UNIT 2 CLASSIFICATION OF PSYCHOPATHOLOGY: DSM IV TR

Structure

2.0 INTRODUCTION

Classification is the core of science. Therefore, classification systems are developed with which we could define or classify behaviour. Abnormal psychology is based on the assumption that behaviour is part of one category or disorder and not of another one. A thorough account of classification of mental disorders will be presented in this unit. First of all, we will discuss meaning, purposes and approaches of classification of mental disorders. This will be followed by a description of history of classification of mental disorders. We will then discuss widely used DSM-IV (TR), the current version of DSM. Finally, DSM-IV (TR) will be evaluated.

2.1 OBJECTIVES

After reading this unit, you will be able to:

- Explain meaning, purpose and approaches of classification of mental disorders;
- Present an account of history of classification of mental disorders;
- Explain ICD-10 for the classification of mental disorders;
- Understand the development of DSM as a system of classification of mental disorders;

- Present an account of DSM-IV (TR); and
- Evaluate DSM-IV (TR).

2.2 MEANING AND PURPOSE OF CLASSIFICATION OF PSYCHOPATHOLOGY

In order to classify the psychological disorders we need a classification system. The term classification refers to process to construct categories and to assign people to these categories on the basis of their attributes. Classification in scientific context refers to taxonomy. It also refers to nomenclature, which describes the names and labels that may make up a particular disorder such as schizophrenia or depression. Classification is at the heart of every science. If we cannot label and order objects or experiences or behaviours scientists could not communicate with one another and our knowledge will not advance.

Without labelling and organising patterns of abnormal behaviour, researchers could not communicate their findings to one another, and progress toward understanding and decision about these disorders would come to a halt. Certain psychological disorders respond better to one therapy than another or to one drug than another. Classification also helps clinicians predict behaviour. Finally, classification helps researchers identify populations with similar patterns of abnormal behaviour. By classifying groups of people as depressed, for example, researchers might be able to identify common factors that help explain the origins of depression. Classification of psychopathology fulfils following five primary purposes:

1) Communication
2) Control
3) Comprehension
4) Distinction
5) Prognosis/prediction

2.2.1 Approaches to the Classification of Psychopathology

Psychologists use three approaches or strategies to classify disorders:

i) **Categorical approach:** It was Kraepelin, the first psychiatrist to classify psychological disorders from a biological or medical point of view. For Kraepelin in term of physical disorders, we have one set of causative factors which do not overlap with other disorders. We have one defining criteria, which everybody in the category or in the group should meet, e. g. Schizophrenia. After a category has been defined, an object is either a member of the category or it is not. A categorical approach to classification assumes that distinctions among members of different categories are qualitative. In other words, the differences reflect a difference in kind (quality) rather than a difference in amount (quantity).

ii) **Dimensional approach:** A second strategy is a dimensional approach, in which we note the variety of cognitions, moods and behaviours with which the patient presents and quantify them on a scale. For example, on a scale of 1 to 10, a patient might be rated as severely anxious (10), moderately depressed (5), and mildly manic (2) to create a profile of emotional functioning (10, 5, 2). Although dimensional approaches have been applied to psychopathology, they are relatively

unsatisfactory. Dimensional approach to classification describes the objects of classification in terms of continuous dimensions. Rather than assuming that an object either has or does not have a particular property, it may be useful to focus on a specific characteristic and determine how much of that characteristic the object exhibits.

iii) **Prototypical approach:** A third approach, for organising and classifying behavioural disorders which is an alternative to the first two. It is called a prototypical approach. It identifies some essential characteristics of a disorder and it also allows for certain non-essential variations that do not necessarily change the classification. With this approach classifying the disorder by different possible features or properties any candidate must meet (but not all) of them to fall in that category. In depression, there are five important symptoms such as: depressed mood all the day, weight loss, insomnia, fatigue and feeling of worthlessness. For a person might have three or four of the characteristics of the depression but not all five of them. Yet we still diagnose the person as depressed.

