



## Psychodiagnostic Classification Systems: A Critical View

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### **Abstract**

The need for a more and more comprehensive classification system of mental disorders that responds to the difficulties of the subject is more imperative than ever. The purpose of this study through a critical look is to highlight the way a diagnostic system "thinks" about the symptoms of each subject. Methodologically, in the context of the modern international literature, an attempt is made to capture perceptions from the field of scientific knowledge regarding psychodiagnostic systems that dominate the mental health field. More specifically, it reflects the way in which each psychodiagnostic system classifies symptoms in the context of a phenomenology of things, leaving aside the personal pain and the uniqueness of each subject. In conclusion, it seems that psychodiagnostic systems talk about symptoms that are divided into clusters and each of them gets a name. They don't talk about causes, they don't take into account the difference, nor the environment and the temperament of each person, as a result of which difficulties are created because they do not aim therapeutically at what gives birth to the symptom, but at what each symptom shows.

**Keywords:** *Mental Health; Classification Systems; Problems; Difficulties*

### **Introduction**

From ancient times people tried to identify the phenomena of mental illness many times, by attributing them to incomprehensible and supernatural forces. According to Hippocrates's theory, the health of individuals was related to the balance that had to exist between the four humours: blood, black bile, white bile and phlegm. Based on this theory, Galen developed his theory of diseases and greatly influenced medical science. Each temperament developed a related pathology, which was related to the imbalance in one of the four humours (Kalachanis, 2011). In the late 18th century, medical science made great strides in understanding the biological origins of medical diseases, especially with the discovery of bacteria as a source of infectious diseases.

At that time, the Germans Kraepelin and Alzheimer were developing various methods to identify individual neurological causes for dementia and differentiate it from other psychiatric illnesses. This helped to talk about possible biological causes for various mental illnesses, an idea that formed the basis for organizing a system for monitoring the symptoms, course and effects of an illness (Suris, Holliday & North, 2016). In 1844 psychiatry was first recognized as a medical specialty in the United States, by the Association of Medical Superintendents of American Institutions for the Insane, an organization that in 1921 became the American Psychiatric Association (APA). The first American enterprise for the development of specific classification tools for mental disorders was made in 1920 by the US Census Bureau. This initiative produced the Statistical Manual for the Use of Institutions for the Insane (SMUII) that would describe 19 psychotic disorders (Fischer, 2012). Amidst 20<sup>th</sup> century, a revolution was beginning in Saint Louis of Missouri that would radically change American psychiatry. Eli Robins and Samuel Guze that would work in the Renard School at Washington University, had the belief that the field of psychiatry had the necessity for more reliable and valid diagnostic criteria to establish meaningful treatments, set the goal of developing operationalized diagnostic criteria for mental disorders. With this perspective, they avoided theoretical assumptions about the etiology of psychiatric illness and focused more at persons with mental disorders and the necessary care through various strategies. (Cloninger, 2001). All this effort which incorporated the biological, psychological and social causal aspects of mental disorders was called the medical model approach to psychiatry and paved the way for the development of hypotheses through epidemiological and genetic research without emphasizing purely causal theories (Robins et al., 1959).

Long before the development of organized, diagnostic classification systems, the medical field didn't have an official basis to support the validation of its diagnostic practice. Nowadays, the data on the development of mental illness are based on the principles of biology, physiology and the influence of various psychosocial factors (Kupfer & Regier, 2011). However, the understanding of what factors and how they affect the development of mental illness remains incomplete. As a result, the main classification systems are based almost exclusively on observable behaviors and self-reported emotions and thoughts rather than on the underlying causal mechanisms. The categories and classification systems that are organized in this way are important because they help us understand the complex symptoms of mental disorders and the effect that exists on personal experience (Owen, 2014).

