

## CHAPTER 1

# Diagnosis and Classification

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Human beings engage in a wide array of behaviors, including eating, sleeping, talking, feeling, thinking, playing, buying, and having sex. All of these forms of behavior include a maladaptive variant that is diagnosed as a mental disorder by the American Psychiatric Association. Dysfunctional, aberrant, and maladaptive feeling, thinking, behaving, and relating to others are of substantial concern to many different professions, the members of which hold an equally diverse array of opinions regarding etiology, pathology, and treatment. It is imperative that these persons be able to communicate meaningfully with one another. The primary purpose of an official diagnostic nomenclature is to provide this common language of communication (Kendell, 1975; Sartorius et al., 1993).

An official diagnostic nomenclature, however, can be an exceedingly powerful document, impacting many important social, forensic, clinical, and other professional decisions (Schwartz & Wiggins, 2002). Persons think in terms of their language and the predominant languages of psychopathology are the fourth edition of the American Psychiatric Association's (1994, 2000) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* and the 10th edition of the World Health Organization's (WHO) *International Classification of Diseases (ICD-10)*; WHO, 1992). As such, these nomenclatures have a substantial impact on how clinicians, social agencies, the government, and the general public conceptualize aberrant, problematic, and maladaptive behavior.

Interpreting *DSM-IV-TR* or *ICD-10* as conclusively validated nomenclatures, however, exaggerates the extent of their scientific support (Frances, Pincus, Widiger, Davis, & First, 1990; Frances & Widiger, in press). There is little within *DSM-IV-TR* or *ICD-10* that is not subject to

significant dispute. Mental disorders are to a substantial extent constructions of clinicians and researchers rather than proven, evident diseases or illnesses (Maddux, Gosselin, & Winstead, 2008). On the other hand, the diagnoses contained within *DSM-IV-TR* and *ICD-10* are not necessarily lacking in credible or compelling empirical support. *DSM-IV-TR* and *ICD-10* contain many flaws, but they are also well-reasoned, scientifically researched, and, for the most part, well-documented nomenclatures that describe what is currently understood by most scientists, theorists, researchers, and clinicians to be the predominant forms of psychopathology (Widiger, in press). This chapter overviews the *DSM-IV-TR* diagnostic nomenclature, beginning with historical background, followed by a discussion of the major issues facing the forthcoming *DSM-5* and future revisions.

## HISTORICAL BACKGROUND

The impetus for the development of an official diagnostic nomenclature was the chaos and confusion generated by its absence (Widiger, 2001). "For a long time confusion reigned. Every self-respecting alienist [the 19th-century term for a psychiatrist], and certainly every professor, had his own classification" (Kendell, 1975, p. 87). For the young, aspiring professor, the production of a new system for classifying psychopathology was a standard rite of passage in the 19th century.

To produce a well-ordered classification almost seems to have become the unspoken ambition of every psychiatrist of industry and promise, as it is the ambition of a good tenor to strike a high C. This classificatory ambition was so conspicuous that

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the composer Berlioz was prompted to remark that after their studies have been completed a rhetorician writes a tragedy and a psychiatrist a classification. (Zilboorg, 1941, p. 450)

In 1908, the American Bureau of the Census asked the American Medico-Psychological Association (which subsequently altered its title in 1921 to the American Psychiatric Association) to develop a standard nosology to facilitate the obtainment of national statistics:

The present condition with respect to the classification of mental diseases is chaotic. Some states use no well-defined classification. In others the classifications used are similar in many respects but differ enough to prevent accurate comparisons. Some states have adopted a uniform system, while others leave the matter entirely to the individual hospitals. This condition of affairs discredits the science. (Salmon, Copp, May, Abbot, & Cotton, 1917, pp. 255–256)

The American Medico-Psychological Association, in collaboration with the National Committee for Mental Hygiene, issued a nosology in 1918, titled *Statistical Manual for the Use of Institutions for the Insane* (Menninger, 1963). This nomenclature, however, failed to obtain wide acceptance. It included only 22 diagnoses and these were confined largely to psychoses with a presumably neurobiological pathology. Therefore, “in the late twenties, each large teaching center employed a system of its own origination, no one of which met more than the immediate needs of the local institution” (American Psychiatric Association, 1952, p. v). There was no common, unified system of diagnosis. Patients being treated at one clinic were given different diagnoses than patients treated at another clinic. Consistent, accumulative research was difficult to produce as each researcher studied his or her own constructions, rarely building upon a common scientific base. A conference was held at the New York Academy of Medicine in 1928 to develop a more authoritative and uniformly accepted manual. The resulting nomenclature was modeled after the *Statistical Manual* but it was distributed to hospitals within the American Medical Association’s *Standard Classified Nomenclature of Disease*. Many hospitals used this system but it eventually proved to be inadequate when the attention of the profession expanded well beyond psychotic disorders during World War II. *ICD-6* and *DSM-I*

The Navy, Army, and Veterans Administration developed their own, largely independent nomenclatures during World War II due in large part to the inadequacies of the *Standard Classified*. “Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists, found themselves operating within the limits of

a nomenclature specifically not designed for 90% of the cases handled” (American Psychiatric Association, 1952, p. vi). The World Health Organization (WHO) accepted the authority in 1948 to produce the sixth edition of the *International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD)*. *ICD-6* was the first edition to include a section devoted to mental disorders (Kendell, 1975), perhaps in recognition of the many psychological casualties of World War II, as well as the increasing impact and contribution of mental health professions within the broader society. The United States Public Health Service commissioned a committee, chaired by the psychiatrist George Raines (notably though with representations from a variety of other professions and public health agencies) to develop a variant of the mental disorders section of *ICD-6* for use within the United States. The United States, as a member of the WHO, was obliged to use *ICD-6*, but adjustments could be made to maximize the acceptance and utility of *ICD-6* within the United States. The resulting nomenclature resembled closely the Veterans Administration system developed by Brigadier General William Menninger (brother to Karl Menninger, 1963). Responsibility for publishing and distributing this nosology was given to the American Psychiatric Association (1952) under the title *Diagnostic and Statistical Manual: Mental Disorders* (hereafter referred to as *DSM-I*).

*DSM-I* was generally successful in obtaining acceptance, due in large part to its expanded coverage, particularly the inclusion of somatoform disorders, stress reactions, and personality disorders. *DSM-I* also included narrative descriptions of each disorder to facilitate understanding and more consistent applications. Nevertheless, fundamental criticisms regarding the reliability and validity of psychiatric diagnosis were also being raised (e.g., Scheff, 1966; Szasz, 1960; Zigler & Phillips, 1961). For example, a widely cited reliability study by Ward, Beck, Mendelson, Mock, and Erbaugh (1962) concluded that most of the poor agreement among psychiatrists’ diagnoses was due largely to inadequacies of *DSM-I*, and more specifically, its failure to provide specific, explicit guidelines as to the diagnostic criteria for each respective disorder, allowing clinicians to vary widely in how they applied the diagnostic system.