2.3 HISTORY OF CLASSIFICATION OF PSYCHOPATHOLOGY

The most ancient classification of psychopathology was of senile deterioration, melancholia and hysteria. The oldest systematic classification finds its mention in the Ayurveda, an Indian body of thought. The Greek philosopher Hippocrates (460–370 B.C.) classified mental illness into delirium, mania, paranoia, hysteria, melancholia resulting from 4 basic temperaments. Philippe Pinel's (1745–1826) father of modern psychiatry, classification system was based on functional disorders of nervous system. He described four functional disorders: dementia, mania, melancholia and idiotism. Karl Ludwig Kahlbaum (1828-1899) distinguished organic and non organic mental disorders. Emil Kraepelin's (1856- 1926) classification system was based on clinical features of disorders: cause, course and outcomes. His primary classifications were manic depressive psychosis and dementia praecox. Eugen Bleuler combined Kraepelin and Meyerian approaches and classified mental disorders on the basis of psycho-pathological processes.

2.3.1 Development of ICD

In 1893 1st international list of causes of death was published. This stimulated worldwide organised effort for classification of diseases which resulted in the publication of International Statistical Classification of Diseases and Related Health Problems-1 (ICD-1) by the World Health Organisation in 1900. However, it was only ICD-6 which was published with a separate section on mental disorder in 1949. ICD-8 was published in 1972 with a comprehensive glossary of mental disorders. ICD-9 was published in 1977 with greater clinical modification. Vol. 1 and 2 of ICD-9 described diagnostic codes, while vol. 3 explained procedure codes for the Mental and Behavioural Disorders.

ICD-10: In 1978, WHO entered into a long-term collaborative project with the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) in the USA, aiming to facilitate further improvements in the classification and diagnosis of mental disorders, and alcohol and drug related problems. A series of workshops brought together researchers and practitioners from a number of different psychiatric traditions and cultures, reviewed knowledge in specified areas, and developed recommendations

for future research. A major international conference on classification and diagnosis was held in Copenhagen, Denmark, in 1982 to review the recommendations that emerged from these workshops and to outline a research agenda and guidelines for future work. Several major research efforts were undertaken to implement the recommendations of the Copenhagen conference. All these efforts resulted in the publication of ICD-10 in 1992 in which in chapter V (F) pertained to the classification of mental disorders explaining their inclusion and exclusion terms.

2.3.2 Classification of Mental Disorders in ICD-10

A brief description of classification of mental disorders as per ICD-10 is given below:

- F00-F09: Organic, including symptomatic, mental disorders: Dementia, delirium, organic.
- F10-F19: Mental and behavioural disorders due to use of psychoactive substances: Alcohol, cocaine and tobacco.
- F20-F29: Schizophrenia, schizotypal and delusional disorders.
- F30-F39: Mood (affective) disorders: Manic, bipolar, depressive.
- F40-F48: Neurotic, stress-related and somatoform disorders: Phobia, OCD, adjustment, dissociative.
- F50-F59: Behavioural syndromes associated with physiological disturbances and physical factors: Eating, sleep, sexual disorders.
- F60-F69: Disorders of personality and behaviour in adult persons: Specific, impulse disorder, gender identity.
- F70-F79: Mental retardation
- F80-F89: Disorders of psychological development: Speech and language, pervasive development.
- F90-F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence: Hyperkinetic, conduct, tic.
- F-99: Unspecified mental disorders.

Self Assessment Questions

1) Explain meaning of classification of psychopathology.

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2) Describe the purpose of classification of psychopathology.

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3) Give an account of approaches to the classification of psychopathology.

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4) Explain the initial efforts of classification of psychopathology.

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5) Describe the importance of ICD in classification of psychopathology.

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6) Present an account of classification of mental disorders prescribed in ICD-10.

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2.4 DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, is the handbook used most often in diagnosing mental disorders in the United States and other countries.