Diagnosis in case of mental disorder is important in order to implement the appropriate treatment, prognosis and communication between the various clinical specialties. This is why there needs to be accuracy in the assessment in order to have a relevant forecast and proper planning. At a time when mental illness classification systems did not yet exist, nor was there a formal basis for supporting and validating psychiatric practices, there were problems with limited respect for other medical specialties and a lack of trust on the part of the people who needed to ask for help. Each type of classification helps to organize the various symptoms without necessarily being directly related to their justification (Regier et al., 2009). Helzer et al. (1997) point out that valid diagnostic criteria are of no use to specialists if they cannot consistently agree on a diagnosis achieved with validated documentation at the level of established classification criteria.

## **Illness and Psychiatry**

One of the most controversial issues in psychiatry is the concept of illness. The anthropological and historical study of mental illness uses a set of general principles, which state that each system allows us to see mental disorders in a synthesis of social, emotional and biochemical factors. Mental illness refers to a disorder in a person's three abilities in thinking, willpower and emotions. In Greek philosophical thought, Plato accepts the theory of the juices of Hippocrates, considers that sacred is any disease that affects the sacred substance, the brain. Aristotle, unlike Hippocrates, did not consider the brain to be the seat of mental functions, but the heart (Ciani, 1983). According to Protagoras, all

perceptions contain an individual truth. The Roman monk doctor Galen (100-200 BC) adopts the ideas of Hippocrates and places the brain as the center of intelligence, he himself will exert great influence in both European and Arabic medicine. During the Middle Ages little progress was made in the knowledge of mental illness, the prevailing view was that madness is a divine punishment for sin and possession by the devil. This resulted in the therapies like exorcisms, repentance and corporal punishment. Diagnosis and treatment in the context of the moral example takes place in a dialogue in which there is no room for the choices, desires and responsibilities of the subject (Stavrakakis & Glynos, 2002). It took the current of the Enlightenment for psychiatrists to begin to think that mental disorders have a cause and a cure and that everyone has a right to them (Ghaemi, 2013). Kraepelin spoke of the link between pathogenesis and the onset of psychiatric disorders, believing that certain symptoms were specific to specific illnesses. Clinical observation has led him to hypothesize that specific combinations of symptoms in relation to the course of psychiatric illness allow one to diagnose a particular mental disorder. Kraepelin considered "praecox dementia" (now known as schizophrenia) to be a biological disease caused by anatomical or toxic processes (Lehmann & Ban, 1997). In 1911, Bleuler revised this idea, renaming "praecox dementia" schizophrenia (Demily, Jacquet & Marie-Cardine, 2009). Szasz (1999) in *The Myth of Mental Illness* states that if I talk to God, I will be a pious person but if God answers me, I will be schizophrenic. It seems that mental illness is a product of every society and every culture creates its own type of patients, who start and develop within it. The problem with modern psychiatry is that after 1980 and the development of the DSM-III, American nosology focused on the clinical picture rather than understanding the causes of mental illness due to the lack of credibility that existed until then in the psychiatric assessments that often for the same person may have been different (Decker, 2013).

## **DSM and ICD Diagnostic Classifications**

Classification is the organization or arrangement of things into categories. It involves the search for a set of things, which share some kind of relationship in order to be grouped. In general, the primary purpose of sorting is to identify the best and clearest possible system, so that when searching for a particular item that has been sorted, it is easier to find (Gask, Klinkman & Fortes, 2008). A classification system makes it possible to identify a number of criteria in order to identify homogeneous symptoms in individuals and to name them accordingly. The purpose of psychopathological classification is to perform a diagnostic assessment that allows the individual to join a category in order to receive appropriate treatment. Diagnostic categories in psychopathology are not facts but names used to organize a reality. Psychiatric classifications work provided they are related to the identification of a specific pathophysiological basis (First et al., 2004). Diagnostic systems are essential for organizing information, facilitating communication between professionals, updating medical records, predicting the patient's clinical course and response to treatment, and facilitating research. Also, the broader goals of psychiatric classifications are to optimize research and facilitate communication between researchers and clinics nationally and internationally through the use of a clearly defined nomenclature (Jablensky, 2007).