*ICD-6* was even less successful. The “mental disorders section [of *ICD-6*] failed to gain [international] acceptance and eleven years later was found to be in official use only in Finland, New Zealand, Peru, Thailand, and the United Kingdom” (Kendell, 1975, p. 91). The WHO therefore commissioned a review by the English psychiatrist,

Erwin Stengel. Stengel (1959) reiterated the importance of establishing an official nomenclature.

A . . . serious obstacle to progress in psychiatry is difficulty of communication. Everybody who has followed the literature and listened to discussions concerning mental illness soon discovers that psychiatrists, even those apparently sharing the same basic orientation, often do not speak the same language. They either use different terms for the same concepts, or the same term for different concepts, usually without being aware of it. It is sometimes argued that this is inevitable in the present state of psychiatric knowledge, but it is doubtful whether this is a valid excuse. (Stengel, 1959, p. 601)

Stengel (1959) attributed the failure of clinicians to accept the mental disorders section of *ICD-6* to the presence of theoretical biases, cynicism regarding any psychiatric diagnoses (some theoretical perspectives opposed the use of any diagnostic terms), and the presence of abstract, highly inferential diagnostic criteria that hindered consistent, uniform applications by different clinicians.

### ***ICD-8 and DSM-II***

*ICD-6* had been revised to *ICD-7* in 1955 but there were no revisions to the mental disorders section. Work began on *ICD-8* soon after Stengel's 1959 report. The final edition was approved by the WHO in 1966 and became effective in 1968. A companion glossary, in the spirit of Stengel's (1959) recommendations, was to be published conjointly, but work did not begin on the glossary until 1967 and it was not completed until 1972. "This delay greatly reduced [its] usefulness, and also [its] authority" (Kendell, 1975, p. 95). In 1965, the American Psychiatric Association appointed a committee, chaired by Ernest M. Gruenberg, to revise *DSM-I* to be compatible with *ICD-8* and yet also be suitable for use within the United States. The final version was approved in 1967, with publication in 1968.

The diagnosis of mental disorders, however, was continuing to receive substantial criticism (e.g., Rosenhan, 1973). A fundamental problem continued to be the absence of empirical support for the reliability, let alone the validity, of its diagnoses (e.g., Blashfield & Draguns, 1976). Researchers, therefore, took to heart the recommendations of Stengel (1959) to develop more specific and explicit criterion sets (Blashfield, 1984). The most influential of these efforts was produced by a group of neurobiologically oriented psychiatrists at Washington University in St. Louis. Their criterion sets generated so much interest that they were published separately in what has become one of the

most widely cited papers in psychiatry (i.e., Feighner et al., 1972).

The Feighner et al. (1972) criterion sets were confined to just the 15 disorders of primary interest to the Washington University researchers. Their approach to diagnosis was greatly expanded by Robert Spitzer (a technical consultant for *DSM-II*; American Psychiatric Association, 1968) into a manual that covered a much wider variety of diagnosis, titled the Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978). The RDC was adopted by many research programs around the world, and contributed to the obtainment of more consistent and replicable research findings. This subsequent research using specific and explicit criterion sets assessed with structured interviews has since indicated that mental disorders can be diagnosed reliably and do provide valid information regarding etiology, pathology, course, and treatment (Kendler, Munoz, & Murphy, 2010).

### ***ICD-9 and DSM-III***

By the time Feighner et al. (1972) was published, work was nearing completion on *ICD-9*. The authors of *ICD-9* had decided to include a glossary, but it was apparent that it would not include the more specific and explicit criterion sets developed and used in research (Kendell, 1975). In 1974, the American Psychiatric Association appointed a Task Force, chaired by Robert Spitzer, to revise *DSM-II* in a manner that would be compatible with *ICD-9* but would also incorporate many of the advances in diagnosis currently being developed. *DSM-III* was published in 1980 and was remarkably innovative, including (a) a multiaxial diagnostic system (most mental disorders were diagnosed on Axis I, personality and specific developmental disorders were diagnosed on Axis II, medical disorders on Axis III, psychosocial stressors on Axis IV, and level of functioning on Axis V), (b) specific and explicit criterion sets for all but one of the disorders (i.e., schizoaffective), (c) a substantially expanded text discussion of each disorder to facilitate diagnosis (e.g., age of onset, sex ratio, course, complications, and familial pattern), and (d) removal of terms (e.g., *neurosis*) that appeared to favor a particular theoretical model for the disorder's etiology or pathology (Spitzer, Williams, & Skodol, 1980).

### ***DSM-III-R***

Many of the criterion sets developed for *DSM-III* lacked much prior history or field testing. Most were constructed by work group members with little guidance as to how

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they would in fact work in general clinical practice or even research settings. As a result, a number of obvious errors occurred (e.g., panic disorder in *DSM-III* could not be diagnosed in the presence of major depression). “Criteria were not entirely clear, were inconsistent across categories, or were even contradictory” (American Psychiatric Association, 1987, p. xvii). The American Psychiatric Association therefore authorized the development of a revision to *DSM-III* to make corrections and refinements. Fundamental revisions were to be tabled until work began on *ICD-10*. However, it might have been unrealistic to expect the authors of *DSM-III-R* to confine their efforts to refinement and clarification, given the impact, success, and importance of *DSM-III*.

The impact of *DSM-III* has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians and researchers for communicating about the disorders for which they have professional responsibility. Recent major textbooks of psychiatry and other textbooks that discuss psychopathology have either made extensive reference to *DSM-III* or largely adopted its terminology and concepts. (American Psychiatric Association, 1987, p. xviii)

Prior to *DSM-III* there were few psychiatrists or psychologists particularly interested in diagnosis and classification. Subsequent to *DSM-III*, psychiatric diagnosis became a major focus of scientific research. It was not difficult to find persons who wanted to be involved in the development of *DSM-III-R*, and everyone wanted to have a significant impact. Ironically, there were considerably more persons involved in *DSM-III-R* than in *DSM-III*, yet its mission was purportedly far more conservative and limited in scope. Not surprisingly, in the end, there were many proposals for major revisions and even new diagnoses. In fact, four of the diagnoses approved for inclusion by the authors of *DSM-III-R* (i.e., self-defeating personality disorder, sadistic personality disorder, late luteal phase dysphoric disorder [the name for which was subsequently changed to premenstrual dysphoric disorder], and paraphiliac rapism) generated so much controversy that a special ad-hoc committee was appointed by the Board of Trustees of the American Psychiatric Association to reconsider their inclusion. A concern common to them all was that their inclusion might result in harm to women. For example, self-defeating personality disorder might have been used to blame female victims for having been abused, whereas sadistic personality disorder could be used to help mitigate the criminal responsibility of the abusing spouse. Paraphiliac rapism could likewise be used to mitigate criminal responsibility for rape. Another concern was the lack

of sufficient empirical support to address or offset these concerns. A compromise was eventually reached in which the two personality disorders and late luteal phase dysphoric disorder were included in an appendix (Endicott, 2000; Widiger, 1995); paraphiliac rapism was deleted entirely.