2.4.1 A Brief History of DSM

Need of statistical information regarding mental disorders stimulated revolution in the efforts of development of a classification system in the United States. The National census of 1840 used a single category, "idiocy/insanity". Seven categories of mental disorders were mentioned in the 1880 census: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. The American Psychiatric Association (APA), then known as Committee on Statistics, together with the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the "Statistical Manual for the Use of Institutions for the Insane" in 1917, which included 22 diagnoses. Subsequently, this was revised several times by APA over the years.

2.4.2 Revisions of DSM

In view of needs arisen from World War II, a committee headed by psychiatrist and brigadier general William C. Menninger with the help of US psychiatrists developed a new classification scheme called Medical 203 in 1943.

DSM-I (1952): In 1949, the World Health Organisation published the sixth revision of the International Statistical Classification of Diseases (ICD-10) which included a section on mental disorders for the first time. Consequently, an APA Committee on Nomenclature and Statistics was empowered to develop a classification system for use in the United States. In 1950 the APA committee undertook a review and consultation to circulated the Diagnostic and Statistical Manual of Mental Disorders-1 (DSM-I) which was approved in 1951 and published in 1952. The structure and conceptual framework were the same as in Medical 203, and many passages of text identical. The manual was 130 pages long and listed 106 mental disorders. DSM-I made 94% changes in nomenclature from the prior system and seventy disorder terms used "Reaction," e.g., schizophrenic reaction. This included reaction to internal conflict. DSM-I is criticised on the basis that it was psychoanalytic in its theoretical orientation. The term "Unconscious" was mentioned a few times in describing psychoneurotic disorders in DSM-I.

DSM-II (1968): Despite APA's involvement in the revision of the mental disorder section of the ICD-8 in 1968), it also published a revision of the DSM in 1968, listed 182 disorders, and was 134 pages long. It was quite similar to the DSM-I. The term "reaction" was dropped but the term "neurosis" was retained. Both the DSM-I and the DSM-II reflected the predominant psychodynamic psychiatry, although they also included biological perspectives and concepts from Kraepelin's system of classification. Symptoms were not specified in detail for specific disorders. Many of the disorders were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis (roughly, anxiety/ depression broadly in touch with reality, or hallucinations/delusions appearing disconnected from reality). Sociological and biological knowledge was also incorporated, in a model that did not emphasise a clear boundary between normality and abnormality. After wide post publication criticism of DSM-II, the term "Homosexuality" was replaced with "Ego-dystonic Homosexuality" in 1973.

DSM-III (1980): To make the DSM nomenclature consistent with the International Statistical Classification of Diseases and Related Health Problems (ICD) the decision to create a new revision of the DSM was made in 1974 with Robert Spitzer as chairman of the task force. This revision was aimed at improving the uniformity and validity of psychiatric diagnosis, standardising diagnostic practices across the world and to facilitate the pharmaceutical regulatory process to avoid criticisms levelled on DSM-II. The criteria for many of the mental disorders were taken from the Research Diagnostic Criteria and Feighner Criteria. New categories of disorder and their criteria were established by consensus during meetings of the committee. The psychodynamic or physiologic view was abandoned, in favour of a regulatory or legislative model. A new "multi-axial" system attempted to yield a picture more amenable to a statistical population census, rather than just a simple diagnosis. DSM conceptualised each of the mental disorders as a clinically significant behavioural or psychological syndrome.

Finally published in 1980, the DSM-III was 494 pages long and listed 265 diagnostic categories. It rapidly came into widespread international use. DSM-III was published with 93% changes in nomenclature from the earlier version of DSM with diagnostic

criteria for each of the disorders mentioned. There was a multi-axial classification with five axes. DSM-III provided a vast increase in background information about each disorder, adding diagnostic features, associated features, cultural and gender features; prevalence, course, familiar patterns, differential diagnosis, decision trees and glossary. However, DSM-III was later criticized on the ground that 20-30 percent of the population would have been diagnosed as having behavioural disorders without having any serious mental problems.

