THE SOCIOCULTURAL PERSPECTIVE

An important criticism of both the biological and psychological perspectives is that they neglect the wider economic, political and social inequality issues that may cause and exacerbate the suffering of individuals. In some instances, biological and psychological perspectives can be prone to a 'blaming the victim' approach by looking for the cause of suffering in the individual's biological or psychological make-up while ignoring pathological features of the social context. The critical psychology movement has argued that psychiatry and clinical psychology can play a part in the control of social upheaval and change by diagnosing individuals as having a mental disorder rather than focusing on changing unfair social structures (Tolman & Maiers, 1991). From this perspective, mental health professions can be seen as agents of oppression rather than as healing professions.

In general, the sociocultural perspective argues that abnormal behaviours are best understood in terms of the social environment of the individual. Sociocultural theories focus on the importance of family functioning, social networks, access to social resources (e.g., education and health services), cultural values and influences, and religious or spiritual beliefs in influencing individuals' behaviours, thinking and emotions. For example, the fact that the overwhelming majority of individuals with eating disorders are female has been hypothesised to be the result of Western culture's increasing emphasis on thinness in women since the 1950s (Rubinstein & Caballero, 2000). Professionals working in the fields of community psychology and social work have made especially important contributions to understanding abnormal behaviours from the sociocultural perspective.

AN INTEGRATIVE APPROACH

The biological, psychological and sociocultural perspectives place different emphases on the various possible causal factors and possible treatment options for mental disorders and abnormal behaviours. A more fundamental difference among these perspectives lies in their disagreement over the definition and conceptualisation of mental disorder and abnormality, particularly whether a continuum or a categorical model more accurately describes psychological abnormality.

In spite of these differences, most researchers and theorists today would agree that none of these perspectives on its own is sufficient to explain human behaviour, be it normal or abnormal. The **biopsychosocial approach** holds that human behaviour can best be explained by incorporating a variety of biological, psychological and sociocultural factors that interact to influence the development of psychological disorders. As will be seen in the following chapters, most contemporary theories of psychological disturbance tend to be variants of the Vulnerability-Stress Model (also known as the **Diathesis-Stress Model**) that explain the causation of psychological disorders or other types of abnormality in terms of the complex interactions among individuals' biological and psychological vulnerabilities and the life events they encounter as they negotiate their roles within their surrounding culture and society.

biopsychosocial approach View that biological, psychological and social factors contribute to the development of abnormality.

Diathesis-Stress Model Originally developed in the context of schizophrenia, the view that abnormality is caused by the combination of a vulnerability or predisposition (the diathesis) and life events (the stressor).

Diagnostic and Statistical Manual of Mental Disorders (DSM) Manual for diagnosing mental disorders published by the American Psychiatric Association containing a list of specific criteria for each disorder.

International Classification of Diseases and Related Health Problems (ICD) System used to classify diseases and other health problems (including mental health problems) published by the World Health Organization (WHO).

The classification and diagnosis of mental disorders

LO 1.3

Currently, the two gold standards for classifying mental disorders are the ***Diagnostic and Statistical Manual of Mental Disorders (DSM)***, published by the American Psychiatric Association (APA) and the ***International Classification of Diseases and Health Related Problems (ICD)***, published by the World Health Organization (WHO). These two publications contain descriptions of various mental disorders and reflect the consensus of mental health professions regarding the definition and classification of mental disorders at the time of their

publication. The *ICD* is primarily used in Europe and in all projects carried out by the WHO, while the *DSM* is more widely used in the United States and Australia.

The current edition, the *DSM-5*, was published in May 2013. It lists more than 300 different mental disorders, some of which are shown in Table 1.4, under a range of categories such as anxiety disorders, depressive disorders and personality disorders. Many of these specific diagnostic categories will be described in subsequent chapters.