### *ICD-10 and DSM-IV*

Work on *DSM-III-R* was supposed to have been completed in 1985, but given the ever-expanding breadth of its expansions and revisions, by the time work was completed on *DSM-III-R*, work had already begun on *ICD-10*. The decision of the authors of *DSM-III* to develop an alternative to *ICD-9* (i.e., include specific and explicit criterion sets) was instrumental in developing a highly innovative manual (Kendell, 1991; Spitzer et al., 1980). However, its innovations were also at the cost of decreasing compatibility with the *ICD-9* nomenclature that was used throughout the rest of the world, which is problematic to the stated purpose of providing a common language of communication. In 1988, the American Psychiatric Association appointed a *DSM-IV* Task Force, chaired by Allen Frances (Frances, Widiger, & Pincus, 1989). Mandates for *DSM-IV* included better coordination with *ICD-10* and improved documentation of empirical support.

The *DSM-IV* committee aspired to use a more conservative threshold for the inclusion of new diagnoses and to have decisions that were guided more explicitly by the scientific literature (Frances & Widiger, in press). Proposals for additions, deletions, or revisions were guided by literature reviews that were required to use a specific meta-analytic format that maximized the potential for informative critical review, containing (for example) a method section that explicitly documented the criteria for including and excluding studies and the process by which the literature had been reviewed (Frances et al., 1989). The purpose of this structure was to make it easier to discover whether the author was confining his or her review only to studies that were consistent with a particular proposal, and failing to acknowledge opposing perspectives. These reviews were published within a three-volume *DSM-IV Sourcebook* (e.g., Widiger et al., 1994). Testable questions that could be addressed with existing data sets were also explored in additional studies, which emphasized the aggregation of multiple data sets from independent researchers, and 12 field trials were conducted to provide reliability and validity data on proposed revisions. The primary purposes of the field trials were to address fundamental questions or concerns with regard to a particular proposal, as well as to compare and contrast alternative proposals. The results



of the field trials were published in the fourth volume of the *DSM-IV Sourcebook* (Widiger et al., 1998). Perhaps most importantly, critical reviews of these projects were obtained by sending initial drafts to advisors or consultants to a respective work group, by presenting drafts at relevant conferences, and by submitting drafts to peer-reviewed journals (Widiger, Frances, Pincus, Davis, & First, 1991; Widiger & Trull, 1993).

### ***DSM-IV-TR***

One of the innovations of *DSM-III* was the inclusion of a relatively detailed text discussion of each disorder, including information on age of onset, gender, course, and familial pattern (Spitzer et al., 1980). This text was expanded in *DSM-IV* to include cultural and ethnic group variation, variation across age, and laboratory and physical exam findings (Frances et al., 1995). Largely excluded from the text was information concerning etiology, pathology, and treatment as this material was considered to be too theoretically specific and more suitable for academic texts. Nevertheless, it had also become apparent that *DSM-IV* was in fact being used as a textbook, and the material on age, course, prevalence, and family history was quickly becoming outdated as new information was being gathered.

Therefore, in 1997, the American Psychiatric Association appointed a *DSM-IV* Text Revision Work Group, chaired by Michael First (Editor of the Text and Criterion Sets for *DSM-IV*) and Harold Pincus (Vice Chair for *DSM-IV*) to update the text material. No substantive changes in the criterion sets were to be considered, nor were any new additions, subtypes, deletions, or other changes in the status of any diagnoses to be implemented. In addition, each of the proposed revisions to the text had to be supported by a systematic literature review that was critiqued by a considerable number of advisors. The *DSM-IV* Text Revision (*DSM-IV-TR*) was published in 2000 (American Psychiatric Association, 2000).

The outcome, however, was not entirely consistent with the original intentions. Revisions were in fact made to the criterion sets for tic disorders and for the paraphilias that involved a nonconsenting victim (First & Pincus, 2002), the latter due to concerns of misapplication within forensic settings (First & Halon, 2008; Frances, 2010a), albeit no acknowledgment of these revisions was provided within the manual. In addition, no documentation of the scientific support for the text revisions was provided, due to the inconsistency in the quality of the effort. Rather than have inconsistent and/or inadequate documentation, it was decided to have none at all.

### **CONTINUING ISSUES FOR *ICD-11* AND *DSM-5***

Work is now well underway for *DSM-5*, chaired by Drs. David Kupfer and Darrel Regier, with an anticipated publication date of 2013. *DSM-5* is likely to include a number of major revisions. The proposals were posted online February 10, 2010, and subsequently revised in January 2011, and June 2011 (see [www.dsm5.org](http://www.dsm5.org)). The process and content of *DSM-5* have been controversial (Frances, 2009). Five issues for *DSM-5* that will be discussed here are (1) the definition of *mental disorder*, (2) the empirical support for proposed revisions, (3) the impact of culture and values, (4) shifting to a dimensional model, and (5) shifting to a neurobiological model.

#### **Definition of *Mental Disorder***

One of the more fundamental and central concerns of the diagnostic manual is what constitutes a mental disorder. The boundaries of the diagnostic manual have been increasing with each edition (Kirk, 2005) and there has long been vocal concern that much of this expansion represents an encroachment into normal problems of living (Caplan, 1995; Follette & Houts, 1996; Maddux, Gosselin, & Winstead, 2008). The authors of *DSM-5* have been proposing quite a few new diagnoses, such as paraphilic coercive, hypersexual, temper dysregulation of childhood, mixed anxiety-depression, olfactory reference syndrome, hoarding, skin picking, premenstrual dysphoric, pedohebephilic, minor neurocognitive, and binge eating disorder. Frances (2010b), the Chair of *DSM-IV*, suggests that many of these additions represent a further encroachment into normal problems of living.

Presumably one should be able to infer what is or is not a mental disorder based on a definition of what constitutes a mental disorder, but this has not worked, for a few reasons. First, new proposals for what to include within the *DSM* tend to come from specialists with a particular interest in a respective syndrome, rather than from any rationale or logical application of any conceptual definition (Frances & Widiger, in press). In addition, there has never been adequate comfort with respect to any particular definition to have it provide authoritative guidance. And, third, the definitions that have been proposed have been so broad and/or vague regarding key constructs that they are unable to provide such guidance.