DSM-III-R (1987): The DSM-III-R was published as a revision of DSM-III in 1987. Categories were renamed, reorganised, and significant changes in criteria were made. Six categories were deleted, while some new categories were added. Controversial diagnoses such as pre-menstrual dysphoric disorder and Masochistic Personality Disorder were discarded. "Sexual orientation disturbance" was also removed and was largely subsumed under "sexual disorder not otherwise specified" which can include "persistent and marked distress about one's sexual orientation." DSM-III-R contained 292 diagnoses and was 567 pages long.

DSM-IV (1994): DSM-IV was published in 1994 listing 297 disorders in 886 pages. Process of development of DSM-IV included extensive literature review of diagnoses, analyses to determine required change in criteria and multicenter field trials relating diagnoses to clinical practice. A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning".

DSM-IV (TR) (2000): A "Text Revision" of the DSM-IV, known as the DSM-IV-TR, was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged. The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes in order to maintain consistency with the ICD.

2.5 DSM-IV (TR): THE CURRENT VERSION OF DSM

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard for classifying mental disorders that are used by mental health professionals in the United States. It is intended to be applicable in a wide variety of contexts and used by clinicians and researchers of many different orientations, for example; biological, psychodynamic, cognitive, behavioural, interpersonal, family/systems.

The DSM IV (Text Revision) has been designed for use across settings such as inpatient, outpatient, partial hospitalisation, consultation-liaison, clinic, private practice and primary care. Professionals that use the DSM diagnosis are psychiatrists, psychologists, social workers, nurses, occupational and rehabilitation therapists, counsellors and other health and mental health professionals. The DSM is also a necessary tool for collecting and communicating accurate public health statistics. The DSM consists of three major components/features: the diagnostic classification, the diagnostic criteria sets and the descriptive text.

i) **The Diagnostic Classification:** The DSM-IV (TR) is a categorical classification system. The categories are prototypes, and a patient with a close approximation to the prototype is said to have that disorder with qualifiers, for example mild, moderate or severe forms of a disorder. For nearly half the disorders, symptoms must be sufficient to cause clinically significant distress or impairment in social, occupational,

or other important areas of functioning, although DSM-IV-TR removed the distress criterion from tic disorders and several of the paraphilias. Making a DSM diagnosis consists of selecting those disorders from the classification that best reflects the signs and symptoms that are afflicting the individual being evaluated. Associated with each diagnostic label is a diagnostic code, which is used primarily by institutions and agencies for data collection. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the ICD-9-CM.

ii) **The Diagnostic Criteria:** Each disorder included in the DSM-IV (TR) includes a set of diagnostic criteria including symptoms that are present and for how long. These criteria called inclusion criteria as well as those symptoms that must not be present called exclusion criteria qualify an individual for a particular diagnosis. Many users of the DSM-IV (TR) find these diagnostic criteria useful because they provide a compact description of each disorder. Use of this diagnostic criterion has increased diagnostic reliability and the likelihood that different individuals will assign the same diagnosis. It is important to remember that these criteria are meant to be used as a guideline by an informed clinician.

iii) **Descriptive Text:** The third component of the DSM-IV (TR) is the descriptive text that accompanies each disorder. The text of the DSM-IV (TR) systematically describes each disorder under the following headings: Diagnostic Features; Subtypes and/or Specifies; Recording Procedures; Associated Features and Disorders; Specific Culture, Age, and Gender Features; Prevalence; Course; Familial Pattern; and Differential Diagnosis.

2.5.1 Multi-Axial Classifications

The DSM-IV (TR) recommends clinicians to assess an individual's mental state across five factors or axes. Together the five axes provide a broad range of information about the individual's functioning, not just a diagnosis. The system contains the following axes.