TABLE 1.4 The categories of mental disorders as contained in Section II: Diagnostic Criteria and Codes of the *DSM-5*

CLINICAL DISORDER CATEGORIES	EXAMPLES OF DISORDERS
Neurodevelopmental disorders	Intellectual disability, communication disorders, autism spectrum disorders, attention-deficit/hyperactivity disorder, learning disorders
Schizophrenia spectrum and other psychotic disorders	Schizotypal (personality) disorder, schizophrenia, delusional disorder, schizoaffective disorder
Bipolar and related disorders	Bipolar I disorder, bipolar II disorder, cyclothymic disorder
Depressive disorders	Disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia)
Anxiety disorders	Separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder (social phobia), panic disorder, agoraphobia, generalised anxiety disorder
Obsessive-compulsive and related disorders	Obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania, excoriation
Trauma- and stressor-related disorders	Reactive attachment disorder, posttraumatic stress disorder, adjustment disorders
Dissociative disorders	Dissociative identity disorder, dissociative amnesia, depersonalisation/derealisation disorder
Somatic symptom and related disorders	Somatic symptom disorder, conversion disorder, factitious disorder
Feeding and eating disorders	Anorexia nervosa, bulimia nervosa, binge eating disorder
Elimination disorders	Enuresis, encopresis
Sleep-wake disorders	**Insomnia** disorder, hypersomnolence disorder, nightmare disorder
Sexual dysfunctions	Erectile disorder, female orgasmic disorder
Gender dysphoria	Gender dysphoria
Disruptive, impulse-control and conduct disorders	Oppositional defiant disorder, conduct disorder, antisocial personality disorder
Substance-related and addictive disorders	Alcohol use disorder, gambling disorder
Neurocognitive disorders	Delirium, major and mild neurocognitive disorders
Personality disorders	Antisocial personality disorder, borderline personality disorder, obsessive-compulsive personality disorder
Paraphilic disorders	Exhibitionistic disorder, sexual masochism disorder, fetishistic disorder
Other mental disorders	Other specified/unspecified mental disorder due to . . . (indicate medical condition)
Medication-induced movement disorders and other adverse effects of medication	Neuroleptic-induced parkinsonism, tardive dyskinesia, antidepressant discontinuation syndrome
Other conditions that may be a focus of clinical attention	Relational problems, abuse and neglect, educational and occupational problems, housing and economic problems

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insomnia
Difficulty in initiating or maintaining sleep.

The current list of mental disorders is a relatively recent phenomenon. Mental disorders were added to the *ICD* for the first time in 1948, and the first edition of the *DSM* was published in 1952. The development

of an appropriate classification system for mental disorders is still a work in progress: progressive editions of both the *ICD* and the *DSM* have included revised diagnostic criteria for some mental disorders, the addition of new disorders and the omission of others.

ADVANTAGES AND DISADVANTAGES OF DIAGNOSIS

Since the *DSM* is a publication of the American Psychiatric Association, its underlying assumptions currently reflect the medical model of mental disorders. The term **diagnosis** is consistent with the key assumptions of the medical model according to which (a) an abnormal condition (which is clearly distinct from normality and from other abnormal conditions) exists and (b) it is driven by clearly identifiable underlying pathological processes. Psychological perspectives on the definition and causation of mental disorders often do not share the categorical assumptions of the medical model. Nevertheless, the majority of research in abnormal psychology today, irrespective of the theoretical background of the researchers, investigates abnormal behaviours as defined by *DSM* diagnoses. In addition, mental health professionals of most theoretical backgrounds, even those who do not subscribe to the medical model of mental disorders, use diagnostic labels in their clinical practice. There are several reasons for the current dominance of *DSM* diagnostic categories in the field of mental health.

diagnosis Label given to a set of symptoms that tend to occur together.

ADVANTAGES OF DIAGNOSIS

In practical terms, a common system of classification and diagnosis improves communication among mental health professionals. Classification is the description of specific disorders in a way that clarifies their essential features and their boundaries from other conditions. Diagnosis involves applying these categories to people to best capture their characteristics (behaviours, thoughts and emotions). When clinicians apply diagnostic labels, they are saying that the pattern of behaviours, feelings and thoughts that the person displays is similar to a pattern that has been previously recognised, whose nature and causes have been studied and for which particular treatments have been found useful. Thus diagnosis helps researchers and therapists to communicate with each other regarding the suspected causes and most effective treatments for individuals experiencing certain patterns of thoughts, feelings and behaviours.