The American Psychiatric Association wanted to create a unified and integrated diagnostic system for the classification of mental disorders throughout the United States. That is why in 1952 he published the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 1952), which provides criteria for classifying the clinical diagnosis of mental disorders. This need arose after World War II when the army and hospitals mobilized large numbers of soldiers with various psychiatric disorders. DSM I was issued in 1952 and contained 106 different diagnostic categories, which in the course proved to be quite vague and ambiguous in terms of diagnostic criteria, symptomatology and causes of mental disorders, this has been attributed to the effect that psychoanalysis had on its development (Wakefield, 2007). Regarding the second version of the DSM II in 1968, although attempts were made to change some diagnostic criteria in order to improve some aspects of it, in fact, there were not very satisfactory results. More in this second edition of the DSM just included some extra vague standard definitions of psychopathological conditions that were quite narrative and inaccurate. This fact

influenced the preparation for the new version of DSM, DSM III in order to improve the reliability of the manual (APA, 1968). The purpose of the DSM III was to create an effective diagnostic communication tool between clinics with uniform classification rules, the use of a series of axes, etc. However, there were some objections among psychiatrists because it spoke of psychological disorders and not for diseases which gave the impression that it denies the medical vision for mental disorders (Shorter, 2009; APA, 1980). Despite the efforts I made in this third edition of the DSM, unfortunately the various taxonomic categories were not limited and seem to have expanded further in order to include all human psychopathology. Various clinicians, such as psychiatrists, psychologists, and others, have argued that for some disorders the diagnosis was difficult and could enhance social status (Evans et al., 2013). The successors to the DSM-III, the DSM-III-R 1987, the DSM-IV 1994, and the DSM-IV-TR 2000, simply followed the philosophy of their predecessor and were to perpetuate certain features in all systems, such as deleting the term illness and replacement. The diagnoses are based on descriptions of symptoms rather than psychological, biological or sociological theories, and the use of functional diagnostic criteria favored the fact that two mental health professionals could more easily agree on similar diagnoses for the same person. In 2013, the DSM-V was released, which is organized into three sections and an appendix. The first section describes the key concepts and provides information on clinical use (APA, 2013). The second section includes the diagnostic criteria for the various disorders and their codes and the third section refers to the possibilities of measuring and evaluating the symptoms (Vahia, 2013). Sachdev et al (2015) stated in the release of the DSM-V that its goal is to help mental health professionals make more accurate diagnoses and improve treatment outcomes for patients.

The ICD (International Classification of Diseases) is an international standard for monitoring morbidity and an epidemiological tool, where each disease and illness corresponds to an alphanumeric code. According to the World Health Organization (WHO) the full name of the standard is referred to as International Statistical Classification of Diseases and Related Health Problems. From the full name of the standard, it is clear that we are dealing with a classification of diseases and health-related problems. The first international edition of the ICD appeared shortly afterwards, in 1949, demonstrating that the need for such a model has always been imperative by those involved in global health (Fulford & Sartorius, 2009). The 10th edition of the standard has been completed and put to use since 1992, so we are talking about the ICD-10. In general, there has been a long way to go from the first version of the ICD until today and this does not stop since in 2022 the latest revised version of the ICD-11 is expected to enter into force (Goldberg et al., 2016; Gaebel, 2012). The beginning of this effort to create the ICD can be considered to have been made in 1770 by François Bossier de Lacroix, who with the work of *Nosologia methodica* tried to classify the most basic diseases. The ICD-11 classification of mental disorders serves as the primary means of identifying individuals in need of support from mental health services in addition to appropriate treatment. Among the innovations offered by the latest version of the ICD is the inclusion of consistent and systematically detailed information, the focus on a disorder and a cultural approach to each disorder (Bobes-Bascaran, Flores, Seijo & Garcia, 2019). One of the main goals of this classification system is to facilitate the early recognition of adverse health effects from the use of prevention substances and timely therapeutic interventions. Another purpose of the latest review is to strengthen the WHO Member States monitoring capacity, the effects of substance use on the population in order to implement comprehensive strategies and comprehensive policies and support the effective design and development of treatment and intervention systems. ICD-11 is a useful tool for reducing the treatment gap between those who can benefit from prevention and treatment interventions and those who actually receive it over time, to improve the coverage of the various interventions including those targeting new psychotropic substances and recently incorporated pathological behaviors, such as addiction to gambling and video games (Goldberg, Prisciandaro & Williams, 2012).

