

A Brief Critique of the DSM-IV

The DSM-IV is a document that has far-reaching consequences. The assignment of a DSM-IV diagnosis affects how an individual is treated medically, therapeutically, professionally and socially. It is precisely because of its direct and indirect ramifications that the construction of the DSM-IV has been the topic of ongoing concern and debate among theorists, researchers and clinicians. Although a number of these discussions have led to productive changes in the structure of the DSM-IV, it is of course inevitable that some problems remain to be addressed. Four such issues will be addressed herein and will be accompanied by corrective suggestions.

I. The assignment of agency

It is self-evident that the final decision regarding the appropriateness of a DSM-IV diagnosis is made by a professional; although the input from the individual will certainly influence the practitioner's decision, they ultimately have little say in whether or not they receive a diagnosis and which diagnosis they are given. The implication of this is two-fold, depending on which disorder is in question. In instances such as schizophrenia, the individual's self-report of subjective experience is irrelevant in making a diagnosis, because that individual is considered incompetent (Widiger & Coker, 2003). In other instances, such as dysthymia, some input from the individual (such as whether their symptoms interfere with daily life) is considered (American Psychiatric Association, 1994). Nevertheless, the individual (who is the expert in reporting their own behaviors, thoughts and emotions) is at the mercy of the professional, who makes the ultimate decision as to whether the profile meets criteria for a disorder.

It could easily be the case that individuals who are experiencing severe difficulties may not be viewed as worthy of a diagnosis (when they would in fact benefit from the psychopharmacology or therapy available). On the other hand, other individuals who are adamant that they are not experiencing difficulties may be diagnosed and treated against their will, which could be seen as a severe breach of human rights (Szasz, 1986). The assignment of a diagnosis in these latter cases must be questioned – for whose benefit is the diagnosis? There are important social policy implications here, and a consideration must be given to whether the diagnosis is given to benefit the individual or to ease the trouble of others in dealing with unusual and potentially problematic behaviors.

There is no clear resolution to this matter; it is not possible nor reasonable to place the diagnostic process into the hands of the lay-person, and yet the individual in question must be considered a reliable source of information regarding their own experience. What is important to keep in mind is that providing a diagnosis does not change the actual phenomenon as experienced by the individual; it does change their access to medical, therapeutic and financial support but may also come with certain social and interpersonal costs. The practitioner should make the individual an active partner in the process of diagnosis to determine whether the consequences of assigning a diagnosis would be accurate and beneficial. In those cases where the individual is, in the eyes of the practitioner, incapable on realistic self-report, family and close friends should be involved in the process in order to keep the best interests of that particular individual in mind.

II. Categorical vs. continuous OR what's pathological?

The issue of whether "pathological" behaviors are discrete from normal behavior or are more extreme (but continuous) forms of typical traits has been the topic of continued debate. It seems undeniable that the characteristics which define a number of (if not all) disorders (i.e., depression, anxiety, involuntary thoughts) are likely present at some point or another, to

varying degrees, in all of us. It seems inaccurate, then, to posit that disorder is clearly distinct from normality and more precise to suppose that what we consider “disordered” is simply characterized by more marked manifestations of typical behaviors and experiences.

Assuming this is the case, then, it seems more appropriate to base diagnosis on a cutoff model rather than a presence/absence framework (currently used by the DSM-IV).

However, we then encounter the issue of determining where the cutoff for “pathology” is on any number of human characteristics. There are ways to do this, based on standardized scores and the selection of a “magic number” (Wakefield, 1992; Widiger & Coker, 2003). This requires the establishment of universally-used, reliable and valid measures which are consistently administered and interpreted (all of which are problems in and of themselves). It is nevertheless unavoidable that a one point difference will be the determining factor between normal and pathological. It seems, then, that although switching to a categorical model may be more reflective of true human behavior, it does not improve the ease or validity of the diagnostic process.

The answer may lie in suggestions discussed above in the previous section. Deciding whether or not an individual is experiencing pathological levels of symptoms may need to be rooted in subjective report, requiring the input of the client themselves. This is not to say that empirical assessment is not a useful tool in the diagnostic process, but there will clearly be an enormous “gray area” between normal and abnormal, and the report of the individual would help to clarify that haziness. Again, it is relevant to consider that issuing a diagnosis does not mean anything in and of itself; its meaning is extracted from the ramifications of the process. If the individual finds that the degree of their symptoms is sufficiently problematic as to require significant outside assistance, that would be valuable information in deciding whether the profile is pathological or not.

III. *Not Otherwise Specified and Comorbidity*

Part II of this essay discussed the possibility that there is no discrete, specific set of behaviors which characterizes pathology; rather, all humans share a common set of traits to varying degrees. Evidence for this perspective could, in fact, be drawn from the DSM-IV itself, although that is not the underlying model of the document. In an attempt to create a framework which is all-inclusive of human disorder, there is a “not otherwise specified” (NOS) sub-category of most disorders, allowing for the classification of individuals who demonstrate some, but not all, of the requisite characteristics of a disorder. Across all disorders, the “NOS” category a disproportionately common category; the implication of this is that the approach used by the DSM-IV – that is, creating a specific, defined cluster of behaviors which must cluster together in precisely the same way across individuals – does not reflect how traits are truly manifested, which appears to be in a more integrated and graded manner.

A second, related issue is that there is considerable comorbidity across disorders, such that individuals who receive one diagnosis are likely to receive a second, as in the case of depression and anxiety (Widiger & Coker, 2003). This seems also be an artifact of the overly-specific criteria of the DSM-IV, such that the system attempts to isolate profiles which are not actually distinct from one another. By dissecting human behavior and experience into such fragmented and prescribed profiles, it is nearly impossible to capture all of the nuances under one heading. We are not only limiting our ability to accurately characterize the particular difficulties that an individual may be facing (and the appropriate interventions), but

we are creating a system which does not mirror the complexities of human experience, both typical and atypical.

