# CHAPTER 3
# Classification and Diagnosis

1. Case Studies
    A. The diagnosis of panic disorder, agoraphobia and dependent personality disorder in the case of Nick.
    B. Howie Mandel

2. Why Do We Need a Classification System for Mental Disorders?

3. The Perfect Diagnostic System

4. Characteristics of Strong Diagnostic Systems

5. The History of Classification of Mental Disorders

6. DSM-5: Organizational Structure
    A. Section I Introduction and Use of the Manual
    B. Section II Diagnostic Criteria and Codes
    C. Section III Emerging Measures and Models

7. Categories of Disorders in DSM-5
    A. Neurodevelopmental Disorders
    B. Schizophrenia Spectrum and Other Psychotic Disorders
    C. Mood Disorders
    D. Anxiety and Related Disorders
    E. Dissociative Disorders
    F. Somatic Symptom and Related Disorders
    G. Feeding and Eating Disorders
    H. Elimination Disorders
    I. Sleep-Wake Disorders
    J. Sexual Disorders and Gender Dysphoria
    K. Disruptive, Impulse-Control, and Conduct Disorders
    L. Substance-Related and Addictive Disorders
    M. Neurocognitive Disorders
    N. Personality Disorders
    O. Other Conditions That May Be a Focus of Clinical Attention
    P. Innovations of DSM-5

8 Focus 3.1 Comorbidity

9. Issues in the Diagnosis and Classification of Abnormal Behaviour
    A. Against Classification
    B. Criticisms Specific to the DSM Diagnostic System

10. The Prevalence of Mental Disorders

11. Focus 3.2 Research Domain Criteria

12. Summary

13. Key Terms

14. Lecture Ideas/Activities
    A. The disadvantages of the DSM approach
    B. Distinguish between a psychological disorder and an illness

## 1. Case Studies

A. Nick, a single 30-year-old man, lives with his mother and becomes anxious when she encourages him to move out and become more independent. Due to his medical conditions, he is convinced he needs his mother's help taking care of himself. Nick also suffers from anxiety and has a history of panic attacks which has kept him mostly socially isolated and afraid of venturing outside of his mother's home. According to a psychological assessment, Nick also has Dependent Personality Disorder.

B. Howie Mandel has publically reported that he has OCD. He is a long-time advocate and spokesperson for various mental health campaigns.

## 2. Why Do We Need a Classification System for Mental disorders?

A diagnostic system provides a common vocabulary for professionals to communicate with each other about individuals with mental disorders, and it provides information that is necessary when making decisions about treatment. Without a classification system we could not conduct research on disorders, and without research, progress in treatment would be stalled. Finally, we need diagnostic systems in order to estimate the prevalence of disorders in the population.

## 3. The Perfect Diagnostic System

The perfect diagnostic system would classify disorders on the basis of sound empirical research findings on the presenting symptoms, etiology, prognosis, and response to treatment of a large number of people. Ideally, different symptom clusters would accurately signal different disorders, and a precise "cure" would be available for each disorder. Unfortunately, attaining the perfect diagnostic system is hindered by the difficulty of systematically observing and measuring many aspects of human functioning in a controlled fashion adhering to strict scientific principles. Despite the shortcomings of diagnostic systems to date, a good classification system is useful for organization of information, communication, prognosis, treatment recommendations, heuristic value, and guidelines for financial support.

## 4. Characteristics of Strong Diagnostic Systems

In order to be useful, a diagnostic system must fulfill the criteria of reliability and validity. One important aspect of reliability of the DSM is **inter-rater reliability**. Concerning validity, the two most relevant types for the DSM are **concurrent validity** and **predictive validity**.

## 5. The History of Classification of Mental Disorders

In the nineteenth century Kraeplin led the way in developing a systematic classification of mental disorders; however, his categories and descriptors are not the ones used in modern systems. The American Psychiatric Association published a classification system, the DSM-I, in 1952. DSM-I and its successor, DSM-II (1968) were highly unsatisfactory, mainly due to the vague, subjective narrative descriptions of disorders, which resulted in very poor inter-rater reliability. DSM-III (1980) and DSM-III-R (1987) were more atheoretical and pragmatic as they moved toward more precise behavioural descriptions and specific criteria. The DSM-III-R was

developed to be **polythetic**, meaning that a person could be diagnosed with a disorder based on only a subset of diagnostic criteria. The advent of the DSM-IV (1994; text revision, 2000) was the result of comprehensive literature reviews and field trials. Most recently, the DSM-5 has been released, following a 12-year process of revision. Old datasets were reanalyzed, comprehensive literature reviews were performed and field trials across a number of clinical settings, including one psychiatric hospital in Canada, were conducted. For the first time, the APA posted proposals for DSM-5 online for public and professional commentary. It is important to note that in Europe, the World Health Organization's International Classification of Diseases (ICD) tends to be used; it too is undergoing revision. The DSM-5 and ICD are not meant to be competing classification systems; in fact, there are references to the ICD in the DSM-5.

