Research into how mental disorders are classified

“ DSM-IV is a classification of mental disorders that was developed for use in clinical, educational, and research settings.” (American Psychiatric Association, DSM-IV-TR, 2000) What the DSM attempts to do is have specific criteria for specific disorders, but at the same time, not have the manual be used in a “ cookbook” fashion. Meaning that the specific diagnostic criteria in the DSM are meant to serve as guidelines concurrently with clinical judgment. As we all know, each disorder included in the DSM has a set of diagnostic criteria that signify what symptoms must be present in order to meet the criteria for a diagnosis. Conversely, there are some disorders where there are symptoms that must not be present in order for an individual to be eligible for the diagnosis. A strong point of this particular set-up of the DSM manual makes finding the disorder and its diagnostic criteria easier because of its conciseness. The use of the DSM diagnostic criteria to diagnose has been shown to increase diagnostic reliability (Mezzich, 2002).

As noted above, the DSM-IV is a manual that helps outline mental disorders. A major strength is that healthcare professionals such as physicians, psychologist, psychiatrists, and others combined their resources and knowledge to create a universal manual (Well in the US anyways) (Speigel, January 3, 2005). Also, the DSM is used for appropriate coding for billing and insurance purposes which, for most psychologists, is imperative in order to receive reimbursement for treatment. Another strength of the DSM is that it allows researchers to gather a group of patients who meet the described criteria for the disorder, try different treatments, and compare the results. For example, a percentage of patients with social phobia might be helped by placebo, and if a greater number will be helped by a psycholeptic, or

psychotherapy, or whatever the treatment is in their design, then one of these treatments can be found valuable. This is important because the idea of evidence based treatment appeals to the general public, to the field, and is just common sense. Therefore, it is known that empirical data is more useful than untested theories and endless debates that are not proven by research.

One weakness that I have found is the reoccurrence of including the social effects of disorders in the criteria by which the same disorders are identified (Widiger & Sankis, 2000). It has been argued that when a person meets or exceeds the criteria for a disorder, the DSM does not satisfactorily take into account the context in which a person is living, and to what degree there is a disorder of an individual versus a psychological response to their negative environment (Chodoff, 2005). Therefore, should someone who is in a very poor living situation (emotional or physical abuse, in poverty, ect) these may be the sole factor for some their symptoms, so should it still be assessed in the criteria? Sometimes, “ an individual’s quantity of impairment is often not correlated with symptom counts, and can stem from various individual and social factors, the DSM’s standard of distress or disability can often produce false positives” (Spitzer R. L., & Wakefield J. C., 1999). However, the reality still is that some individuals who don’t meet all the symptom criteria may still experience similar suffering or dysfunction in their life.

The DSM-IV is practically known as a categorical classification system. The categories are models, and a patient with a high relation to the model is said to have that disorder. The DSM-IV (2000) states, “ there is no assumption each category of mental disorder is a completely discrete entity with

absolute boundaries...” At the same time, unique, mild, or non-criterion symptoms are not given any importance in the diagnosis (Maser, JD., & Patterson, T., 2002). On the other hand, qualifiers are sometimes used when explaining the level of disorder; for example: mild, moderate or severe forms. For many the disorders, symptoms must be adequate to cause “ clinically significant distress or impairment in social, occupational, or other important areas of functioning.” (APA, DSM-IV-TR, 2000) It has been said that ever since the DSM was created, it has been argued that its system of classification makes indiscrete categorical distinctions between disorders, and uses somewhat random cut-offs between normal and abnormal (Widiger & Coker, 2003, p. 3). I agree that the cut-offs seem a bit arbitrary, and though it is not always voiced, my professors seem to silently have the same opinion. It has been argued that rather than using a categorical approach, a fully dimensional or continuum approach may enhanced the diagnosis people and make it more individualized. (Dalal P. K., & Sivakumar T., (2009).

What I feel would make the next version DSM superior comes from a suggestion by Dr. Kraemer at the American Psychiatric Association 2007 Annual Meeting, in San Diego, California. (Busko, June 14, 2007) She stated “ that the purpose of a diagnostic system of mental health disorders, such as the DSM, is not to say what is “ normal” or “ acceptable” but to describe the presentation of a person who comes to get clinical help.” The point being made is when a healthcare professional uses the DSM they have to answer this question, “ Does the patient fit this mental disorder category?” Right now, there are only 2 options: Yes or No, which makes the DSM very categorical. However, a dimensional diagnosis, would give us 3 or more

potential values that can be ordered. An example, provided by Dr. Kraemer was:

- “ Absolutely sure patient has this disorder.”

- “ Not absolutely sure patient has this disorder.”

- “ Absolutely sure patient doesn’t have this disorder.”

While I think that having more than a binary option is a good idea, I am not sure about this “ Absolutely Sure or Unsure” categorization that is presented. Yes, the diagnostic classification should lead to a diagnosis that is reliable and valid, but it should also trust in the professionals’ life experiences and knowledge in determining how any one disorder is presented in an individual. At the same time, I am cautious about having a classification system that starts running into subclinical diagnosis. I feel that this would lead into everyone leaving a psychologists or psychiatrists office with a disorder. One side note I would like to add, is that as it has been presented by the APA, the DSM-5 is leaning towards making Asperger’s Syndrome a combined disorder with Autism Spectrum Disorder. As a person who has a brother with Aspeger and having worked with the general Autistic community, I feel abhorred that such a thing would be considered. They are similar, but not the same thing. Especially when we are discussing an individual’s ability to live independently and function in their community. For me, this would be like combining Schizoid personality disorder and Schizotypal personality disorder. Well, I will just stop my rambling for now.

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Chodoff, P. (2005). Psychiatric Diagnosis: A 60-Year Perspective. Psychiatric News. June 3, 2005 Volume 40 Number 11, p17