The definition of *mental disorder* provided in *DSM-IV-TR* (American Psychiatric Association, 2000) was the result of an effort by the authors of *DSM-III* to develop specific and explicit criteria for deciding whether a

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behavior pattern (homosexuality in particular) should be classified as a mental disorder (Spitzer & Williams, 1982). The intense controversy over homosexuality has largely abated, but the issues raised in this historical debate continue to fester. For example, in order to be diagnosed with pedophilia, *DSM-III-R* (American Psychiatric Association, 1987) required only that an adult have recurrent intense urges and fantasies involving sexual activity with a prepubescent child over a period of 6 months and have acted on them (or be markedly distressed by them). However, a difficulty with this definition is that every adult who engaged in a sexual activity with a child for longer than 6 months would meet these diagnostic criteria. The authors of *DSM-IV* were concerned that *DSM-III-R* was not providing adequate guidance for determining when deviant sexual behavior is the result of a mental disorder. Presumably, some persons can engage in deviant, aberrant, and even heinous activities without being compelled to do so by the presence of psychopathology. *DSM-IV* therefore added a requirement that “the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association, 1994, p. 523).

Spitzer and Wakefield (1999), however, argued that this impairment criterion was inadequate. They concurred with the National Law Center for Children and Families that *DSM-IV* might be contributing to a normalization of pedophilic and other paraphilic behavior by allowing the diagnoses not to be applied if the persons who have engaged in these acts are not themselves distressed by their behavior or do not otherwise experience impairment. In response, Frances et al. (1995) had argued that pedophilic sexual “behaviors are inherently problematic because they involve a nonconsenting person (exhibitionism, voyeurism, frotteurism) or a child (pedophilia) and may lead to arrest and incarceration” (p. 319). Therefore, any person who engaged in an illegal sexual act (for longer than 6 months) would be exhibiting a clinically significant social impairment and would therefore meet the *DSM-IV* threshold for diagnosis. However, a problem with this argument is that one should not use the illegality of an act to help determine when an illegal act is a disorder. This undermines the rationale for the inclusion of the impairment criterion to help distinguish immoral or illegal acts from abnormal or disordered acts, and it is inconsistent with the definition of a mental disorder that states that neither deviance nor conflicts with the law are sufficient to warrant a diagnosis (American Psychiatric Association, 2000).

The diagnostic criteria for pedophilia were subsequently revised in *DSM-IV-TR* (one of only two revisions to any diagnostic criterion set in *DSM-IV-TR*) to return to what was provided in *DSM-III-R* in order to try to avoid the misunderstanding that a denial of distress or impairment would mean that the behavior is considered to be normal (First & Halon, 2008). However, the *DSM-IV-TR* criteria again state that simply the presence of the behavior for longer than 6 months indicates the presence of the disorder, thereby providing no meaningful distinction between pedophilic behavior that is willful and volitional from pedophilic behavior that is driven by some form of organismic pathology (First & Frances, 2008).

The threshold proposed for *DSM-5* is the occurrence of the behavior with at least two children (if both are prepubescent) or three or more (if one is pubescent), or a preference for pedophilic pornography over other forms of pornography (see [www.dsm5.org](http://www.dsm5.org)). The rationale for these specific requirements is not provided, but it is evident that the intention is to increase the threshold for the diagnosis by requiring more than one partner (albeit a preference for pedophilic pornography will not require any actual pedophilic acts for the diagnosis to be made).

Spitzer and Wakefield (1999) have suggested that the distinction between disordered and non-disordered abuse of children should require an assessment for the presence of an underlying, internal pathology (e.g., a neurochemical dysregulation or an irrational cognitive schema). Wakefield and colleagues have provided examples of other diagnoses from *DSM-IV-TR* that are less politically or socially controversial than pedophilia that they suggest also fail to make a necessary distinction between maladaptive problems in living and true psychopathology due to the reliance within the criterion sets on indicators of distress or impairment rather than references to pathology (Wakefield & First, 2003). For example, the *DSM-IV-TR* criterion set for major depressive disorder currently excludes most instances of depressive reactions to the loss of a loved one (i.e., uncomplicated bereavement). Depression after the loss of a loved one can be considered a mental disorder, though, if “the symptoms persist for longer than two months” (American Psychiatric Association, 1994, p. 327). However, allowing 2 months to grieve before one is diagnosed with a major depressive disorder might be as arbitrary and meaningless as allowing a person to engage in a sexually deviant act only for 6 months before the behavior is diagnosed as a paraphilia (it is being proposed for *DSM-5* to allow just 2 weeks to grieve; see [www.dsm5.org](http://www.dsm5.org)).

The inclusion of pathology within diagnostic criterion sets (e.g., irrational cognitive schemas, unconscious defense mechanisms, or neurochemical dysregulations) would be consistent with the definition of mental disorder provided in *DSM-IV-TR*, which states that the syndrome “must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual” (American Psychiatric Association, 2000, p. xxxi). However, a limitation of this proposal is that there is little agreement over the specific pathology that underlies any particular disorder. There is insufficient empirical support to give preference to one particular cognitive, interpersonal, neurochemical, psychodynamic, or other theoretical model of pathology. The precise nature of this pathology could be left undefined or characterized simply as an “internal dysfunction” (Wakefield, Pottick, & Kirk, 2002), but an assessment of an unspecified pathology is unlikely to be reliable. Clinicians will have very different opinions concerning the nature of the internal dysfunction and quite different thresholds for its attribution.

Of course, the problem might not be with the ever-expanding diagnostic manual. The problem might be not recognizing that the manual has not expanded nearly far enough (Widiger, in press). Perhaps the assumption that the expansion of the nomenclature is subsuming normal problems in living is faulty. Persons critical of the nomenclature have decried the substantial expansion of the diagnostic manual over the past 50 years (e.g., Follette & Houts, 1996; Kirk, 2005). However, it might have been more surprising to find that scientific research and increased knowledge have failed to lead to the recognition of more instances of psychopathology (Wakefield, 1998, 2001). The assumption that only a small minority of the population currently has, or will ever have, a mental disorder (Regier & Narrow, 2002) might be naïve, if not self-serving. Very few persons fail to have at least some physical disorders, and all persons suffer from quite a few physical disorders throughout their lifetime. It is unclear why it should be so terribly different for mental disorders, as if most persons have been fortunate to have obtained no problematic genetic dispositions or vulnerabilities and they have never sustained any psychological injuries or experienced significant economic, environmental, or interpersonal stress, pressure, or conflict that would tax or strain their psychological functioning (Widiger, in press).

Optimal psychological functioning, as in the case of optimal physical functioning, might be an ideal state that is achieved by only a small minority of the population, if any. The rejection of a high prevalence rate of psychopathology may reflect the best of intentions, such as concerns

regarding the stigmatization of mental disorder diagnoses (Kirk, 2005), the potential impact on funding for treatment (Regier & Narrow, 2002), or the use of excessive pharmacotherapy (Frances, & Widiger, in press), but these social and political concerns could also hinder a more dispassionate and accurate recognition of the true rate of a broad range of psychopathology within the population (Widiger & Sankis, 2000).