**6. DSM-5: Organizational Structure**

One of the major innovations in the DSM-III and later editions was the use of multiaxial classifications that addressed a broad array of information that might be of importance in relation to a patient. Following a thorough assessment, clinicians would record information about 5 axes: Axis I concerned the disorders to be potentially treated. Axis II focused on the presence of long-term, enduring disorders (e.g., a personality disorder) that may have an impact on the presentation or treatment of the Axis I condition. Axis III covered any medical disorder that might be relevant to the understanding or management of the psychological disorder(s). Axis IV summarized information on the patient's life circumstances (e.g., job loss, relationship dissolution). Axis V was a score that represented level of impairment or maladjustment.

In 2013 the DSM-5 did away with the multi-axial system. Numerous other innovations were introduced including the addition, removal, and renaming of mental disorders and an increased emphasis on cultural issues. The DSM-5 is divided in three sections:

**A.** **Section I:** the first section is largely an introduction to the DSM-5 development process and provides guidance on the appropriate use of the manual.

**B.** **Section II:** the second section contains the diagnostic criteria for all psychological disorders, including disorders that formerly were considered Axis II disorders, like personality pathology. This section also elaborates on life circumstances and stressors that may have an impact on the presentation and treatment of psychological disorder.

**C.** **Section III:** The third section contains new measures to assess impairment and quality of life which represents a significant advance from the former Axis V. This section also contains a new highly detailed Cultural Formulation Interview which is designed to guide the clinician to ask about cultural factors that may play a role in the expression of psychological symptoms. Finally, a new model for the diagnosis of personality disorders is featured, whose main innovation is its dimensional approach.

## 7. Categories of Disorders in DSM-5

### A. Neurodevelopmental Disorders

Included in this broad-ranging category of disorders are the intellectual, emotional, and physical disorders that typically begin in infancy or childhood (e.g., attention deficit/hyperactivity disorder, autistic spectrum disorder). Intellectual disability substitutes for mental retardation.

### B. Schizophrenia Spectrum and Other Psychotic Disorders

The disorders known as part of a schizophrenia spectrum are marked by deficits in cognition and perception. Individuals with such diagnoses suffer from varying degrees of psychosis--a loss of contact with reality that includes delusions and hallucinations.

### C. Mood Disorders

Mood Disorders (depressive disorders) involve disturbances in mood that do not seem to be proportional or expectable reactions to life events. In DSM-5 the depressive disorders include **major depressive disorder** and **persistent depressive disorder (dysthymic disorder);** whereas, the bipolar and related disorders include mania and bipolar disorders I and II.

### D. Anxiety and Related Disorders

Anxiety and Related Disorders are characterized by excessive fear, worry, or anticipatory anxiety. Avoidance is also a common feature. Disorders included in the *anxiety disorders* category are specific phobias, generalized anxiety disorder, social anxiety disorder, panic disorder, and agoraphobia. Obsessive compulsive disorder is now categorized under Obsessive Compulsive and Related Disorders and posttraumatic stress disorder is now classed as a Trauma- and Stressor-Related Disorder. It is important to note that mood-related disorders often coincide with anxiety and related disorders.

### E. Dissociative Disorders

Dissociative Disorders are characterized by a sudden and profound alteration in consciousness that affects an individual's memory and identity. This category includes dissociative amnesia, dissociative fugue, and depersonalization/derealization disorder.

### F. Somatic Symptom and Related Disorders

Somatic Symptom and Related Disorders are disorders that involve preoccupation with somatic symptoms or patterns of somatic symptoms that are not explainable by a physical disease process. Included in this category are somatic symptom disorder and illness anxiety disorder (formerly, hypochondriasis), conversion disorder, and factitious disorders.

### G. Feeding and Eating Disorders

Feeding and Eating Disorders are characterized by extreme eating patterns that significantly impair functioning. These include anorexia nervosa, bulimia nervosa and binge-eating disorder.

**H. Elimination Disorders**

These are typically diagnosed in childhood or adolescence. Enuresis is the repeated voiding of one's bladder in inappropriate places, and encopresis is the repeated passage of feces in inappropriate places. Either can occur voluntarily or involuntarily.

**I. Sleep – Wake Disorders**

Individuals with these disorders display two major categories of sleep disturbances. In the dyssomnias, sleep is disturbed in amount, quality, or onset. The parasomnias are marked by abnormal physiological events during sleep.