1) **Axis I:** *Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention:* This axis incorporates a wide range of clinical syndromes, including anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, adjustment disorders, and disorders usually first diagnosed during infancy, childhood, or adolescence (except for mental retardation, which is coded on Axis II). Axis I also includes relationship problems, academic or occupational problems, and bereavement, conditions that may be the focus of diagnosis and treatment but that do not in themselves constitute definable psychological disorders. Also coded on Axis I are psychological factors that affect medical conditions, such as anxiety that exacerbates an asthmatic condition or depressive symptoms that delay recovery from surgery. The Axis I clinical disorder categories are as follows:
    1) Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
    2) Delirium, Dementia, and Amnestic and Other Cognitive Disorders
    3) Mental Disorders Due to a General Medical Condition Not Elsewhere Classified
    4) Substance Related Disorders
    5) Schizophrenia and Other Psychotic Disorders
    6) Mood Disorders
    7) Anxiety Disorders

8) Somatoform Disorders
9) Factitious Disorders
10) Dissociative Disorders
11) Sexual and Gender Identity Disorders
12) Eating Disorders
13) Sleep Disorders
14) Impulse Control Disorders Not Elsewhere Classified
15) Adjustment Disorders
16) Other Conditions That May Be a Focus of Clinical Attention

2) **Axis II: Personality Disorders and Mental Retardation:** Personality disorders are enduring and rigid patterns of maladaptive behaviour that typically impair relationships with others and social functioning. These include antisocial, paranoid, narcissistic, and borderline personality disorders. Mental retardation, which is also coded on Axis II, involves pervasive intellectual impairment. People may be given either Axis I or Axis II diagnoses or a combination of the two when both apply. For example, a person may receive a diagnosis of an anxiety disorder (Axis I) and a second diagnosis of a personality disorder (Axis II). This axis includes following disorders:
   1) Paranoid Personality Disorder
   2) Narcissistic Personality Disorder
   3) Schizoid Personality Disorder
   4) Avoidant Personality Disorder
   5) Schizotypal Personality Disorder
   6) Dependent Personality Disorder
   7) Antisocial Personality Disorder
   8) Obsessive-Compulsive Personality disorder
   9) Borderline Personality Disorder
   10) Personality Disorder Not Otherwise Specified
   11) Histrionic Personality Disorder
   12) Mental Retardation
3) **Axis III: General Medical Conditions:** All medical conditions and diseases that may be important to the understanding or treatment of an individual's mental disorders are coded on Axis III. For example, if hypothyroidism were a direct cause of an individual's mood disorder (such as major depression), it would be coded under Axis III. Medical conditions that affect the understanding or treatment of a mental disorder (but that are not direct causes of the disorder) are also listed on Axis III. For instance, the presence of a heart condition may determine whether a particular course of drug therapy should be used with a depressed person.
4) **Axis IV: Psychosocial and Environmental Problems:** The psychosocial and environmental problems that affect the diagnosis, treatment, or outcome of a mental disorder are placed on Axis IV. These include job loss, marital separation or divorce, homelessness or inadequate housing, lack of social support, the death or loss of a friend, orexposure to war or other disasters. Some positive life events, such as a job promotion, may also be listed on Axis IV, but only when they create problems for the individual, such as difficulties adapting to a new job. Table 1 lists examples from this axis.

Table 1: Psychosocial and Environmental Problems

Problem Categories	Examples
Problems with primary support group	Death of family members; health problems of family members; marital disruption in the form of separation, divorce, or estrangement; sexual or physical abuse within the family; child neglect; birth of a sibling
Problems related to the social environment	Death or loss of a friend; social isolation or living alone; difficulties adjusting to a new culture (acculturation); discrimination; adjustment to transitions occurring during the life cycle, such as retirement
Educational problems	Illiteracy; academic difficulties; problems with teachers or classmates; inadequate or impoverished school environment
Occupational problems	Work-related problems including stressful workloads and problems with bosses or co-workers; changes in employment; job dissatisfaction; threat of loss of job; unemployment
Housing problems	Inadequate housing or homelessness; living in an unsafe neighbourhood; problems with neighbours or landlord
Economic problems	Financial hardships or extreme poverty; inadequate welfare support
Problems with access to health care services	Inadequate health care services or availability of health insurance; difficulties with transportation to health care facilities
Problems related to interaction with the legal system/crime	Arrest or imprisonment; becoming involved in a lawsuit or trial; being a victim of crime
Other psychosocial problems	Natural or human-made disasters; war or other hostilities; problems with caregivers outside the family, such as counsellors, social workers, and physicians; lack of availability of social service agencies