Wakefield (1992) developed an alternative “harmful dysfunction” definition of mental disorder where dysfunction is a failure of an internal mechanism to perform a naturally selected function (e.g., the capacity to experience feelings of guilt in a person with antisocial personality disorder) and harm is a value judgment that the design failure is harmful to the individual (e.g., failure to learn from mistakes results in repeated punishments, arrests, loss of employment, and eventual impoverishment). Wakefield’s model has received substantial attention and was being considered for inclusion in *DSM-5* (Rounsaville et al., 2002). However, Wakefield’s model has also received quite a bit of critical review (e.g., Bergner, 1997; Kirmayer & Young, 1999; Lilienfeld & Marino, 1999; Widiger & Sankis, 2000). A fundamental limitation of his definition is his reliance on evolutionary theory, thereby limiting its relevance and usefulness to alternative models of etiology and pathology (Bergner, 1997). Wakefield’s model might even be inconsistent with some sociobiological models of psychopathology. Cultural evolution may at times outstrip the pace of biological evolution, rendering some designed functions that were originally adaptive within earlier time periods maladaptive in current environments (Lilienfeld & Marino, 1999; Widiger & Sankis, 2000). The problem is then not that the mechanisms within the organism are inconsistent with the “intentions” of evolution (whatever they might be), but that biological evolution has not yet responded adequately to changes in the environment. Inadequate biological evolution would then be a fundamental part of the etiology for the disorder. For example, as Wakefield and others have suggested elsewhere, “the existence in humans of a preparedness mechanism for developing a fear of snakes may be a relic not well designed to deal with urban living, which currently contains hostile forces far more dangerous to human survival (e.g., cars, electrical outlets) but for which humans lack evolved mechanisms of fear preparedness” (Buss, Haselton, Shackelford, Bleske, & Wakefield, 1998, p. 538).

Missing from Wakefield’s (1992) definition of mental disorder, as well as the definition likely to be included in *DSM-5* (Stein et al., 2010), is any reference to dyscontrol. Mental disorders are perhaps best understood as

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dyscontrolled impairments in psychological functioning (Kirmayer & Young, 1999; Klein, 1999; Widiger & Trull, 1991). “Involuntary impairment remains the key inference” (Klein, 1999, p. 424). Dyscontrol is a fundamental component within Bergner’s (1997) “significant restriction” and Widiger and Sankis’ (2000) “dyscontrolled maladaptivity” definitions of mental disorder. Dyscontrol might also provide a basis for a fundamental distinction between mental and physical disorder, as dyscontrol is not a meaningful consideration for a physical disorder.

Bergner (1997) and Widiger and Sankis (2000) suggest that it is the inability or difficulty, relative to a normal person, to alter or adjust problematic feelings, thoughts, or behaviors that suggests the presence of a mental disorder. To the extent that persons willfully, intentionally, freely, or voluntarily engage in harmful sexual acts, gambling, drug usage, or child abuse, they would not be considered to have a mental disorder. Persons seek professional intervention in large part to obtain the insights, techniques, skills, or other tools (e.g., medications) that help increase their ability to better control and manage their mood, thoughts, or behavior.

Dyscontrol as a component of mental disorder does not imply that a normal person has free will, a concept that is at best difficult to scientifically or empirically verify (Bargh & Ferguson, 2000; Howard & Conway, 1986). One does not have to validate the existence of free will in order to recognize that it is dyscontrol that is central to the concept of a mental disorder, as dyscontrol is a matter of degree, not kind. A person with a mental disorder is perhaps comparable to a computer lacking in the necessary software to combat particular viruses or execute effective programs. Pharmacotherapy alters the neural connections of the central nervous system (the hardware), whereas psychotherapy alters the cognitions (the software) in a manner that increases a person’s behavioral repertoire, allowing the person to act and respond more effectively. A computer provided with new software has not been provided with free will, but has been provided with more options to act and respond more effectively.

### Empirical Support

Frances et al. (1989) had suggested that “the major innovation of *DSM-IV* will not be in its having surprising new content but rather will reside in the systematic and explicit method by which *DSM-IV* will be constructed and documented” (p. 375). Frances (2009), the Chair of *DSM-IV*, has suggested more recently that the authors of *DSM-5* may have flipped this priority on its head, with emphasis

being given to surprising new content and inadequate attention to first conducting systematic, thorough, and balanced reviews to ensure that the proposals have adequate justification and empirical support. Concerns with respect to the process with which *DSM-5* was being constructed were perhaps first raised by Robert Spitzer, Chair of *DSM-III* and *DSM-III-R*, after having been denied access to the minutes of *DSM-5* Work Group meetings (Decker, 2010). Frances and Spitzer eventually submitted a joint letter to the American Psychiatric Association Board of Trustees on July 7, 2009, expressing a variety of concerns with respect to the process with which *DSM-5* was being constructed.

The Chair and Vice Chair of *DSM-5* have stated that the development of *DSM-5* is following the procedure used for *DSM-IV*, including literature reviews, data reanalyses, and field trials (Regier, Narrow, Kuhl, & Kupfer, 2010). However, the letter by Frances and Spitzer was initiated because the field trial for *DSM-5* was about to begin before the proposals had received any critical review or even been revealed to the field for input and review. Frances followed this joint letter with additional letters of his own and a series of articles that eventually led to the decision to postpone the field trial until after all of the proposals had been posted on a Web site, thereby allowing for at least some external review and public awareness (Decker, 2010). Frances, however, has continued to provide critical reviews through a blog affiliated with *Psychology Today* (e.g., Frances, 2010b). His primary concern is that *DSM-5* is likely to contain quite a few major revisions without adequate review of the empirical research, with little attention being given to potential costs and risks (Frances & Widiger, in press). The field trial, for instance, will not include any of the *DSM-IV-TR* criterion sets or even external validators, and will therefore be unable to provide information concerning a shift in the reliability or validity of the diagnostic manual resulting from a proposed revision.

Kendler, Kupfer, Narrow, Phillips, and Fawcett (2009) developed guidelines for *DSM-5* Work Group members. These guidelines indicate that any change to the diagnostic manual should be accompanied by “a discussion of possible unintended negative effects of this proposed change, if it is made, and a consideration of arguments against making this change should also be included” (p. 2). Kendler et al. further stated that “the larger and more significant the change, the stronger should be the required level of support” (p. 2). Some of the *DSM-5* literature reviews posted on the *DSM-5* Web site do appear to meet the spirit of the Kendler et al. guidelines (e.g., see the review for the new diagnoses of temper dysregulation of childhood and hypersexual disorder; [www.dsm5.org](http://www.dsm5.org)). However, others do not.