**J. Sexual Disorders and Gender Dysphoria**

Sexual Disorders and Gender Dysphoria include the three main categories of sexual dysfunctions (e.g., premature ejaculation), paraphilic disorders (e.g., exhibitionistic), and gender dysphoria.

**K. Disruptive, Impulse-Control, and Conduct Disorders**

Disruptive, Impulse-Control, and Conduct Disorders include a number of conditions in which people are chronically unable to resist impulses, drives, or temptations to perform acts harmful to themselves or to others. These disorders include intermittent explosive disorder, conduct disorder, and oppositional defiant disorder.

**L. Substance-Related Disorders and Addictive Disorders.**

When the use of substances that affect the central nervous system, such as alcohol or amphetamines, results in social, occupational, psychological, or physical problems, it is considered a mental disorder. Gambling disorder is new to this category and is considered a "behavioural addiction" that shares underlying features with classical substance use disorders.

**M. Neurocognitive Disorders.**

Delirium is characterized by a disturbances in consciousness, wavering attention, and an incoherent stream of thought. Cognitive impairments refer to a deterioration of mental capacities.

**N. Personality Disorders**

Personality Disorders are characterized by rigid, maladaptive behaviours that are stable across time and across contexts/situations. Personality pathology begins before adulthood. There are 10 personality disorders and examples include antisocial personality disorder and dependent personality disorder.

**O. Other Conditions That May Be a Focus of Clinical Attention**

This broad category is used for conditions that are not mental disorders but are important to assess as they may have an influence on presenting symptoms or treatment course. For example, marital problems may be an explanatory factor in what appear to be symptoms of depressive disorders or anxiety disorders.

**P. Innovations of DSM-5.**

The DSM-5 was developed based on the most recent scientific evidence pertaining to the disorders within it. It is a "living document" – more frequent updates and revisions are expected which is important considering that DSM-5 was published 13 years after the text revision of DSM-IV (2000). The DSM-5 also contains a scale to help clinicians rate the severity of disorders. Controversy continues with respect to the categorical approach of the DSM (i.e., dichotomous diagnostic decision making based on arbitrary thresholds and symptom counts). Some researchers are advocating for a dimensional approach to the assessment of psychological disorders.

## 8. Focus 3.1 Comorbidity

Research has demonstrated that **comorbidity** (i.e., meeting the criteria for more than one disorder at any one time) may be present in more than 50% of cases. The occurrence of comorbidity leads to difficult questions about the nature of the relationship between the two or more disorders and how to treat them.

## 9. Issues in the Diagnosis and Classification of Abnormal Behaviour

There are two main areas of controversy regarding the use of diagnostic systems in classifying abnormal behaviour. One camp objects to classification/categorization *in general*, and a second camp objects to the DSM, *specifically*.

**A. Against Classification**

***Medical Model***

A considerable number of professionals argue that the diagnosis of psychopathology is flawed because of its allegiance to the medical model. According to this viewpoint, medical disorders, unlike mental disorders are characterized by a clear and recognizable deviation in anatomical structure e.g., presence of a lesion. Wakefield has skillfully counterargued that there also are many accepted medical disorders for which there are no known lesions or anatomical abnormalities. He also argues that the absence of anatomical or physiological deviation in mental disorder may signify that we simply have not yet discovered them.

***Stigmatization***

Another argument against diagnosis is that it unfairly labels an individual. The label of "mental illness" may lead an individual to identify with that label and experience further impairment. It has been counterargued that the flaw lies not in the classification system, but in the general population's negative reactions to the concept of mental disorder.

***Loss of information***

A common criticism of diagnosis is that information is lost through the use of labels. However, it is also possible that the information lost by using a diagnostic label is often irrelevant to the diagnostic endeavour, and in turn this may actually facilitate intervention procedures, research and communication between health professionals. What seems most important is to reduce bias among professionals and the public via education.

**B. Criticisms Specific to the DSM**

***Gender Bias***

Gender bias is still a concern in the DSM, although major improvements have been made in this area from DSM-I to the current DSM-5. Some critics claim that societal gender bias is reflected in the DSM descriptions of many psychiatric disorders, making a diagnosis more likely for women, even when no pathology is actually present.

***Cultural Bias in the DSM***

Cultural bias is another important factor that influences the diagnostic process. Although the DSM-5 strives to remain atheoretical and to highlight cultural variation in the expression of symptoms, decisions about the normality or abnormality of behaviours continue to be fraught with cultural and professional biases, especially considering that disorders in the DSM have been determined largely by the consensus of English-speaking clinical researchers trained primarily in North America.