In addition to communicating with each other, mental health professionals need to collaborate with other institutions in society. Diagnoses are usually required when mental health professionals are working with a health insurance company or are involved in a legal matter, worker's compensation schemes or government departments. To balance and forecast their budgets, hospitals need to collect data regarding the numbers of individuals with different diagnoses (e.g., schizophrenia or major depression) that they treat. Schools receive special funding on the basis of the number of children with diagnoses such as autism or learning disabilities that they educate. Therefore, the diagnostic categories of the *DSM* have become the primary means of communicating about mental health and illness not only among mental health professionals but also in wider society.

DISADVANTAGES OF DIAGNOSIS

Despite these advantages, the practice of diagnosis is also associated with potential problems. First, the widespread use of *DSM* diagnostic labels in society has often resulted in their reification. Both mental health professionals and others often refer to these diagnostic categories as if they exist in nature the same way many physical diseases exist. For most mental disorders, however, an underlying biological disease process has not yet been identified. Mental disorders are simply theoretical constructs and they are not independent of changing social values and theoretical orientations (as the examples of homosexuality and drapetomania at the beginning of this chapter have shown).

Related to the above problem, *DSM* diagnoses are often used in common language and by some health professionals as if they were explanatory rather than merely descriptive terms. For instance, when the diagnostic category of 'schizophrenia' is applied, it should be taken as simply a description of a constellation of symptoms including hallucinations or delusions. However, sometimes the application of this label gives an illusion of explanation, leading to the erroneously attached meaning, 'he is hallucinating *because* he has schizophrenia'.

Finally, it is important to keep in mind that applying diagnoses may sometimes be harmful to people. In some instances, individuals may be stigmatised by others and their opportunities limited as a result of having been labelled as mentally ill (Rosenhan, 1973; Szasz, 1961). Diagnostic labels may also be self-limiting, as in the case of those who take on a sick role ('I have a mental illness'), which can lead to increasing beliefs of helplessness regarding their capacity to think, feel and behave differently. Such beliefs may then interfere with the process of recovery.

Thus, while the vocabulary of the *DSM*—its diagnostic categories—is the primary means of communicating about mental health and illness in today's society, its widespread use is also associated with risks and limitations. It is crucial for mental health professionals, therefore, to be aware of the main underlying assumptions that guided the establishment of these diagnostic categories and any strengths and limitations associated with these assumptions.

THE DEVELOPMENT OF THE *DSM* SYSTEM OF CLASSIFICATION AND DIAGNOSIS

This section will trace the development of the *DSM* from its inception in 1952 to its most recent, fifth, edition published in 2013. This historical overview aims to outline the ongoing improvements that have occurred over time and forecast some of the future directions for diagnostic practice.

THE EARLY YEARS: *DSM-I* (1952) AND *DSM-II* (1968)

Given the dominance of psychoanalytic thinking between the 1940s and 1970s, the way mental disorders were conceptualised in the *DSM-I* (APA, 1952) and its successor the *DSM-II* (APA, 1968) was greatly influenced by psychoanalytic theories about the nature and causation of mental disorders. One important assumption of the time was that some mental disorders were biological in origin while others were psychological. As a result, both the *DSM-I* and *DSM-II* had two main sections. The first section was titled 'Diseases of the Psychobiologic Unit' and contained disorders known to have a biological causation. These disorders were subclassified according to their presumed cause, for example, intoxication or a vitamin deficiency. The second section had the self-explanatory title, 'Disorders of Psychogenic Origin or Without Clearly Defined Physical Cause or Structural Change in the Brain'. These disorders were referred to as 'reactions', implying that the disorder was a psychological reaction to the individual's environment or internal processes. Disorders were presented under several subcategories, the most important of which were 'Psychotic Disorders' and 'Psychoneurotic Disorders'. Consistent with a psychoanalytic approach, the various symptoms of both psychotic and psychoneurotic disorders were thought to reflect the patient's unconscious defence mechanisms. Psychotic disorders were characterised by a 'varying degree of personality disintegration and a failure to test and evaluate external reality in various spheres' (APA, 1952, p. 24). The same underlying general assumption regarding causation guided the definition of each type of psychotic reaction: 'a psychotic reaction may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilises severe affective disturbance, profound autism and withdrawal from reality and/or formation of delusions or hallucinations' (APA, 1952, p. 12). For example, paranoid schizophrenia was seen as a psychotic reaction where the person uses the defence mechanism of projection, which ascribes to others characteristics the individual cannot accept in him/herself. In psychoneurotic reactions anxiety was the chief characteristic. Such anxiety was either directly felt or automatically controlled by such defences as depression, phobia formation, or repetitive

