DSM. In this chapter we present the major DSM-IV-TR categories in brief summary. We then evaluate classification in general and the DSM in particular. In the next chapter we consider assessment procedures that provide the data on which diagnostic decisions are based.

The Diagnostic System of the American Psychiatric Association (DSM-IV-TR)

Several major innovations distinguish the third edition and subsequent versions of the DSM. One of these changes is the use of **multiaxial classification**, whereby each individual is rated on five separate dimensions, or axes (Table 3.1). In this section we briefly discuss these five axes and then describe the major diagnostic categories.

Five Dimensions of Classification

The five axes of DSM-IV are:

Axis I. All diagnostic categories except personality disorders and mental retardation.
Axis II. Personality disorders and mental retardation.
Axis III. General medical conditions.
Axis IV. Psychosocial and environmental problems.
Axis V. Current level of functioning.

The multiaxial system, by requiring judgments on each of the five axes, forces the diagnostician to consider a broad range of information.

Axis I includes all diagnostic categories except the personality disorders and mental retardation, which make up Axis II. Thus Axes I and II comprise the classification of abnormal behavior. A detailed presentation of Axes I and II appears inside the front cover of the book. Axes I and II are separated to ensure that the presence of long-term disturbances, as occur in the personality disorders and mental retardation, are not overlooked. Most people consult a mental health professional for an Axis I condition, such as depression or an anxiety disorder. But prior to the onset of their Axis I condition, they may have had an Axis II condition, such as dependent personality disorder. The separation of Axes I and II is meant to encourage clinicians to be attentive to this possibility. The presence of an Axis II disorder along with an Axis I disorder generally means that the person's problems will be more difficult to treat.

The inclusion in the DSM of Axes III, IV, and V indicates that factors other than a person's symptoms should be considered in an assessment so that the person's overall life situation can be better understood. On Axis III the clinician indicates any general medical conditions believed to be relevant to the mental disorder in question. For example, the existence of a heart condition in a person who was also diagnosed with depression would have important implications for treatment; some antidepressant drugs could worsen the heart condition. Axis IV codes psychosocial and environmental problems that the person has been experiencing and that may be contributing to the disorder. These include occupational problems, economic problems, interpersonal difficulties with family members, and a variety of problems in other life areas, which may influence psychological functioning. Finally, on Axis V, the clinician indicates the person's current level of adaptive functioning, using the Global Assessment of Functioning (GAF) scale. Life areas considered are social relationships, occupational functioning, and use of leisure time. These ratings of current functioning are meant to provide an assessment of how much the person needs treatment.

Diagnostic Categories

In this section we provide a brief description of the major diagnostic categories of Axes I and II. Before presenting the diagnoses we should note that for many of them, the DSM includes a provision for indicating that the disorder is due to a medical condition or substance abuse. For example, depression resulting from an endocrine gland dysfunction would be diagnosed in the depression section of the DSM but listed as caused by a medical problem. Clinicians must therefore be sensitive not only to the symptoms of their patients but also to possible medical causes of their patients' condition. It should also be noted that beginning with DSM-III, there has been a dramatic expansion of the number of diagnostic categories. Eating disorders, some anxiety disorders (for example, posttraumatic stress disorder), several personality disorders (for example, schizotypal personality disorder), and many of the disorders of childhood were all added in DSM-III or subsequent editions. Focus on Discovery 3.1 describes some diagnoses and axes that are not regarded as well-enough established to be included in DSM-IV-TR, but are in need of further study.

Table 3.1 DSM-IV-TR Multiaxial Classification System

Axis I

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
Delirium, Dementia, Amnestic and Other Cognitive Disorders
Substance-related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders
Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse Control Disorders Not Elsewhere Classified
Adjustment Disorders

Axis II

Mental Retardation
Personality Disorders

Axis III

General Medical Conditions

Axis IV
Psychosocial and Environmental Problems

Check:

___ Problems with primary support group.
Specify:

___ Problems related to the social environment.
Specify:

___ Educational problem.
Specify:

___ Occupational problem.
Specify:

___ Housing problem.
Specify:

___ Economic problem.
Specify:

___ Problems with access to health care services.
Specify:

___ Problems related to interaction with the legal system/crime.
Specify:

___ Other psychosocial and environmental problems.
Specify:

Axis V
Global Assessment of Functioning Scale (GAF Scale)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health/illness. Do not include impairment in functioning due to physical (or environmental) limitations.

CODE

100–91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his many positive qualities. No symptoms.

90–81 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

80–71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).

70–61 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

60–51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

50–41 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40–31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30–21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

20–11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

10–1 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information.

