Think about all that we have read and discussed in class regarding the DSM-IV. From this process, identify and describe 4 major ideas linked to the diagnosis of adult psychopathology that you thought were most problematic and in need of change. Explain why you believe those ideas are problematic and then provide a constructive proposal for resolving each of them. Be specific and cite your readings.

Four major ideas linked to the DSM-IV diagnosis of adult psychopathology that I thought were most problematic and in need of change were: the idea that disorders are "categories" with distinct boundaries, the idea that Axis I and Axis II represent qualitatively different clusteres of disorders, the idea that diagnostic criteria can equally be applied to both genders, and the idea that culture and ethnicity are of secondary concern. I will discuss each of them below, explaining why I thought they were problematic and my opinions as to how they can be solved or improved.

The DSM-IV is a *categorical* classification of mental disorders (APA, 2000, p.xxxi; Frances, First, Widiger, Miele, Tilly, Davis, & Pincus, 1991; Widiger & Coker, 2003, p.3). The DSM-IV gives an impression that each disorder – with its own name, code, and criterion – is a distinct category with clear boundaries. However, the categorical approach to mental disorders is far from without limitations and has been criticized by many researchers and clinicians (Widiger & Coker, 2003, p.3). The boundaries among the DSM-IV diagnoses are vague. Problems that arise from categorical model include high comorbidity among different disorders (e.g. anxiety and depression) (Widiger & Coker, 2003, p.10), the need for boundary categories (e.g. schizoaffective disorder) (Widiger & Coker, 2003, p.13), and the debates on the validity of certain diagnoses (e.g. generalized social phobia vs. avoidant personality disorder) (Widiger & Coker, 2003, p.12). Moreover, the fact that the Not-Otherwise-Specified is the most common diagnosis in clinical settings (Widiger & Coker, 2003, p.3) implies that diagnostic categories in the DSM-IV – although there are already hundreds of them – are not enough in number. All these suggest there is "something wrong" with the current approach.

Opponents of categorical model advocate a *dimensional* approach to the classification of mental disorders. Dimensional approach emphasizes the need to classify disorders based on underlying core processes rather than overt symptoms (Widiger & Coker, 2003, p.11). However, dimensional classification is not without shortcomings. Above all, there will always be the issue of demarcation. For example, the DSM-IV diagnosis that is currently the closest to dimensional approach is mental retardation. There is no doubt that intelligence is on a continuum (dimensional approach), but the point of demarcation (IQ of 70) is arbitrary (Widiger, 2002, p.27-28). How different in the level of functioning is a person with an IQ of 69 from a

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person with an IQ of 71? Furthermore, I have doubts as to whether the problems mentioned to argue against categorical classification can be better dealt with in dimensional approach. For example, how can the comorbidity problem solved? Should all the disorders that show high comorbidity with one another be put on a same spectrum? Do they share a common underlying process?

I do not think the DSM should stick to just *one* approach – either categorial or dimensional. Even the current DSM, although for the most part is a categorical approach, also has dimensional features to it (e.g. using the IQ to diagnose mental retardation). Since both approaches have their own merits and limitations, and it would be difficult, if not impossible, to pursue only one approach (the current DSM claims to be categorical but has dimensional features, and the dimensional approach would still have demarcation issues), the best would be to try to combine both approaches to improve the current DSM-IV. On the one hand, effort should be made to identify disorders that are currently classified as separate but share fundamental etiologies. For example, to examine whether anxiety and depression have the same origin, a wide range of data from different sources such as brain studies, comorbidity, abnormalities in cognitive processing, and response to treatment should be synthesized. On the other hand, the cut-off points that separate a disorder from normal functioning and from other disorders should be considered cautiously. For example, in the mental retardation example above, a person with an IQ of 69 and a person with an IQ 71 should be compared in their academic, occupational, and interpersonal functioning before concluding that an IQ of 70 is a meaningful – albeit arbitrary – point of demarcation.