thoughts and acts. For example, depressive reaction was described in the DSM-I as follows: 'the anxiety in this reaction is allayed, and hence partially relieved, by depression and self-deprecation. The reaction is precipitated by a current situation, frequently by some loss sustained by the patient, and is often associated with a feeling of guilt for past failures or deeds. The degree of the reaction in such cases is dependent upon the intensity of the patient's ambivalent feeling toward his loss (love, possession) as well as upon the realistic circumstances of the loss' (APA, 1952, pp. 33–34).

LIMITATIONS OF THE *DSM-I* AND *DSM-II*

In general, the constructs involved in psychoanalysis were complex and difficult to measure with precision. The same problem applied to the diagnostic systems based on psychoanalytic thinking. Foremost among the problems was the limited reliability of the diagnostic categories. **Reliability** refers to the ability of a measurement system to yield the same results, no matter when, where and by whom it is used. So, a 30-centimetre ruler measures exactly the same length in Sydney or in Perth, whether it is used by one person or another, and whether it is used today or in six months' time. Similarly, diagnostic categories need to be defined clearly enough to enable different clinicians at different locations and times to arrive at the same diagnosis when assessing the same person. In order to apply modern scientific methods and empirically investigate the causes of a mental disorder or its treatment, researchers at different sites need to be able to apply diagnostic criteria with a high level of agreement between them. At a more fundamental level, the investigators need to be able to agree on whether a person meets the criteria for a disorder or not. That is, the line between mental health and disorder needs to be clearly identifiable.

reliability Degree of consistency in a measure, that is, the extent to which it yields accurate measurements of a construct across different trials, samples, raters and forms of the measure.

Psychoanalytic theory, and hence the first two editions of the *DSM,* were unable to meet these needs. Returning to the example of the description of depressive reaction in the *DSM-I,* a number of obstacles to reliable diagnosis become apparent. First, at the very basic level, the description does not give the diagnostician any indication as to when a depressive reaction becomes severe enough to warrant a diagnosis and treatment, that is, when it ceases to be a normal reaction and becomes 'abnormal'. How much of each of the listed symptoms is required to be considered abnormal? For example, how much self-deprecation is required? How long does the self-deprecation need to continue for? These considerations were not important for psychoanalysis, as the theory explicitly accepted that the dividing line between normality and disorder is blurred.

In addition to not giving any indication regarding the difference between normal and abnormal levels of the symptoms, it is also not known whether all of the symptoms are required or only some of them to establish a diagnosis. Should a person who feels depressed but does not express self-deprecation be diagnosed with a depressive reaction or not? Are some of the symptoms more important than others? Such questions were not explicitly stated in the diagnostic criteria in the first two editions of the *DSM* and it was left to individual therapists or researchers to make decisions regarding the answers. This subjective judgment introduced a great deal of unreliability to the diagnostic process since it allowed a high level of disagreement to occur between individual therapists making diagnoses.

The other important limitation of the first two editions of the *DSM* was the lack of evidence for their assumptions regarding causation. The ultimate aim of medical diagnostic systems is to classify different disorders according to their underlying causation. The fact that psychoanalytic concepts were extremely difficult to research empirically meant that the presumed psychodynamic causation underlying the diagnostic categories in the *DSM-I* and *DSM-II* received no empirical support. The diagnostic system was ultimately based on unproven and untestable assumptions about the aetiology of the disorders. It was not possible to ascertain whether the disorders really existed as described—that is, whether the category descriptions were consistent with what occurs in nature. In other words, the diagnostic system had limited validity.