Source: Adapted from the *DSM-IV-TR* (APA, 2000)

5) **Axis V: Global Assessment of Relational Functioning (GARF):** The clinician rates the client's current level of psychological, social, and occupational functioning using a 0-100 scale. The clinician may also indicate the highest level of functioning achieved for at least a few months during the preceding year. The level of current functioning indicates the current need for treatment or intensity of care. The level of highest functioning is suggestive of the level of functioning that might be restored. The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship (APA, 2000).

Table 2: Global Assessment of Functioning (GAF) Scale

Code	Severity of Symptoms	Examples
91-100	Superior functioning across a wide variety of activities of daily life	Lacks symptoms Handles life problems without them "getting out of hand"
81-90	Absent or minimal symptoms, no more than everyday problems or concerns	Mild anxiety before exams Occasional argument with family members
71-80	Transient and predictable reactions to stressful events, or no more than slight impairment in functioning	Difficulty concentrating after argument with family Temporarily falls behind in schoolwork
61-70	Some mild symptoms, or some difficulty in social, occupational, or school functioning, but functioning pretty well	Feels down, mild insomnia Occasional truancy or theft within household
51-60	Moderate symptoms, or moderate difficulties in social, occupational, or school functioning	Occasional panic attacks Few friends, conflicts with co-workers
41-50	Serious symptoms, or any serious impairment in social, occupational, or school functioning	Suicidal thoughts, frequent shoplifting Unable to hold job, has no friends
31-40	Some impairment in reality testing or communication, or major impairment in several areas	Speech illogical Depressed man or woman unable to work, neglects family, and avoids friends
21-30	Strong influence on behaviour of delusions or hallucinations, or serious impairment in communication or judgment, or inability to function in almost all areas	Grossly inappropriate behaviour, speech sometimes incoherent Stays in bed all day, no job, home, or friends
11-20	Some danger of hurting self or others, or occasionally fails to maintain personal hygiene, or gross impairment in communication	Suicidal gestures, frequently violent Smears feces
1-10	Persistent danger of severely hurting self or others, or persistent inability to maintain minimal personal hygiene, or seriously suicidal act	Largely incoherent or mute Serious suicidal attempt, recurrent violence

Source: Adapted from the *DSM-IV-TR* (APA, 2000)

2.6 EVALUATION OF DSM-IV (TR)

DSM has provided a common language for discussing diagnoses. There has been an increase in attention to behaviours and the facilitation of the overall learning of psychopathology. Seligman (1990) has indicated that knowledge of diagnosis is important for counsellors so that they may provide a diagnosis for clients. In addition, the DSM diagnosis assists with accountability, record keeping, treatment planning, communication with other helping professionals and identification of client with issues beyond areas of expertise. The disadvantages associated with using the DSM have included the promotion of a mechanistic approach to mental disorder assessment. There is a false impression that the understanding of mental disorders is more advanced than is actually the case. There is an excessive focus on the signs and symptoms of mental disorders to the exclusion of a more in depth understanding of the client's problems including human development. The major issues of criticisms against DSM-IV (TR) are as follow:

i) **Validity and reliability:** The most fundamental scientific criticism of the DSM concerns the validity and reliability of its diagnoses. This refers, roughly, to whether the disorders it defines are actually real conditions in people in the real world that can be consistently identified by its criteria. These are long-standing criticisms of the DSM, originally highlighted by the Rosenhan experiment in the 1970s, and continuing despite some improved reliability since the introduction of more specific rule-based criteria for each condition (Dalal & Sivakumar, 2009).

