Reliability of Selected DSM Diagnoses

Diagnosis	Kappa
Bipolar disorder	.84
Major depression	.64
Schizophrenia	.65
Alcohol abuse	.75
Anorexia nervosa	.75
Bulimia nervosa	.86
Panic disorder	.58
Social phobia	.47

Source: Williams et al., 1992.

Note: The numbers here are a statistic called kappa, which measures the proportion of agreement over and above what would be expected by chance. Generally, kappas over .70 are considered good.

adhere as precisely to the criteria as do those whose work is being scrutinized in formal research studies.

4. Although the improved reliability of the DSM *may* lead to more validity, there is no guarantee that it *will*. The diagnoses made according to the DSM criteria may not reveal anything useful about the patients.
5. Subjective factors still play a role in evaluations made according to DSM-IV-TR. Consider again the criteria for manic syndrome in Table 3.3. What exactly does it mean to say that the elevated mood must be abnormally and persistently elevated? Or, what level of involvement in pleasurable activities with high potential for painful consequences is excessive? As another example, on Axis V the clinician must judge the patient's level of current functioning. The clinician determines what is adaptive for the patient and how the patient's behavior compares with that of an average person. Such a judgment sets the stage for the insertion of cultural biases as well as the clinician's own personal ideas of what the average person *should* be doing at a given stage of life and in particular circumstances (C. B. Taylor, 1983). A male clinician might have a considerably different take on a single, fifty-year-old female patient than would a female therapist; for example, the female therapist might view such a patient's childlessness more negatively than would the male therapist.
6. Not all the DSM classification changes seem positive. Should a problem such as difficulty in learning arithmetic or reading be considered a psychiatric disorder? By expanding its coverage the DSM seems to have made too many childhood problems into psychiatric disorders, without good justification for doing so.

In sum, although the DSM is continually improving, it is far from perfect. Throughout this book, as we present the literature on various disorders, we will have further opportunities to describe both the strengths and the weaknesses of the DSM-IV-TR and to consider how it may deal with some of the problems that still exist. What is most heartening about the DSM is that its attempts to be explicit about the rules for diagnosis make it easier to detect problems in the diagnostic system. We can expect more changes and refinements over the next several years.

◆ SUMMARY ◆

Diagnosis is a critical aspect of the field of abnormal psychology. Having an agreed-upon system of classification makes it possible for clinicians to communicate effectively with one another and facilitates the search for causes and treatments for the various psychopathologies.

The recent editions of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, reflect the continuing efforts by mental health professionals to categorize the various psychopathologies. A novel feature of the DSM is its multiaxial organization; every time a diagnosis is made the clinician must describe the patient's condition according to each of five axes, or dimensions. Axes I and II make up the mental disorders per se; Axis III lists any physical disorders believed to bear on the mental disorder in question; Axis IV is used to indicate the psychosocial and environmental problems that the person has been experiencing; and Axis V rates the person's current level of adaptive functioning. A multiaxial diagnosis is believed to provide a more multidimensional and useful description of the patient's mental disorder.

Several general and specific issues must be considered when evaluating the classification of abnormality. An important one is whether the categorical approach of the DSM, as opposed to a dimensional classification system, is best for the field. Because recent versions of the DSM are far more concrete and descriptive than was DSM-II, diagnoses based on these versions are more reliable, that is, independent diagnosticians are now likely to agree on the diagnosis they make of a particular case. Construct validity—how well the diagnosis relates to other aspects of the disorder, such as prognosis and response to treatment—however, remains more of an open question. In chapters dealing with specific disorders we will see that validity varies with the diagnostic category being considered.

◆ KEY TERMS ◆

Diagnostic and Statistical Manual of Mental Disorders (DSM)
multiaxial classification
categorical classification
dimensional classification
reliability
interrater reliability
construct validity