By the 1970s this state of affairs was no longer acceptable to the medical profession. Psychiatry needed to introduce a new system for the classification of mental disorders that was more consistent with the prevailing

values of modern medical science. The next edition of the *DSM*, therefore, represented a significant departure from the psychoanalytic model.

THE NEO-KRAEPELINIAN APPROACH: *DSM-III* (1980) AND ITS SUCCESSORS

The publication of the *DSM-III* has been seen by many as probably the most significant development in psychiatric classification in the twentieth century. The *DSM-III* and its successors have attempted to address the problems of limited reliability and validity that were characteristic of the previous editions by adopting a neo-Kraepelinian, descriptive approach to classification comparable to Kraepelin's earlier work at the end of the nineteenth century. This approach avoided organising a diagnostic system around hypothetical but unproven theories about aetiology. Instead, the diagnostic categories were defined at the level of their observable features only, until their underlying causation was identified by further research. Implicit in this perspective is the assumption that different mental disorders can be categorised and diagnosed using the same principles that are used to categorise and diagnose physical disorders. These principles have also been adopted in the development of the revised third edition (*DSM-III-R*) (APA, 1986), the fourth edition (*DSM-IV*) (APA, 1994) and its text revised version (*DSM-IV-TR*) (APA, 2000), as well as the current, fifth, edition (*DSM-5*) (APA, 2013). The main differences between the first two and later editions are summarised in Table 1.5.

TABLE 1.5 The main differences between recent editions of the *DSM* and their predecessors

DSM-III, DSM-III-R, DSM-IV, DSM-IV-TR* AND *DSM-5	***DSM-I* AND *DSM-II***
Specific diagnostic criteria for each category	Unspecific, general descriptions of categories
No explicit assumptions about causation	Assuming causation from a psychoanalytic viewpoint
Polythetic format: a set of optional diagnostic criteria is provided; only a subset is needed for diagnosis	Monothetic format: general description of criteria without specifying which ones are necessary and which ones are optional

To illustrate the differences between the current and earlier editions, the *DSM-5* category of major depressive disorder can be compared to the description given in the *DSM-I*. The *DSM-5* criteria for major depressive disorder are shown in Table 1.6. To be diagnosed with the disorder, an individual needs to fulfil

hypersomnia Being chronically sleepy and sleeping for long periods of time.

psychomotor agitation Excessive motor activity (such as pacing and fidgeting) stemming from mental tension.

TABLE 1.6 The *DSM-5* diagnostic criteria for major depressive disorder

Criterion A	At least five of the following symptoms have been present for at least two weeks. At least one of these symptoms must be either (1) or (2):
	1. Depressed mood for most of the day, nearly every day
	2. Loss of interest or pleasure in most activities for most of the day, nearly every day
	3. Significant weight loss/gain or decrease/increase in appetite nearly every day
	4. Insomnia or **hypersomnia** nearly every day
	5. **Psychomotor agitation** or retardation nearly every day
	6. Fatigue nearly every day
	7. Feelings of worthlessness or excessive guilt
	8. Reduced ability to think, concentrate or make decisions nearly every day
	9. Recurrent thoughts of death, which might include suicidal thoughts
Criterion B	These symptoms result in significant distress or impaired functioning in an important area (or areas) of life such as the individual's ability to function at work/study.
Criterion C	These symptoms are not due to the effects of a substance or another medical condition.