For example, one of the likely changes to the diagnostic manual will be the creation of a new class of addiction disorders that will subsume both the substance use disorders and pathological gambling, and will allow for the diagnosis of additional behavioral addictions, such as Internet and shopping addiction. The posted literature review that provides the rationale and empirical support for this major revision consists of just two sentences indicating that pathological gambling has commonalities with substance dependence, followed by a list of references in which various commonalities can be gleaned (see [www.dsm5.org](http://www.dsm5.org)). Only one of the articles listed directly addresses the question of whether pathological gambling is an addiction syndrome, and it is a review paper by Petry (2006) that is in opposition to the proposal. None of the concerns raised by Petry are addressed.

The proposals for the personality disorders have been among the most radical, including the deletion of half of the diagnoses, the abandonment of diagnostic criterion sets, and the inclusion of an alternative dimensional trait model (Clark & Krueger, 2010; Skodol, 2010). Not surprisingly, perhaps, they were met with considerable external criticism, the common theme being that the posted reviews were sorely lacking in objectivity or comprehensiveness, emphasizing instead the research by Work Group members, and failing to give due consideration to alternative perspectives (e.g., Gunderson, 2010; Pilkonis et al., 2011; Ronningstam, 2011; Shedler et al., 2010; Widiger, 2011; Zimmerman, 2011). Even one of the Work Group members published his own critique of the proposals, stating that “the reformulation is a confusing mixture of innovation and a return to previous ways of representing diagnostic constructs that is inconsistent, incoherent, impractical, and frequently incompatible with empirical facts” (Livesley, 2010, p. 304).

### Culture and Values

It was the intention of the authors of *ICD-10* to provide a universal diagnostic system, but diagnostic criteria and constructs can have quite different implications and meanings across different cultures. *DSM-IV-TR* addresses cultural issues in three ways. First, the text of *DSM-IV-TR* provides a discussion of how each disorder is known to vary in its presentation across different cultures. Second, an appendix of *culture-bound* syndromes describes disorders that are currently thought to be specific to a particular culture. Third, an additional appendix provides a culturally informed diagnostic formulation that considers the cultural identity of the individual and the culture-specific explanations of the person’s presenting complaints (Lim, 2006).

Because there is no discussion of cross-cultural issues on the *DSM-5* Web site (see [www.dsm5.org](http://www.dsm5.org)), it is unclear what revisions, if any, will occur with respect to addressing cross-cultural concerns.

There is both a strong and a weak cross-cultural critique of current scientific understanding of psychopathology. The weak critique does not question the validity of a concept of mental disorder but does argue that social and cultural processes affect and potentially bias the

science of psychopathology and diagnosis: (a) by determining the selection of persons and behaviors as suitable material for analysis; (b) by emphasizing what aspects of this material will be handled as relevant from a [clinical] standpoint; (c) by shaping the language of diagnosis, including that of descriptive psychopathology; (d) by masking the symptoms of any putative “universal” disorder; (e) by biasing the observer and would-be diagnostician; and (f) by determining the goals and endpoints of treatment. (Fabrega, 1994, p. 262)

These concerns are not weak in the sense that they are trivial or inconsequential but they do not dispute the fundamental validity of a concept of mental disorder or the science of psychopathology. The strong critique, in contrast, is that the construct of mental disorder is itself a culture-bound belief that reflects the local biases of western society, and that the science of psychopathology is valid only in the sense that it is an accepted belief system of a particular culture (Lewis-Fernandez & Kleinman, 1995; Maddux et al., 2008).

The concept of mental disorder does include a value judgment that there should be necessary, adequate, or optimal psychological functioning (Wakefield, 1992). However, the acknowledgment of this value judgment has at times been misunderstood, as if it is an acknowledgment of the validity of the strong critique of mental disorder. This same value judgment is also a fundamental component of the construct of physical disorder (Widiger, 2002). In a world in which there were no impairments or threats to physical functioning, the construct of a physical disorder would have no meaning except as an interesting thought experiment. Meaningful and valid scientific research on the etiology, pathology, and treatment of physical disorders occurs because in the world as it currently exists there are impairments and threats to physical functioning. It is provocative and intriguing to conceive of a world in which physical health and survival would not or should not be valued or preferred over illness, suffering, and death, but this form of existence is unlikely to emerge any time in the near future. In fact, placing a value on adequate or optimal physical functioning is probably a natural result of

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evolution within a world in which there are threats to functioning and survival. This value judgment probably has a strong biological etiology.

Likewise, in the world as it currently exists, there are impairments and threats to adequate psychological functioning. It is also provocative and intriguing to conceive of a society (or world) in which psychological health would not or should not be valued or preferred, but this form of existence is also unlikely to emerge any time in the near future. Placing a value on adequate, necessary, or optimal psychological functioning might be inherent to and a natural result of living in the world as it currently exists. Any particular definition of what constitutes adequate, necessary, or optimal psychological functioning would likely be biased to some extent by local cultural values, but this is perhaps best understood as only the failing of one particular conceptualization of mental disorder (i.e., a weak rather than a strong critique). Valuing adequate, necessary, or optimal psychological functioning is likely again a logical and natural result of existing in a world in which there are threats to psychological functioning, just as placing a value on adequate, necessary, or optimal physical functioning would be a logical and natural result of existing in a world in which there are threats to physical functioning (Widiger, 2002).

Different societies, cultures, and even persons within a particular culture will disagree as to what constitutes optimal or pathological biological and psychological functioning (Lopez & Guarnaccia, 2000; Sadler, 2005). An important and difficult issue is how best to understand the differences between cultures with respect to what constitutes dysfunction and pathology (Alarcon et al., 2002). For example, simply because diagnostic criterion sets are applied reliably across different cultures does not necessarily indicate that the constructs themselves are valid or meaningful within these cultures (Lewis-Fernandez & Kleinman, 1995). A reliably diagnosed criterion set can be developed for an entirely illusory diagnostic construct. Lewis-Fernandez and Kleinman (1995) argue that it is necessary “to produce a comprehensive nosology that is both internationally and locally valid” (p. 435).

Nevertheless, it is unclear why it should be necessary for the establishment of a disorder’s construct validity to obtain cross-cultural (i.e., universal) acceptance. A universally accepted diagnostic system will have an international social utility and consensus validity (Kessler, 1999; Sartorius et al., 1993), but it is also apparent that belief systems vary in their veridicality. Recognition of and appreciation for alternative belief systems is important for adequate functioning within an international community but respect

for alternative belief systems does not necessarily imply that all belief systems are equally valid (Widiger, 2002).