   Critics argue that the DSM lacks validity because it has no relation to an agreed scientific model of mental disorder and therefore the decisions taken about its categories (or even the question of categories vs. dimensions) were not scientific ones; and that it lacks reliability partly because different diagnoses share many criteria, and what appear to be different criteria are often just rewordings of the same idea, meaning that the decision to allocate one diagnosis or another to a patient is to some extent a matter of personal prejudice (McLaren, 2007).

ii) **Superficial symptoms:** By design, the DSM is primarily concerned with the signs and symptoms of mental disorders, rather than the underlying causes. It claims to collect them on the basis of statistical or clinical patterns and avoids causative or explanatory basis/biases. The DSM is based on an underlying structure that assumes discrete medical disorders that can be separated from each other by symptom patterns. However, its claim to be "atheoretical" is held to be unconvincing because it makes sense only if all mental disorders are categorical by nature, which only a biological model of mental disorder can satisfy. However, the Manual recognises psychological causes of mental disorder, e.g. PTSD, so that it negates its only possible justification (McLaren, 2007).

   The DSM's focus on superficial symptoms is claimed to be largely a result of necessity (assuming such a manual is nevertheless produced), since there is no agreement on a more explanatory classification system. Reviewers note, however, that this approach is undermining research, including in genetics, because it results in the grouping of individuals who have very little in common except superficial criteria as per DSM or ICD diagnosis (Dalal & Sivakumar, 2009).

iii) **Unjustified Categorical Distinctions:** Despite caveats in the introduction to the DSM, it has long been argued that its system of classification makes unjustified categorical distinctions between disorders, and uses arbitrary cut-offs between normal and abnormal. A psychiatric review noted that attempts to demonstrate

natural boundaries between related DSM syndromes or between a common DSM syndrome and normality have failed (Dalal & Sivakumar, 2009). Some argue that rather than a categorical approach, a fully dimensional, spectrum or complaint-oriented approach would better reflect the evidence (Bentall, 2006).

In addition, it is argued that the current approach based on exceeding a threshold of symptoms does not adequately take into account the context in which a person is living and to what extent there is internal disorder of an individual versus a psychological response to adverse situations (Wakefield, Schmitz, First, & Horwitz, 2007).. Axis IV of the DSM-IV (TR) includes a step for outlining "Psychosocial and environmental factors contributing to the disorder" once someone is diagnosed with that particular disorder. Because an individual's degree 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 & Wakefield, 1999). On the other hand, individuals who don't meet symptom counts may nevertheless experience comparable distress or disability in their life.

iv) **Cultural Bias:** Some psychiatrists argue that diagnostic standards of DSM-IV (TR) rely on an exaggerated interpretation of neurophysiological findings and so understate the scientific importance of social-psychological variables (Widiger, & Sankis, 2000). It is contended that the cultural and ethnic diversity of individuals is often discounted by researchers and service providers. In addition, current diagnostic guidelines have been criticized as having a fundamentally Euro-American outlook. It is argued that even when diagnostic criteria set is accepted across different cultures, it does not necessarily indicate that the underlying constructs have any validity within those cultures and reliable application can only demonstrate consistency, not legitimacy (Widiger, & Sankis, 2000).

v) **Influence of Drug Companies:** The way the categories of the DSM-IV (TR) are structured and the number of categories have been substantially expanded is often attributed to the influence of pharmaceutical companies and psychiatrists (Healy, 2006). Roughly half of the authors who selected and defined the DSM-IV psychiatric disorders had financial relationships with the pharmaceutical industry at one time, raising the prospect of a direct conflict of interest.

In view of these criticisms and in pursuit of continuous improvements, the next (fifth) edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, is currently in consultation, planning and preparation. It is due for publication in May 2013. APA has made its draft versions public which includes several changes, including proposed deletion of several types of schizophrenia.

Self Assessment Questions

1) Explain the process of development of various editions of DSM.

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2) Describe the major components of DSM-IV (TR).

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3) Present an account of multi-axial approach to the classification of psychopathology as provided by DSM-IV (TR).

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4) Evaluate DSM-IV (TR) with its merits and demerits.