Source: *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Copyright 2013, American Psychiatric Association.

criteria A, B and C. Unlike the *DSM-I,* the *DSM-5* criteria explicitly specify how many symptoms need to be present, how long they need to be present for, and which symptoms are necessary or optional. Further, the *DSM-5* gives clear guidelines for **differential diagnosis**, that is, differentiating the individual's disorder from other possible diagnoses, for example, by specifying that a history of manic episodes would qualify for a diagnosis of bipolar disorder, rather than major depressive disorder. Similar changes to all diagnostic categories resulted in greatly improved levels of **interrater reliability** for all editions of the *DSM* following the introduction of the new approach in *DSM-III.* That is, the advent of the *DSM-III* introduced an increased ability for different diagnosticians to agree on *when* a diagnostic category is applicable and *which* one it is.

differential diagnosis Determination of which of two or more possible diagnoses is appropriate for an individual.

interrater reliability Extent to which an observational measure yields similar results across different raters/judges.

THE VALIDITY OF THE CURRENT *DSM* CLASSIFICATION OF DISORDERS

> *Current classification in psychiatry . . . resembles the medicine of 50–100 years ago, before the underlying pathophysiology of many disease processes was understood.*
>
> Charney et al., 2002, p. 33

The primary strength of the current *DSM* categorical system is its ability to improve communication among clinicians and researchers, that is, its increased reliability. However, although it is now possible to agree on specific diagnoses with a satisfactory level of reliability, it is still unknown whether these diagnostic categories are at all meaningful, that is, valid disease entities that actually exist. The ultimate aim of medical diagnostic systems is to classify different disorders according to their underlying causation. The neo-Kraepelinian approach introduced in the *DSM-III* aimed to identify symptom clusters (syndromes) that would eventually be found to share a common causation and to respond to specific treatments. This aim has not yet been achieved. Indeed, there is now an increasing amount of empirical evidence questioning the validity of the current classification system. The main problems identified include diagnostic instability (the finding that individuals often move from one disorder to another over time), a lack of treatment specificity (the finding that the same treatment—for example, antidepressant medication—is effective for a variety of different disorders such as depression and anxiety disorders), and a high level of **comorbidity** (the co-occurrence of two or more disorders in the same person) found among psychiatric disorders (Clark, Watson, & Reynolds, 1995; Krueger & Piasecki, 2002). Each of these findings questions the assumption that the categories of mental disorder, as implied by the medical model and currently described in the *DSM,* are independent from each other.

comorbidity Co-occurrence of two or more disorders in the same person.

Among these problems, the largest amount of research attention has been devoted to comorbidity. Studies involving large community samples both in the United States and in Australia have found that it is quite uncommon to have only one psychological disorder. These studies agree that 50–60 per cent of individuals with one disorder also have at least one other, comorbid disorder (Andrews, Hall, Teeson, & Henderson, 1999; Kessler et al., 1994). These rates are much higher in clinical samples (i.e., among individuals who have sought treatment for their condition), where finding individuals with only one diagnosis is clearly the exception rather than the rule. Moreover, the co-occurrence of mental disorders often follows a pattern. For example, individuals with major depression often receive diagnoses of one or more anxiety disorders, and individuals with borderline personality disorder are often diagnosed with eating disorders and substance use disorders (Clark et al., 1995; Krueger & Piasecki, 2002; Widiger & Sankis, 2000).

High rates of comorbidity pose two important challenges to researchers and to the classification system. One problem is that comorbidity complicates any efforts to study the nature, causation and treatment of individual disorders. If, for example, researchers find that individuals with bulimia nervosa also have low self-esteem, it is difficult to know whether this finding is associated with the eating disorder itself or with the several other disorders (such as major depression) that individuals with bulimia nervosa may also have. A possible solution to this problem is to study only pure cases of the disorder, that is, individuals who do not have any comorbid conditions. However, these cases may be rare and not representative of the population

of individuals with bulimia nervosa. So, given the problems of extensive comorbidity and the often marked heterogeneity among individuals with the same diagnosis, research framed by the current putative categories of mental disorder can be very hard to interpret.