Kirmayer, Young, and Hayton (1995) illustrate well many of the complexities of cross-cultural research. For example, a woman’s housebound behavior might be diagnosed as agoraphobic within western cultures but considered normative (or even virtuous) within a Muslim culture; submissive behavior that is diagnosed as pathologic dependency within western societies might be considered normative within the Japanese culture. However, simply because a behavior pattern is valued, accepted, encouraged, or even statistically normative within a particular culture does not necessarily mean it is conducive to healthy psychological functioning. “In societies where ritual plays an important role in religious life . . . such societies may predispose individuals to obsessive-compulsive symptoms and mask the disorder when present” (Kirmayer et al., 1995, p. 507). “The congruence between religious belief and practice and obsessive-compulsive symptoms also probably contributes to relatively low rates of insight into the irrationality of the symptoms” (Kirmayer et al., 1995, p. 508).

On the other hand, it is equally important not to assume that what is believed to be associated with maladaptive (or adaptive) functioning in one culture should also be considered to be maladaptive (or adaptive) within all other cultures (Alarcon et al., 2002). “This possible tension between cultural styles and health consequences is in urgent need of further research” (Kirmayer et al., 1995, p. 517) and it is important for this research to go beyond simply identifying differences in behaviors, belief systems, and values across different cultures. This research also needs to address the fundamental question of whether differences in beliefs actually question the validity of any universal conceptualization of psychopathology or suggest instead simply different perspectives on a common, universal issue (Maddux et al., 2008).

### Shifting to a Dimensional Model of Classification

“DSM-IV-TR is a categorical classification that divides mental disorders into types based on criterion sets with defining features” (American Psychiatric Association, 2000, p. xxxi). This categorical classification is consistent with the medical tradition in which it is believed (and often confirmed in other areas of medicine) that individual disorders have specific etiologies, pathologies, and treatments (Zachar & Kendler, 2007). The intention of the diagnostic manual is to help the clinician determine which particular disorder is present, the diagnosis of which would indicate the presence of a specific pathology

that would explain the occurrence of the symptoms and suggest a specific treatment that would ameliorate the patient's suffering (Kendell, 1975; Frances et al., 1995).

It is evident, however, that *DSM-IV-TR* routinely fails in guiding a clinician to the identification of one specific disorder. Despite the best efforts of the authors of each revision to the diagnostic manual to revise the criterion sets to increase their specificity, multiple diagnoses are the norm (Widiger & Clark, 2000). As expressed by the Vice Chair of *DSM-5*, "the failure of *DSM-III* criteria to specifically define individuals with only one disorder served as an alert that the strict neo-Kraepelinian categorical approach to mental disorder diagnoses advocated by Robins and Guze (1970), Spitzer, Endicott, & Robins (1978), and others could have some serious problems" (Regier, 2008, p. xxi). As expressed by Kupfer, First, and Regier (two of whom are the Chair and Vice Chair of *DSM-5*):

In the more than 30 years since the introduction of the Feighner criteria by Robins and Guze, which eventually led to *DSM-III*, the goal of validating these syndromes and discovering common etiologies has remained elusive. Despite many proposed candidates, not one laboratory marker has been found to be specific in identifying any of the *DSM*-defined syndromes. Epidemiologic and clinical studies have shown extremely high rates of comorbidities among the disorders, undermining the hypothesis that the syndromes represent distinct etiologies. Furthermore, epidemiologic studies have shown a high degree of short-term diagnostic instability for many disorders. With regard to treatment, lack of treatment specificity is the rule rather than the exception. (Kupfer, First, & Regier, 2002, p. xviii)

Most (if not all) mental disorders appear to be the result of a complex interaction of an array of biological vulnerabilities and dispositions with a number of significant environmental, psychosocial events that often exert their progressive effects over a developing period of time (Rutter, 2003). There is never likely to be a single gene that is the lone cause of a particular mental disorder. Each individual's mental disorder is more likely to be the result of an array of genetic dispositions and vulnerabilities (Frances & Widiger, in press). The symptoms and pathologies of mental disorders are also highly responsive to a wide variety of neurobiological, interpersonal, cognitive, and other mediating and moderating variables that help to develop, shape, and form a particular individual's psychopathology profile. This complex etiological history and individual psychopathology profile are unlikely to be well described by single diagnostic categories that attempt to make distinctions at nonexistent discrete joints along the continuous distributions (Widiger & Samuel, 2005).

The categorical model of classification is failing in many ways, including an absence of a provision of reliably distinct boundaries, an absence of a credible rationale for diagnostic thresholds, an inadequate coverage of existing clinical populations, and the absence of specific etiologies and treatments (Kupfer et al., 2002; Widiger & Trull, 2007). In 1999, a *DSM-5* Research Planning Conference was held under joint sponsorship of the American Psychiatric Association and the NIMH, the purpose of which was to set research priorities that would optimally inform future classifications. An impetus for this effort was the frustration with the existing nomenclature (Kupfer et al., 2002). At this conference, Research Planning Work Groups were formed to develop whitepapers that would set a research agenda for *DSM-5*. The Nomenclature Work Group, charged with addressing fundamental assumptions of the diagnostic system, concluded that it is "important that consideration be given to advantages and disadvantages of basing part or all of *DSM-V* on dimensions rather than categories" (Rounsaville et al., 2002, p. 12).

The whitepapers developed by the Research Planning Work Groups were followed by a series of international conferences whose purpose was to further enrich the empirical database in preparation for the eventual development of *DSM-5* (a description of this conference series can be found at [www.dsm5.org](http://www.dsm5.org)). The first conference was devoted to shifting personality disorders to a dimensional model of classification (Widiger, Simonsen, Krueger, Livesley, & Verheul, 2005). The chapter by Trull, Carpenter, and Widiger (this volume) discusses the dimensional model of personality disorder proposed for *DSM-5*. The final conference was devoted to dimensional approaches across the diagnostic manual, including substance use disorders, major depressive disorder, psychoses, anxiety disorders, and developmental psychopathology, as well as the personality disorders (Helzer, Kraemer et al., 2008).

Work on *DSM-5* is now well underway, and it is evident that a primary goal is to shift the manual toward a dimensional classification (Helzer, Wittchen, Krueger, & Kraemer, 2008; Regier et al., 2010). Nevertheless, the shifts likely to be taken in *DSM-5* will be neither fundamental nor significant. "What is being proposed for *DSM-V* is not to substitute dimensional scales for categorical diagnoses, but to add a dimensional option to the usual categorical diagnoses for *DSM-V*" (Kraemer, 2008, p. 9).