The second issue I would like to raise is the relation of Axis I to Axis II. The current multiaxial assessment assumes that the two Axes are distinct; Axis I disorders are of primary clinical attention whereas Axis II disorders are (although can be of primary concern) usually conditions that are to be considered in assessment and treatment (personality disorders, PDs and mental retardation, MR). The intention of giving PDs and MR a separate axis so they are not overlooked was good in that they have important influences in long-term functioning, but it can also be problematic due to ambiguous distinction between Axis I and Axis II (Frances *et al*., 1991). What is the difference between the two Axes? Are Axis I disorders more severe than Axis II? Are Axis I disorders possible to treat whereas Axis II disorders are difficult to deal with? Is medicatioin effective only for Axis I disorders but not for Axis II disorders? Do Axis I disorders have biological bases whereas Axis II disorders do not? It is unclear how Axis I and Axis II are defined and different disorders classified as one or the other. Moreover, the definition and classification of PDs themselves are not yet well established (Frances *et al*., 1991). Ambiguous distinction between Axis I and Axis II, and unclear diagnoses of PDs create cause problems not only in academic

realm but also in practice (Frances *et al.*, 1991).

To solve this problem, I think the definition of Axis I and Axis II should be made before anything else. The distinction may be based on severity, treatment, or etiology, but it should be *clear and consistent*. Disorders then can be classified as either Axis I or Axis II. Efforts should also be made to give more accurate and valid diagnoses of PDs. In the meanwhile, I thought it might be better not to have separate Axes for DSM disorders, or have Axis I as disorders that are of primary clinical interest and Axis II as of secondary concern (so even PDs and MR would be in Axis I if needed). There are cases where Axis II disorder is of primary concern (e.g. a person with antisocial PD who committed a crime, a person with borderline PD who has suicidal ideation), but the current system make it seem like Axis II disorders are not as serious or worthy of clinical attention compared to Axis I disorders. When the DSM is more refined, the use of Axis I and Axis II would be more accurate and helpful.

The third problem of the current diagnosis is the idea that diagnostic criteria can equally be applied to both male and female. However, this can be problematic if symptoms of certain disorders are different depending on gender. Hartung and Widiger (1998) gave examples of potential biases within diagnostic criteia in disorders such as sexual desire disorders, histrionic PD, conduct disorder, somatization disorder, and dependent PD. Antisocial PD can be another disorder that is likely to show different symptoms across gender. A female aggressor might express her aggression in a more indirect and subtle way (e.g. spreading bad rumors) whereas a male aggressor in a more direct and blatant way (e.g. physical attack). This kind of possibilities, which can lead to misunderstanding and mistreatment of mental disorders across gender, is not considered in the current DSM.

I think the initial step to improve the diagnostic criteria to sensitively capture the potential difference of symptoms across gender would be to check whether there actually exist such differences in various mental disorders. In the example of antisocial PD, female patients should be identified using strategies other than the potentially biased DSM criteria (e.g. peer nomination), and then examined for any differences in symptoms compared to male patients. In addition, the field trials in revising the DSMs should be planned cautiously to ensure that the procedure is not biased favoring one gender over the other. The participants should not only include the DSM-diagnosed patients and the current DSM should not be used as criteria to evaluate alternative criteria, since the DSM may already be gender-biased.