A more fundamental implication of the high comorbidity of mental disorders is that it questions the validity of separate, independent diagnostic categories. To give an example from physical illnesses, even though tonsillitis and diabetes are caused by two different disease processes, these two diseases may nevertheless occasionally co-occur in the same person. However, these two diseases have not been found to be co-occurring at a rate above chance (i.e., people with tonsillitis are not more likely to have diabetes than any other disorder). In contrast, increasing amounts of data suggest a lack of independence among mental disorder categories. Data showing extensive comorbidity and a lack of treatment specificity undermine the premise of the medical model that different mental disorders represent distinct (if unknown) aetiologies: if the disorder categories are caused by different factors, then they should not regularly co-occur and should not respond to the same treatment. It is argued, therefore, that the co-occurrence of disorders reflects their common underlying psychopathology, which would mean that they are not entirely distinct from one another.

Developing a reliable and valid diagnostic system for mental disorders is an ongoing challenge.

DSM-5 AND BEYOND: ALTERNATIVES TO THE CURRENT CLASSIFICATION SYSTEM

Each new edition of the *DSM* following the publication of the *DSM-III* in 1980 retained the principal features of the *DSM-III* but was more research-based than previous editions and made relatively small, iterative changes to the list of mental disorders and their diagnostic criteria. For example, the task force for the *DSM-IV* conducted literature reviews, analyses of existing data sets and field studies to collect empirical evidence to guide any decisions for the *DSM-IV* diagnostic categories. The main changes introduced in the *DSM-IV* included the creation of 13 new disorders, the omission of eight previously described disorders and the revision of the diagnostic criteria for several others.

A similar process occurred during the development of the *DSM-5*, which involved preparation in the form of empirical research spanning more than a decade. The planning process for the revisions that eventually led to the publication of the *DSM-5* began in 1999. The initial phase of this planning process culminated in the publication of a six-chapter volume summarising the American Psychiatric Association's research agenda for the *DSM-5* (Kupfer, First, & Regier, 2002). This agenda aimed to provide direction for research that could improve the scientific basis of the *DSM-5* and future classification systems of mental disorders. Topics included developmental issues, disability and impairment, and cross-cultural issues. In addition, fundamental questions about the nature of classification and diagnosis were considered in the chapter 'Basic Nomenclature Issues for *DSM-5*' (Rounsaville et al., 2002), including the need to work towards achieving a more valid definition of mental disorder—a problem that has remained unresolved in spite of many years of effort and controversy (Broome & Bortolotti, 2010; First & Wakefield, 2010). The authors of the *DSM-5* research agenda also emphasised that one of the main shortcomings of the *DSM-IV-TR* was its presentation of various diagnostic categories as if they were equal in validity (Rounsaville et al., 2002) so that practising

clinicians had no way of knowing that certain disorders (e.g., anxiety disorders) listed in the *DSM-IV-TR* were better established than others (e.g., most personality disorders). Finally, the authors emphasised the need to determine whether a dimensional approach should be substituted for the current categorical approach as a way of improving the validity of the current classification system.

Consequently, the Dimensional Approaches to Psychiatric Classification Work Group was convened in 2006 to critically appraise the use of dimensional constructs in psychiatric diagnostic systems. Resultant papers appeared in a special issue of the *International Journal of Methods in Psychiatric Research* (Allardyce, Suppes, & van Os, 2007; Andrews et al., 2007; Kraemer, 2007; Lopez, Compton, Grant, & Breiling, 2007; Regier, 2007; Shear, Bjelland, Beesdo, Gloster, & Wittchen, 2007). The authors of these papers agreed that psychiatric disorders can be viewed not only in categorical terms (i.e., as absent or present) but can also be assessed dimensionally via measures such as frequency and severity. There is now strong evidence suggesting that the symptoms of psychiatric disorders exist on a continuum of severity and that the cut-off point on this continuum at which a clinical diagnosis is made and treatment is offered (that is, where 'normal' is differentiated from 'abnormal') is largely arbitrary. Nevertheless, the Work Group's proposal for the *DSM-5* was not to substitute dimensional scales for categorical diagnoses, but to add a dimensional option to the usual categorical diagnoses (e.g., major depressive disorder of varying degrees of severity including mild, moderate or severe). The introduction in the *DSM-5* of such adjunct dimensional measures is an initial, modest step towards a dimensional diagnostic system.