As acknowledged by Helzer, Kraemer, and Krueger (2006), "our proposal not only preserves categorical definitions but also does not alter the process by which these definitions would be developed. Those charged with developing criteria for specific mental disorders would

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operate just as their predecessors have" (p. 1675). Dimensional proposals for *DSM-5* are only to develop "supplementary dimensional approaches to the categorical definitions that would also relate back to the categorical definitions" (Helzer, Wittchen et al., 2008, p. 116). These dimensions will merely serve as ancillary descriptions that will lack any official representation within a patient's medical record (i.e., they will have no official alphanumeric code and may then not even be communicated to any public health-care agency). In sum, "what is being proposed for *DSM-V* is not to substitute dimensional scales for categorical diagnoses, but to add a dimensional option to the usual categorical diagnoses for *DSM-V*" (Kraemer, 2008, p. 9). In the end, *DSM-5* will remain a categorical diagnostic system.

### Shifting to a Neurobiological Model

The first editions of the *DSM* favored the psychodynamic theoretical model. The authors of *DSM-III* removed terms (e.g., *neurosis*) that appeared to refer explicitly to psychodynamic constructs in order to have the manual be atheoretical, or at least be reasonably neutral with respect to alternative models of psychopathology (Spitzer et al., 1980). However, it appears that all theoretical perspectives have found the language of *DSM-IV-TR* to be less than optimal for their own particular perspective. Interpersonal and systems theoretical perspectives, which consider dysfunctional behavior to be due to a pathology of a wider social system rather than simply within the individual, consider the organismic diagnoses of *DSM-IV-TR* to be fundamentally antithetical to their theoretical perspective (Reiss & Emde, 2003). Psychodynamically oriented clinicians bemoan the fact that as the succeeding editions of the manual have become increasingly objective, descriptive, and atheoretical, they have inevitably minimized the subjective and inferential aspects of diagnosis on which most psychodynamically oriented clinicians depend. They have now constructed their own diagnostic manual, the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006). Behaviorists argue that the organismic perspective of *DSM-IV-TR* is inconsistent with the situational context of dysfunctional behavior (Follette & Houts, 1996). Even neurobiologically oriented psychiatry is unhappy. "Although there is a large body of research that indicates a neurobiological basis for most mental disorders, the *DSM* definitions are virtually devoid of biology" (Charney et al., 2002, pp. 31–32).

The aspiration to be atheoretical is slowly but surely dissipating. *DSM-I* favored a psychodynamic perspective

(American Psychiatric Association, 1952; Spitzer et al., 1980). In striking contrast, the American Psychiatric Association and NIMH are shifting explicitly toward a neurobiological orientation. This is evident in a number of different ways, both implicitly and explicitly. For example, a reading of the table of contents of any issue of the two leading journals of psychiatry (i.e., *American Journal of Psychiatry* and *Archives of General Psychiatry*) will evidence a strong neurobiological orientation. *DSM-IV* included a new section of the text devoted to laboratory and physical exam findings (Frances et al., 1989). All of the laboratory tests included therein were concerned with neurobiological findings, with no reference to any laboratory test that would be of particular relevance to a cognitive, psychodynamic, or interpersonal-systems clinician. The definition of mental disorder in *DSM-5* will refer to a "psychobiological dysfunction" in recognition that mental disorders ultimately reflect a dysfunction of the brain (Stein et al., 2010). The head of NIMH has indicated that priority for funding in the future will be given to studies that formally adopt a "clinical neuroscience" perspective that contributes to an understanding of mental disorders as "developmental brain disorders" (Insel, 2009, p. 132). This is being accomplished in part through the development of research domain criteria (RDoC) that will represent a biological alternative to *DSM-5*, "with a strong focus on biological processes, and emphasis on neural circuits" (Sanislow et al., 2010, p. 633). "The RDoC framework conceptualizes mental illnesses as brain disorders" (Garvey et al., 2010, p. 749). As indicated by Miller (2010), "over the next 2 to 3 years, NIMH will encourage researchers to shift from using *DSM* criteria in their grant proposals to using the RDoC categories" (p. 1437), such as "fear circuitry disorder."

It is unlikely that one could create a diagnostic manual that is entirely neutral or atheoretical. In fact, if a diagnostic manual is to be guided by the existing empirical support (Frances et al., 1989) the manual would inevitably favor the theoretical perspective, which has obtained the greatest empirical support. However, the diagnostic manual should probably continue to at least attempt to remain above the competitive fray rather than embrace any particular team, including the one that currently has the most points (Widiger, in press). The *DSM* is used by clinicians and researchers from a wide variety of theoretical perspectives, including (but not limited to) neurobiological, psychodynamic, interpersonal, cognitive, behavioral, humanistic, systems, and feminist theoretical perspectives (Widiger & Mullins-Sweatt, 2008). An important function of the manual is to provide a common means for



communication among and research concerning these competing theoretical orientations in a language that would not favor one perspective over the other (Frances et al., 1989). A language that purposely favors one particular perspective would not provide an equal playing field and would have an insidiously subtle, cumulative effect on the subsequent scientific research and discourse (Wakefield, 1998). It might be impossible to construct a diagnostic manual that is truly theoretically neutral, but this is not a compelling reason for abandoning the effort, particularly if the manual is to be used for research attempting to determine the validity of alternative theoretical perspectives.

## CONCLUSIONS

Nobody is fully satisfied with, or lacks valid criticisms of, *DSM-IV-TR*. This is unlikely to change with *DSM-5*. Zilboorg's (1941) suggestion that budding 19th-century theorists and researchers cut their first teeth by providing a new classification of mental disorders still applies, although the rite of passage today is to provide a critique of the *DSM*.

Nobody, however, appears to suggest that all official diagnostic nomenclatures be abandoned (Widiger, in press). The benefits do appear to outweigh the costs (Salmon et al., 1917; Stengel, 1959). Everybody finds fault with this language, but there is at least the ability to communicate disagreement. Communication among researchers, theorists, and clinicians would be much worse in the absence of this common language.

Nevertheless, as an official diagnostic nomenclature *DSM-IV-TR* is an exceedingly powerful document with a considerable impact on how psychopathology is not only diagnosed, but also understood and treated. Persons think in terms of their language, and *DSM-5* will govern the manner in which clinicians think about psychopathology for many years to come, for better or for worse. It is perhaps time to shift the authority for the construction of the diagnostic manual away from one particular mental health profession and allow for a more open and critical construction.

A new auspice should perhaps be found for its future development (Frances & Widiger, in press). New diagnoses can be fully as dangerous as new drugs. Paradoxically, the government requires a fairly careful process of regulatory approval for new drugs through the Food and Drug Administration, but psychiatry simultaneously performs only a perfunctory vetting of new diagnoses,

allowing them to be developed by small and parochial panels of experts who have a narrow experience and a vested interest in their inclusion.

Perhaps the best choice would be to create a new institutional auspice working under the supervision of the Institute of Medicine. The goal would be broad representation of participation, an evidence-based approach, recommendations by persons with no vested interest, and a careful attention to the risks and benefits of each suggestion for change to the individual patient, to public policy, and to forensic applications.

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