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quate, although each has merit and captures some part of what might be the full definition. Consequently, abnormality is usually determined based on the presence of several characteristics at one time. Our best definition of abnormal behavior takes into account the characteristics of statistical infrequency, violation of norms, personal distress, disability or dysfunction, and unexpectedness.

Statistical Infrequency

One aspect of abnormal behavior is that it is infrequent. For example, episodes of depression and mania such as those Ernest experienced occur in only about 1 percent of the population. The **normal curve**, or bell-shaped curve, places the majority of people in the middle as far as any particular characteristic is concerned; very few people fall at either extreme. An assertion that a person is normal implies that he or she does not deviate much from the average in a particular trait or behavior pattern.

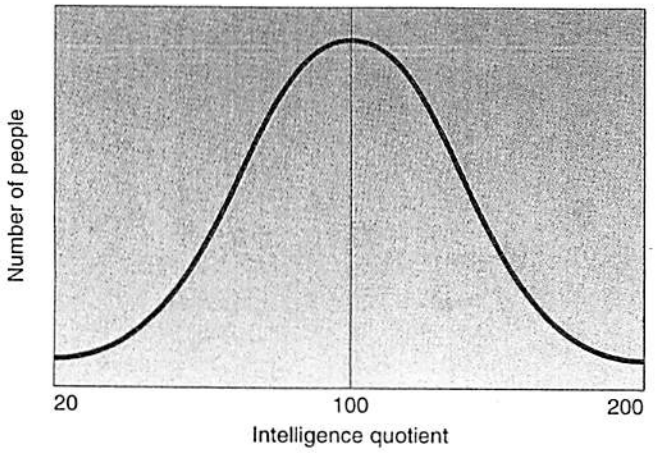


Figure 1.1 The distribution of intelligence among adults, illustrating a normal, or bell-shaped curve.

Statistical infrequency is used explicitly in diagnosing mental retardation. Figure 1.1 shows the normal distribution of intelligence quotient (IQ) measures in the population. Though a number of criteria are used to diagnose mental retardation, low intelligence is a principal one (see p. 498). When an individual's IQ is below 70, his or her intellectual functioning is considered sufficiently subnormal to be designated as mental retardation.

Although some infrequent behaviors or characteristics of people do strike us as abnormal, in some instances the relationship breaks down. Having great athletic ability is infrequent, but few would regard it as part of the field of abnormal psychology. Only certain infrequent behaviors, such as experiencing hallucinations or deep depression, fall into the domain considered in this book. Unfortunately, the statistical component gives us little guidance in determining which infrequent behaviors psychopathologists should study.

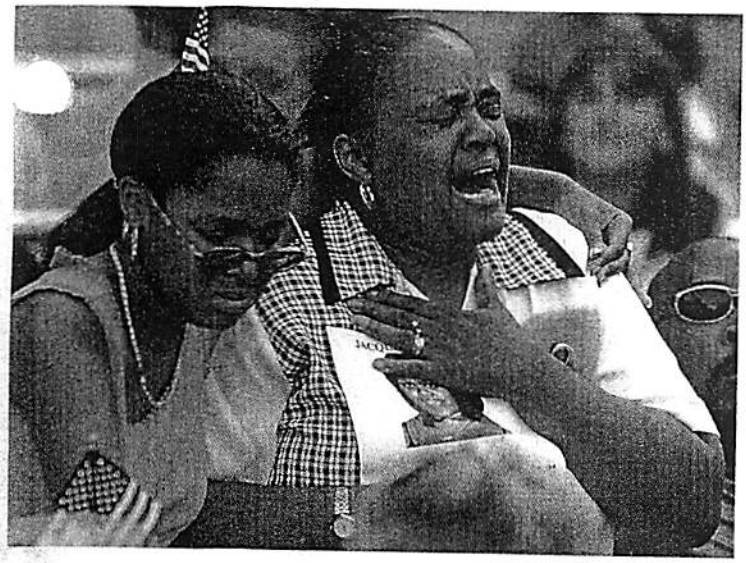
Violation of Norms

Another characteristic to consider when determining abnormality is whether the behavior violates social norms or threatens or makes anxious those observing it. Ernest's verbal and physical attacks on his wife illustrate this criterion. The antisocial behavior of the psychopath also fits the definition, as do the obsessive-compulsive person's complex rituals and the psychotic patient's conversations with imaginary voices. Yet this component also is at once too broad and too narrow. Criminals and prostitutes violate social norms but are not usually studied within the domain of abnormal psychology; and the highly anxious person, who is generally regarded as a central character in the field of abnormal psychology, typically does not violate social norms and would not be bothersome to many lay observers.