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2.7 LET US SUM UP

Classification of psychological disorders refers to the process to construct categories of abnormal behaviours and to assign people to these categories on the basis of their behavioural attributes and dysfunctional symptoms. It fulfils the basic purposes of communication, control, comprehension, distinction and prognosis/prediction of psychological disorders. Psychologists use three approaches or strategies to classify disorders: categorical, dimensional and prototypical approach. There have been a number of individual efforts of classification of mental disorders. This worldwide organised effort for classification of diseases was stimulated by the publication of International Statistical Classification of Diseases and Related Health Problems-1 (ICD-1) by the World Health Organisation in 1900. However, it was only ICD-6 which was published with a separate section on mental disorder in 1949. The most recent, tenth edition of ICD was published in 1992 in which chapter V (F) pertained to the classification of mental disorders explaining their inclusion and exclusion terms.

The most influential efforts of classification of psychological disorders began with The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association which is now used as the handbook for diagnosing mental disorders in the United States and other countries. After publication of its first edition, DSM-1 in 1952, its five subsequent editions have been published. The current version of DSM is DSM-IV (TR) published in 2000. The DSM-IV (TR) consists of three major components/features: the diagnostic classification, the diagnostic criteria sets and the descriptive text. The DSM-IV (TR) recommends clinicians to assess an individual's mental state across five factors or axes. Together the five axes provide a broad range of information about the individual's functioning, not just a diagnosis. Axis I assesses clinical disorders and other conditions that may be a focus of clinical attention. This axis incorporates a wide range of clinical syndromes, including anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, adjustment disorders, and disorders usually first diagnosed during infancy, childhood,

or adolescence. Axis II assesses Personality Disorders and Mental Retardation. All medical conditions and diseases that may be important to the understanding or treatment of an individual's mental disorders are coded on Axis III. The psychosocial and environmental problems that affect the diagnosis, treatment, or outcome of a mental disorder are placed on Axis IV. On Axis V, Global Assessment of Relational Functioning (GARF), the clinician rates the client's current level of psychological, social, and occupational functioning using a 0-100 scale. DSM-IV (TR) is criticised on the issues of validity and reliability; classifying mental disorders on the basis of superficial symptoms, culturally biased and unjustified categorical distinctions; and influence of drug companies in classification.

2.8 UNIT END QUESTIONS

1) Explain meaning, purpose of and approaches to classification of psychopathology.

2) Describe the history of history of classification of psychopathology.

3) Describe the importance of ICD in classification of psychopathology and present an account of classification of mental disorders prescribed in ICD-10.

4) Provide a historical account of development of various editions of DSM and describe the major components of DSM-IV (TR).

5) Present an account of multi-axial approach to the classification of psychopathology as provided by DSM-IV (TR).

6) Evaluate DSM-IV (TR) with its merits and demerits.

2.9 GLOSSARY

Classification of Psychological Disorders : classification of psychological disorders refers to process to construct categories and to assign people to these categories on the basis of their attributes.

Categorical Approach : A categorical approach to classification assumes that distinctions among members of different categories are qualitative.

Dimensional Approach : Dimensional approach to classification describes the objects of classification in terms of continuous dimensions.

Prototypical Approach : A prototypical approach identifies some essential characteristics of a disorder and it also allows for certain non-essential variations that do not necessarily change the classification.

Diagnostic Criteria : A diagnostic criteria provides a compact description of a disorder.

Multi-axial Classification : Assessing an individual's mental state across various factors or axes to provide a broad range of information about the individual's functioning, not just a diagnosis, recommended by DSM-IV (TR).

Personality Disorders	:	Personality disorders are enduring and rigid patterns of maladaptive behaviour that typically impair relationships with others and social functioning. These include antisocial, paranoid, narcissistic, and borderline personality disorders.
Mental Retardation	:	Mental retardation involves pervasive intellectual impairment.
Global Assessment of Relational Functioning (GARF)	:	A 0-100 scale on which the clinician rates the client's current level of psychological, social and occupational functioning using.
Validity and reliability of a Classification System	:	This refers to whether the disorders as a classification system defines are actually real conditions in people in the real world that can be consistently identified by its criteria.

2.10 SUGGESTED READINGS

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