ICD and DSM are considered classic categorical systems. That is, they both classify mental disorders as if they were separate entities while recognizing that individuals diagnosed with different disorders often have common characteristics despite the fact that mental disorders are not distinct

disorders but complex combinations of psychological, social and biological problems. It is clear that combining the complex, multidimensional nature of mental illness with the structure of these classification systems is a major challenge. Usually, we think that people with mental illness have a specific disorder and we would like to believe that every disorder is different from all the others. However, individuals diagnosed with a mental disorder are substantially more likely to meet the criteria for at least one more disorder, and many individuals may meet the diagnostic criteria for three or more disorders (Kessler et al., 1994). This is related to the problem just mentioned, namely the application of classical categorical systems to multidimensional phenomena, as is the case with personality disorders in which similar symptoms can often occur in more than one of these disorders (Markon, Krueger & Watson, 2005).

## **Psychodiagnostic Classifications a Critical Look**

The history of psychiatry in the 19th and 20th centuries is the history of the ongoing effort and failure to define psyche in such a way as to give a functional conceptual unity in order to clearly capture a differential clinic of psychopathological disorders. This failure forces psychiatry to return to the relative security of nosocomial systems and classifications aimed at understanding a clinical reality. The security provided by nosology and classification is the illusion of control over something unknown or incomprehensible, and it is indeed an illusion because nosological names never correspond to empirical reality, in fact they rather kill that reality (Verehaeghe, 1994).

Currently, clinical diagnosis is based on the phenomenological system described in the DSM and ICD diagnostic series. The phenomenological approach that was prominent in the DSM was based on the research diagnostic criteria (Spitzer et al., 1978), which were developed to facilitate clinical trials in patients with mood disorders and schizophrenia. However, many mental health professionals do not fully agree on the validity of the results of diagnostic systems such as the DSM and the ICD because it is supported by a lack of information about the causes and role of various factors in the development of mental illness (Gabbard, Litowitz & Williams, 2011).

Prior to the publication of the DSM-III in 1980, psychiatric diagnosis was a matter of little interest or importance because it was unreliable and not particularly useful in planning treatment. The DSM-III marked a sudden and dramatic change that made assessment the focus of attention and the starting point of all treatment guidelines. The provision of clearly defined criteria allowed the reliable diagnosis and targeting of specific symptoms that became the focus of treatment (Frances, 2013).

The influence of the DSM-III exceeded all expectations, in some ways useful, but it had one major drawback: The prevailing mental health approach before the DSM-III was the biopsychosocial model. At that time, clinicians realized the symptoms that result from the complex interaction of brain function, psychological factors, and family and social conditions. Perhaps unintentionally, the DSM-III degraded psychological and social factors and placed too much emphasis on biological factors (Frances, 2013).

The DSM-III was advertised as "atheoretical" and neutral. To some extent this was true, but the DSM-III's emphasis on purely descriptive psychiatry strongly favored biological therapies over cognitive behavioral therapies. This bias has proved disastrous for family and psychodynamic therapies. The descriptive method of DSM-III focused attention on the superficial symptoms in the individual and ignored the deeper psychological understanding and social and family contexts. Mental health clinicians often adopted a symptom checklist for evaluation and did not take into account that a full evaluation should take into account psychological factors, social support and stress factors (Malt, 1986).