In addition, cultural diversity can affect how people view social norms—what is the norm in one culture may be abnormal in another. This subtle issue is addressed throughout the book (see especially Chapter 4, pp. 105–107).

Personal Distress

Another characteristic of some forms of abnormality is personal suffering; that is, behavior is abnormal if it creates great distress and torment in the person experiencing it. Ernest's self-consciousness and distress about being evaluated illustrate this criterion. Personal distress clearly fits many of the forms of abnormality considered in this book—people experiencing anxiety disorders and depression truly suffer greatly. But some disorders do not necessarily involve distress. The psychopath, for example, treats others coldheartedly and may continually violate the law without experiencing any guilt,

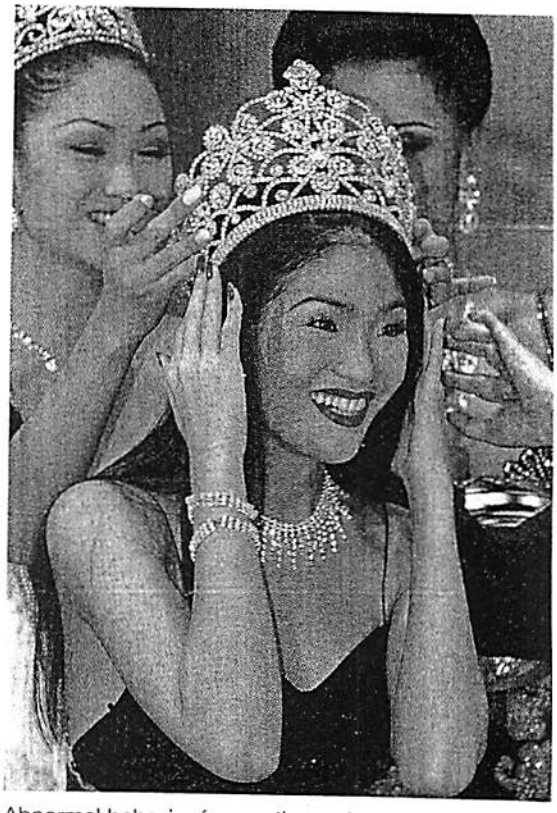


Personal distress such as that shown in this photo, is also part of the definition of abnormal behavior, but unlike grief, which is an expected response to losing a loved one, the distress most relevant to psychopathology is not expected given the situation in which it occurs.

remorse, or anxiety whatsoever. And not all forms of distress—for example, hunger or the pain of childbirth—seem to belong to the field.

Disability or Behavioral Dysfunction

Disability, that is, whether the individual is impaired in some important area of life (e.g., work or personal relationships) because of the abnormality, can also be a component of abnormal behavior. The disruption of Ernest's marital relationship fits this criterion. S nce-use disorders are also defined in part by the social or occupational disability (e.g., poor work performance, serious arguments with one's spouse) created by substance abuse. Similarly, a phobia can produce both distress and disability, for example, if a severe fear of flying prevents someone from taking a job promotion. Like suffering, though, disability applies to some, but not all, disorders. For example, transvestism (cross-dressing for sexual pleasure), which is currently diagnosed as a mental disorder if it distresses the person, is not necessarily a disability. Most transvestites are married, lead conventional lives, and usually cross-dress in private. Other characteristics that might in some circumstances be considered disabilities—such as being short if you want to be a professional basketball player—do not fall within the domain of abnormal psychology. As with distress, we do not have a rule that tells us which disabilities belong and which do not.



Abnormal behavior frequently produces disability or dysfunction. But some diagnoses, such as transvestitism, are not clearly disabilities. Shown here is Thailand's Miss Transvestite.

Unexpectedness

We have just described how not all distress or disability falls into the domain of abnormal psychology. Distress and disability are often considered abnormal when they are unexpected responses to environmental stressors (Wakefield, 1992). For example, an anxiety disorder is diagnosed when the anxiety is unexpected and out of proportion to the situation, as when a person who is well-off worries constantly about his or her financial situation. Hunger, on the other hand, is an expected response to not eating and thus would be excluded as a state of distress that is relevant to abnormal behavior. Ernest was experiencing some life stress, but many people do so without developing psychological problems.

We have considered here several key characteristics of a definition of abnormal behavior. (See Focus on Discovery 1.1 for a controversial perspective on defining abnormality.) Again, none by itself yields a fully satisfactory definition, but together they offer a l framework for beginning to define abnormality.

Keep in mind too that what we present in a text such as this are human problems that are currently considered abnormal. The disorders we discuss will undoubtedly change