***Politics and the DSM***

There are concerns about the secrecy surrounding the DSM revision process, and about the composition of the membership of the committees that are worked on DSM-5. One hundred percent of the committee members working on revisions for the categories of "Mood disorders" and "Schizophrenia and Other Psychotic Disorders" have financial ties to the pharmaceutical industry.

## 10. The Prevalence of Mental Disorders

Around the world, about one-third of people have a mental disorder and the majority do not receive treatment. Depression is the leading cause of disability (e.g., inability to work) around the world.

## 11. Focus 3.2 Research Domain Criteria

The National Institute of Mental Health, the major funding body for mental health research in the United States, published a new framework for the study of psychopathology called the Research Domain Criteria. The framework encourages the study of mechanisms of disorder and in particular, features that appear to cut across the DSM-5 disorders (e.g., attention dysregulation).

## 12. Summary

1. The endeavour of diagnosing mental disorders has been criticized for its adherence to the medical model, unfairly stigmatizing people, and the information lost through the use of classification labels.
2. The DSM, in particular, has been criticized for its gender bias and cultural bias.
3. Inter-rater reliability refers to the extent to which two clinicians agree on the diagnosis of a particular patient and is an important requirement of any diagnostic system.
4. Validity refers to the degree to which a classification system, for example, measures what it purports to measure. The two most important types of validity for diagnostic systems are concurrent validity and predictive validity.
5. The DSM-5 is the latest of an ongoing attempt to improve reliability and validity by employing more specific criteria based on empirical findings.

## 13. Key Terms

assessment (p. 50)
atheoretical (p. 52)
bipolar disorders (p. 54)
categorical approach (p. 57)
comorbidity (p. 55)
concurrent validity (p. 51)
diagnosis (p. 49)
diagnostic system (p. 49)
dimensional approach (p. 57)
inter-rater reliability (p. 51)
major depressive disorder (p. 54)
mania (p. 54)
polythetic (p. 52)
predictive validity (p. 51)
reliability (p. 51)
validity (p. 51)

## 14. Lecture Ideas/Activities

### A. The disadvantages of the DSM approach

As your text notes, not everyone was happy with the multiaxial approach and the philosophy introduced with the DSM-III in 1980. One such critic was George Valliant, who found five problems with this DSM approach. Discuss with your students the fact that many of these criticisms of the DSM continue to persist decades later even with subsequent revisions to the DSM.

1. The DSM is anchored in an American system of values and does not give adequate consideration to other cultures. For example, although recent editions of the DSM call for clinicians to be more culturally sensitive in their assessments of psychopathology, there are few concrete standards in place that guide therapists on how to address cultural variations in the manifestation and severity of symptoms or the cross-cultural prevalence of various diagnoses.

2. The DSM is based on the premise that diagnoses are categorical, however, most diagnoses are dimensional. Although some diagnoses, such as pregnancy, fall neatly into a categorical distinction of present/not present, most (e.g., depression, anxiety) occur in degrees, with people having more or less of the factor at any given time.

3. The DSM places too much attention on surface phenomena, while failing to attend to the longitudinal course of psychological disturbances.

4. The DSM inadequately addresses important etiological factors that may influence the severity and course of a disorder.

5. The DSM sacrifices validity for the sake of reliability. Although use of the DSM will encourage clinicians to come up with the same diagnoses both across clinicians and over time (reliability), it does not always guarantee an accurate diagnosis (validity).

Additional concerns include:

6. The DSM is a system designed for the primary purpose of determining a diagnosis for a client. This is based on a deficit, rather than a strengths perspective, which presumes someone is demonstrating psychopathology. Some believe the process of labeling someone with a mental illness is inherently problematic and harmful. Such labels may also cause the individual and those around them to behave as if it is true and behave accordingly. The DSM-5 has made significant strides in addressing the above concerns.

Valliant, G. E. (1984). The disadvantages of DSM-III outweigh its advantages. *American Journal of Psychiatry, 141*, 542-545.

 

**B. Distinguish between a psychological disorder and an illness**

A common misunderstanding of the DSM system of assessment stems from our greater familiarity with the medical model, in which symptoms are linked with causes in the course of diagnosing and treating an illness. However, in the DSM-5, abnormal behaviours are viewed as signs of mental disorders, which are clinically significant clusters of features that may be identified and treated without necessarily knowing the underlying causes. In fact, for most mental disorders the etiology is unknown. Thus, the DSM-5 tries to be atheoretical with regard to etiology or causal factors, except in regard to those disorders for which this is well established, as in many of the cognitive disorders with organic origins. The major justification for this approach is that the inclusion of etiological theories would be an obstacle for the use of the manual by clinicians of varying theoretical orientations, including psychologists. Also, it would not be possible to present all the reasonable theoretical orientations.