Despite the splintered structure of the DSM-IV, it does provide some insight as to what some possible universal elements of experience might be, and this is a step in a better direction. The inclusion of common subjective experiences such as depression, anxiety, and physiological distress, as well as the incorporation of various personality traits, may serve us more effectively as a model for holistic description of an individual. While it is likely artificial to attempt to classify an individual's behavior into a single disorder, it would be more legitimate to consider the exhibition of characteristics (particularly those which may be problematic) within each of these realms and incorporate this comprehensive profile with the client's input to determine where the primary problems lie and what features are associated with them. Professionals would then be able to prioritize which issues should be addressed most directly, as well as how to make therapeutic efforts as multifaceted as possible.

IV. *The importance of context*

The issue of context is one which complicates the definition and validity of a number of disorders. The DSM-IV bases diagnosis on the fulfillment of a number of behavioral criteria which are or are not met by a particular individual. The individual is considered the unit of focus; their personal history and current situation, the interpersonal systems in which they are embedded, and the immediate and extended social contexts are all disregarded. The validity of this approach (and the underlying assumptions) to diagnosing psychopathology can be questioned in a number of ways.

When exploring symptoms that are typically viewed as "pathological," it is ill-advised to disregard personal history and recent events. The presence of a number of behaviors and self-reported characteristics can be quite influenced by the experiences of the individual. While in some cases, they may seem like inappropriate consequences of recent occurrences, in other cases they may actually be quite appropriate and justifiable and thus *not* pathological but rather the manifestation of a stress response or coping mechanism. Post-traumatic Stress Disorder, which (by definition) must follow a traumatic event, is an example of this. Considering the ghastly experiences of war veterans and rape victims (for instance), the symptoms of Post-traumatic Stress Disorder (i.e., nightmares, avoiding stimuli which remind the individual of the experience, unpleasant and frequent recollections) may actually be a normative response for a significant minority of individuals (McNally, 1999). It may be important to keep in mind that when "healthy" individuals have anxiety and fear surrounding an event, it is not uncommon to have unpleasant dreams or recurrent thoughts about it.

Secondly, there is a dismissal of the individual's social network (Sarason, 1981). There is a considerable contingent of psychologists and psychiatrists who see the individual as being an inseparable element of a social context (Magnusson & Hakan, 1998), and any attempt to isolate the individual from the functional dynamics of the system is necessarily meaningless. Consequently, an attempt to define an individual's behavior as either pathological or normal solely on the basis of practitioner observation and questioning – without any consideration of the *function* the behaviors may serve within the social network, which may be quite adaptive or appropriate – is invalid.

Lastly, it has been observed the prevalence rates of various disorders varies according to culture and ethnicity (Okazaki & Sue, 1995; Tsai, Butcher, Munos, & Vitousek, 2001). It is unclear what the reason is for this. It could be attributable to a number of factors (true differences in the biochemical makeup of different cultures, different values of what is

“normal” and what is not, varying beliefs regarding how inner experiences are manifested, etc.). Nevertheless, it is an indication that there is not an objective boundary between what is pathological and what is healthy; rather, what is believed to be pathological is constructed by the society itself (Prilleltensky, 1989). This is important to keep in mind not only when comparing international incidence of disorders but also in diagnosing individuals who have not been raised according to the values and beliefs that produced the DSM-IV.

The individuals responsible for revising the DSM-IV, then, should include a consideration of the events surrounding an individual's behavior, the function it may serve within the individual's social network, and the cultural influences involved in perceiving and interpreting the individual's behavior. There is a conflict involved in creating hard and fast rules about how the practitioner should use this information in making a diagnosis (i.e., basing conclusions purely on the individual having just experienced a significant loss or being Chinese): as a researcher who wholeheartedly agrees with a systems approach, I recognize that it is not possible to establish a rubric on how the practitioner should apply all of these details, since each individual have a different profile.

Nevertheless, the DSM-IV should encourage the practitioners to firstly query the individual's personal history, both for normative significant events (i.e., divorce, death of loved one) but also for events which may be atypical but quite meaningful for the individual. An attempt must also be made to involve at least two other individuals who are significant to the client, investigating the types of relationships that the individual has, consistencies and inconsistencies and what purpose any “pathological” behaviors may serve in these (and other) relationships. Lastly, the professional must consider the values and beliefs held any groups with which the individual identifies themselves; consider also the values and beliefs held by the individual and how these characteristics may bear on the individual's perception of their experiences and response.

It is undeniable that the DSM-IV is fraught with a variety of problems. Some might argue that the issues discussed above, as well as a number of others, are the product of the atheoretical foundation of the DSM – that is, its lack of theory behind what mental disorders are and how (or if) they can be addressed (Follette & Houts, 1996). Surely, this dearth of a driving premise regarding the definition of pathology is the source of some of these complications, as well as the reason why resolving them has proven so conflictual and protracted. It seems that we are left with two alternatives in addressing the complications surrounding the DSM-IV: dismiss the work as unfounded and develop a new framework or consider it a work in progress.

As much as I recognize and agree with the argument that the DSM is plagued by its lack of an underlying schema, I would suggest that we should accept the text as problematic and work towards addressing the concerns. I would argue that 1) the absence of a core theory permits a healthy and ongoing discussion about what defines “pathology,” and requiring all researchers and practitioners to all abide by one central perspective would be counter-productive; 2) extensive funding and research has been established and made available in the name of the DSM, and it would be otherwise quite difficult to conduct and compile the investigations necessary to further our understanding of human behavior and experience; and 3) any text which has such significant ramifications for social policy, health care and quality of life should never be considered complete.

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