Moreover, it seems that "comorbidity is the rule and not the exception" (Echeburua, Salaberría & Cruz-Saez, 2014) because there are few patients with a unique and clearly defined diagnosis. This



conclusion is shared by other authors (Moffitt et al., 2007), who also agree on the observation of comorbidity as an aspect that has dominated the DSM since its third edition. In the same direction and the views of Nesse & Stein (2012) state that «*Most people who have a disorder also qualify for additional diagnoses*» (p. 2).

The stigma created by the diagnosis of a mental disorder is another of the problems associated with DSM. In this regard, Ben-Zeev, Young & Corrigan (2010) in post-studies have reported focus on the development of stigma according to the DSM diagnostic assessments and talk about a difference between public stigma and self-stigma, although they report in the fact that the former is generally the cause of the latter. Public stigma is constructed with certain stereotypes and prejudices associated, in this case, with people diagnosed with a mental disorder.

Diagnostic validity, as Hyman (2010) explains, «*means that a diagnosis takes on a 'natural order' based on etiology or pathophysiology*» (p. 158). This does not appear to be the case in many diagnostic categories of DSM and is therefore often cited as another controversial aspect of the manual. Ghaemi (2013) is very categorical in relation to this aspect of the DSM-5 argues that «*of these 400 diagnoses, very few can be said to have been studied in remarkable detail and nosological validity*» (p. 210) and that in these few cases, many aspects are scientifically unfounded or even questionable.

McWilliams (2011) reports that the DSM lacks a reliable definition of mental health and emotional well-being. Also, despite a great effort to increase the level of validity and reliability in the DSM, unfortunately both of these parameters remain low (Herzig & Licht, 2006).

Attempts to redefine psychopathology in ways that facilitate certain forms of research have produced erroneous descriptions of various clinical disorders that are artificially discernible and fail to capture patients' complex experiences. The emphasis on the phenomenology of the patient's symptoms has created a flat relationship with them without focusing on what the clinical phenomena represent.

The categorical approach to mental disorders has benefited the pharmaceutical companies, which have shown a strong interest in them because, as they claim, the choice of appropriate medication is becoming more distinct and they can provide specific drugs for each category of disorders without being able to simultaneously support different biological causes for each of them. Many of the decisions about what should be included in the DSM after 1980 appear to be arbitrary, inconsistent and influenced by links with pharmaceutical companies (Bredstrom, 2017). Pharmaceutical companies have benefited from the way the DSM-III approached mental disorders, especially since 1987, when a specific pharmaceutical industry promoted Prozac as an antidepressant. Pharmaceutical companies have benefited from the way the DSM-III approached mental disorders, especially since 1987, when a specific pharmaceutical industry that promoted Prozac as an antidepressant, adopted a new tactic by first informing the public about the disease of depression emphasizing the fact that the depressive disorder is the result of a chemical imbalance of the brain so the drug was necessary. As a result, the use of drugs has skyrocketed, resulting in pharmaceutical companies making millions of dollars but also paying large fines for illegal marketing practices, which continues to this day due to huge profitability (Grady & Stahl, 2012; Blashfield et al., 2014).). In the other case the categorization phenomenon seems to be reinforced by the insurance companies, which encourage the governments to determine the lowest common denominator in the coverage of the insurance contributions for each category by reducing the cost because often the treatment is based on the absence of symptoms and not in addressing the causes behind this fact which means more healing time and therefore higher costs. According to relevant research, psychotherapy is as effective as drugs and its results are much more durable. However, insurance companies further strengthen the field of competition, consistently favoring the administration of drugs over psychotherapy based on the false assumption that it will be cheaper. In fact, psychotherapies cost less because their effects are lasting and consistent over time, and medication may be necessary for many years or a lifetime (McHugh, 2013).