Lastly, I thought the issue of culture and ethnicity should receive more attention in the diagnosis of adult psychopathology. People from different cultures and ethnic groups may express symptoms of certain disorders in different ways, and even show disorders that are not observed in mainstream American culture. For example,

Asians have been reported to somatize their depressive symptoms more than Westerners (Tsai, Butcher, Munoz, & Vitousek, 2001). Culture-bound syndromes included as an appendix in the DSM-IV represent disorders found in specific cultures and ethnic groups (APA, 2000, pp.897-903). The inclusion of this "culture" section seems to be one of the most important progresses made in DSM revisions. However, I think more efforts should be made to emphasize the influence of culture and ethnicity on the diagnosis of psychopathology and to address some problems that have not yet received much interest as far as the DSM is concerned. One problem related to culture and ethnicity is the issue of culturally biased points of demarcation. Even a disorder is commonly found across different cultures and ethnic groups, the cut-off points (boundaries between "normal" functioning and "abnormal" functioning) can be different (Widiger, 2002). For example, a person diagnosed with the DSM as having a depressive disorder may be maladaptive in one culture/ethnic group but not in another culture/ethnic group. Another issue that I think needs to be addressed in the diagnosis is the possibility of misdiagnosis in clinical practice. Pavkov, Lewis, and Lyon (1989) suggested that the race influenced the diagnosis of schizophrenia. In their study, being Black predicted a diagnosis of schizophrenia. The above mentioned problems in diagnosis related to culture and ethnicity will be solved most effectively if they are more directly addressed in the DSM.

I would like to suggest two solutions to the problem. First, I think culture and ethnicity should be formally included as a mandatory part in the diagnosis as a separate Axis in the multiaxial assessment of the DSM. Then, culture and ethnicity – how they affect people's the diagnosis and prognosis of mental disorders – will receive more attention in research and practice. Secondly, I do not think it is a good idea to have culture-bound syndromes in the appendix as it gives an impression that they are of secondary concern and not important. Moreover, to address the problems mentioned above (culturally biased points of demarcation, misdiagnosis, etc) the culture and ethnicity section needs to be increased both in breadth and depth. It would be difficult, if not impossible, however, to include all relevant information in the DSM (e.g. to include in the diagnostic criteria how the points of demarcation might differ across cultures). Furthermore, not all researchers or clinicians need that section (e.g. a clinician who for the most part sees Caucaisan patients). Therefore, I thought it might be more helpful if all the culture and ethnicity issues are addressed in a separate book of the DSM. Then, it will be possible to give more extensive and intensive information regarding culture and ethnicity to those when needed. If the culture and ethnicity were included in the diagnostic system as a new Axis, this supplemental book would not be considered lightly. There is little doubt that the culture and ethnicity plays an important role in one's well-being. Changes should be made to ensure that the culture and ethnicity receive more attention in diagnosis of

psychopathology.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington DC: Author.

Frances, A. J., First, M. B., Widiger, T. A., Miele, G. M., Tilly, S. M., Davis, W. W., & Pincus, H. A. (1991). An A to Z guide to DSM-IV conundrums. *Journal of Abnormal Psychology, 100*, 407-412.

Hartung, C. M., & Widiger, T. A. (1998). Gender difference in the diagnosis of mental disorders: Conclusion and controversies of the DSM-IV. *Psychological Bulletin, 123*, 260-278.

Pavkov, T. W., Lewis, D. A., & Lyon, J. S. (1989). Psychiatric diagnosis and racial bias: An empirical investigation. *Professional Psychology: Research and Practice, 20*, 364-368.

Tsai, J. L., Butcher, J. N., Munos, R. F., & Vitousek, K. (2001). Culture, ethnicity, and psychopathology. In P. B. S. H. E. Adams (Ed.), *Comprehensive handbook of psychopathology* (3rd ed., pp. 105-127). New York: Kluwer Academic.

Widiger, T. A. (2002). Values, politics, and science in the construction of the DSMs. In J. Z. Sadler (Ed.), *Description and prescriptions: Value, mental disorders, and the DSMs* (pp. 25-41). Baltimore: Johns Hopkins University Press.

Widiger, T. A., & Coker, L. A. (2003). Mental disorders as discrete clinical conditions: Dimensional versus categorical classifications. In S. M. T. a. M. Hersen (Ed.), *Adult psychopathology and diagnosis* (4th ed., pp. 3-35). NY: John Wiley & Sons.