Dimensional models of psychopathology not only argue that the boundary between normality and abnormality (or the presence or absence of disorder) is indistinct, they also challenge the notion that the hundreds of diagnostic categories contained in the current version of the *DSM* represent separate, independent disorders. As explained previously, the pattern and rates of co-occurrence among the mental disorders are thought to reflect the existence of a shared underlying dimension of psychopathology based on a common causation (Kessler et al., 2005; Krueger, 1999; Slade & Watson, 2006). Several research groups have sought to identify underlying dimensions that explain the co-occurrence of mental disorders. Their ultimate aim is to replace the many categories of mental disorders in the *DSM* with a small number of basic dimensions. For example, Watson (2005) has proposed a model in which the anxiety, depressive and bipolar disorders of the *DSM* exist along a continuum of increasing severity (rather than constituting different disorders) that would explain their observed comorbidity. Similarly, Krueger, Markon, Patrick, and Iacono (2005) proposed a dimensional model of disorders such as conduct disorder, antisocial personality disorder and substance use disorders.

Although there has been a large amount of research devoted to the issue of a dimensional understanding of underlying psychopathology, no agreement has yet been reached on what parameters the dimensions should assess or how many dimensions are necessary to describe the entire domain of psychopathology. Partly because of this lack of consensus, a dimensional diagnostic system reflecting common underlying factors was not introduced in the *DSM-5*. Nevertheless, a tentative step toward a dimensional approach is reflected in the new organisational structure of the *DSM-5:* specific disorders with similar symptom patterns, high levels of comorbidity, shared genetic or environmental risk factors, or common treatment responses have been placed in the same chapter and disorders thought to be related to each other have been placed in adjacent chapters. For example, as shown in Table 1.4, the chapter containing obsessive-compulsive and related disorders is placed adjacent to the chapter containing anxiety disorders. The adjacent placement emphasises the commonalities between these two clusters of disorders, both of which together with depressive disorders belong to the overarching internalising group of disorders. Similarly,

specific disorders thought to express an underlying externalising factor (e.g., substance use disorders or conduct disorders) have been clustered together to emphasise their similarity and possible relatedness. This regrouping of mental disorders in the *DSM-5* is intended to stimulate research across the various categories and to enhance understanding of underlying commonalities. However, the placement of some specific disorders in larger categories has been controversial. For example, although attention-deficit/hyperactivity disorder (ADHD) has been placed within the 'Neurodevelopmental Disorders' chapter in the *DSM-5,* empirical findings also support its placement within the 'Disruptive, Impulse-control, and Conduct Disorders' chapter. Future research might change the placement of individual disorders in further revisions of the *DSM.*

During the development of the *DSM-5* it was predicted that a change toward a dimensional system was likely to occur first in the field of personality disorders, where the most research evidence for common dimensions underlying the current categories exists (Krueger, Skodol, Livesley, Shrout, & Yueqin, 2007; Samuel & Widiger, 2006). Indeed, the *DSM-5* Personality and Personality Disorders Work Group developed a new dimensional conceptualisation of personality disorders, characterised by impairments in various underlying personality traits. However, despite the well-documented problems posed by the previous categorical system, the *DSM-5* Task Force decided that it was premature to include this alternative conceptualisation of personality disorders in the *DSM-5.* Instead, the same criteria found in the *DSM-IV* were retained and the alternative conceptualisation of personality disorders was included in the section on 'Conditions for further study' in the *DSM-5.* These diagnostic criteria are expected to stimulate further research in the field of psychiatric classification (APA, 2013).

Given the usual time lag of 10–15 years between new research findings and their incorporation into formal diagnostic systems, the *DSM-5* is not radically different from previous editions. Nevertheless, recent developments indicate that the mental health field is now moving towards a re-evaluation of commonly accepted ideas about the nature of mental disorders. The outcomes of such investigations will aid in the development of a dimensional approach to diagnosis that is likely to replace the current categorical approach in coming years. Moreover, these developments illustrate the way in which the foundation of the *DSM* mental disorder categories is increasingly moving from expert clinical consensus to one based on extensive empirical research.