Angermeyer & Matschinger (2005) states that classifications in psychiatry can become inhuman labeling systems or potential sources for social and political violence. Intense protests for DSM-V are connected to transparency problems, field trials, links with pharmaceutical industry and mostly the intense focus to the biomedical definition of a mental disorder (Kriegler & Bester, 2014). Various studies using the DSM as a diagnostic tool have been shown to address validity issues and while seemingly reliable, various problems are usually identified in the research sequence (Barber, 2014).

Diagnostic systems focus mainly on symptoms, which translate more directly into treatment strategies to achieve change in problem behavior (Sartorius, 2015) but this does not mean more accurate and complete effective intervention as they do not follow the complexity of the psyche and emotional differentiation of individuals. While the mental health clinician should combine more information regarding the patient's symptoms and image in order to modify the underlying causation factors. Unfortunately, when the mental health professional focuses on and observes these obvious features in the DSM or ICD diagnostic categories, then he or she is automatically led to make a label.

## ***Discussion***

Mental illness classification systems are pioneers in the field of psychiatry through the ongoing revisions made in recent decades (Hebebrand & Bulik, 2011). Based on the symptoms of each mental illness, diagnostic systems allow mental health professionals to decide on the appropriate treatment. However, these systems focus on the symptoms in order to change the problem behavior (Moller, 2009) without taking into account the diversity of each individual and the context of his psychological development. It is important that the science of psychopathology and especially the field of psychiatry unhook itself from this "obsessive" attachment to symptomatic phenomenology and give more emphasis to the mental pain that each subject expresses in his symptoms as well as to what causes these symptoms "speak". The inability to create a diagnostic system that classifies symptoms and categories of mental disorders based on a more accurate localized causality, uniform etiology, and accurate prognosis for any disorder that perfectly matches clinical reality is perhaps more urgent than ever. It is time to take seriously the idea that science, as traditionally designed, is simply "inappropriate" to deal effectively with understanding those parts of the human mind that will lead to a better life. In its early days, psychiatric diagnosis did not start from the lists of symptoms, but from the complex original descriptions of the symptoms and the causes that caused them. At that time, psychiatric textbooks did not contain catalogs of data, but "clinical images" for each patient through narrative descriptions of various forms of psychopathology.

Regardless of the great strides made in understanding psychiatric classification and how these advances have been translated into the development of the DSM-V and ICD-11, there are concerns that they will fail to address issues related to each individual diversity what expresses its symptom (Maldonado et al., 2011). One of the current problems faced by DSM and ICD classification systems is the lack of a theoretical or explanatory database of classifying and how these arise. As no substantial framework for understanding the dynamic relationship between biological and sociocultural factors and how these factors contribute to the manifestation of psychopathology is captured (Walsh et al., 2015). To this day, the answer to what really is psychopathology in all cultures is pending.

For both ICD and DSM, it is important to find ways to reduce artificial comorbidity so that each disorder is scientifically more accurate and clinically useful and the symptoms match those described in the literature without large discrepancies and overlaps. Unfortunately, in both cases, both the DSM and the ICD, more emphasis has been placed on the statistical criteria for summation and combination of symptoms, at a certain time and intensity with the main element being the absence of defined boundaries between normal and pathological boundaries (Zabaleta, 2018) and the risk as reported Paris (2013) is to

expand the spectrum of mental disorder so that everyone can be diagnosed with a mental disorder given the impossibility of establishing clear boundaries between the disorders.

Diagnosis is more than just classification as it consists of mapping the regularities, irregularities and impasses in a person's functioning and understanding the contextual factors that determine how a person tries to understand his or her own anxiety.

The field of mental health needs to take a different approach and move away from focusing entirely on pathology and treatment, focusing on wellness and prevention. Only by moving in this direction can health professionals and scientists fully address the wide range of mental health needs.

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