ICD & The DSM Classification System. Essay, Research Paper

Although at first sight the DSM-IV classification system appears to provide clinicians with a useful framework of which to view their clients, on closer inspection however, the picture is somewhat less satisfactory. Criticisms of the system range from Wakefield’s (1997) analysis that psychological presentation ranges from problems of living to harmful dysfunction; through to Livesley, Schroeder & Jang’s (1994) counter-argument that evidence of discontinuity between different diagnoses and normality would support the DSM’s proposal of distinct diagnostic categories. Since these issues involved are quite distinct, both these points of view are presented in relation to a cause and consequence debate. Finally, conclusions are reflected in terms of the classification of the impulse control disorders not else where specified (DSM-IV, 1996). Particularly, discussion is given to the sub category of Kleptomania.

Criticisms of DSM -IV classification:

The four major criticisms of DSM -IV classification system are (1) that categories lack independence, (2) the principles underlying them are diverse, (3) they are too heterogeneous and (4) the reliability (consistency) and conceptual validity (correctness) (Wakefield, 1997) of diagnosis is too low to be of any value. This leads to Wakefield’s (1997) argument that the diagnostic criteria of the DSM encompasses too many conditions that do not adequately reflect a true indication of one psychological disorder. Wakefield (1997) further argues that a pattern labelled ‘harmful dysfunction’ results in confusion between boundaries along the continuum of disorder and non-disorder. Harmful dysfunction results from a lack of consistency, clarification or identification of quite simply, what should be diagnosed where. The harm in this case can result in negative evaluation of an undesirable outcome that is placed within a specific diagnostic category. According to the harmful dysfunction analysis, a disorder only exists where there is a clear and identifiable internal mechanism resulting in harm to the individual. However it becomes apparent that when using the DSM as a major diagnostic criteria in assessment, that many clinicians in relying heavily upon criteria, over estimate the role of dysfunction in their clients, therefore misinterpreting consequences and causes.

In relating this to classification of specific distress, Wakefield’s (1997) analysis of harmful dysfunction, implies that the DSM is formulated within a medical model that suggests that psychological causation is involved in all DSM-IV and preceding classification systems. In so much, common argument that all mental disorders must be brain diseases is due to the fact that all mental states are regarded as brain states in classification (Wakefield, 1997). A consequence is found through the harmful dysfunction analysis that the application of medical approaches to both physical and mental disorder, contrary to common suggestion (E.g.: the mind body dualism) are not necessarily true for all instances of behaviour (Wakefield, 1997). Therefore, one must sharply distinguish between the medical concept of a disorder from the representation of behavioural consequence. According to Wakefield (1997) when a condition involves no significant harm to the individual’s overall well being or the well being of others, there is no disorder, even if this obvious dysfunction is a naturally selected mechanism. This notion is further discussed in relation to the overconclusivness of kleptomania in classification.

In exploring this debate as relating to the impulse control disorders not elsewhere specified (ICD) – kleptomania, one can see the overlap of boundaries or in diagnostic terms, classification of what acts of impulsivity are either a cause or consequence of mental illness. Specifically, many authors (Dust, 1997; Bradford & Balmaceda, (1983), 1997; Keck, 1997; McElroy, 1992) have explored the commonality between what is described as an impulse control disorder and what results in impulsivity as a consequence of another diagnostic category. Such linkages include OCD, depression and anxiety. Table 1 summarises the overlap between kleptomania and other diagnostic criteria according the literature exploring the overconclusivness of the DSM classification system. These results indicate percentages of clients who present with Kleptomania yet held differential diagnosis in both in and out patient settings.

Table 1:

Depression 13% (Dust, 1997

Mood Disorders 50% (Bradford & Balmaceda, (1983), 1997)

Bulimia 14.79% (Bradford & Balmaceda, (1983), 1997)

Dependence Disorders 4.7%(Leyjoyeux, 1997)

Mania 56%(Keck, 1997)

OCD 62% (McElroy, 1992)

Anxiety 23%(McElroy, 1992)

Kleptomania:

Debate over impulsion leading to compulsion has led to the notion according to many authors such as McElroy, Hudson, Harrison, Kreck and Aizley (1992) that impulsion is an indirect response to the need to reduce anxiety. This exemplifies that the diagnostic criteria of ICD, does not represent individual criteria per se, but rather impulse control is an inevitable consequence of the desire to reduce anxiety. Likening OCD to kleptomania, McElroy et al., (1992) further argue that although not prevalent until further diagnostic exploration is attempted, does the clinician gain an adequate insight into how kleptomania is a result of the need to reduce anxiety. These authors argue that in a total of 124 clinical samples, anxiety was a major predisposing factor within a spectrum disorder pattern. In this kleptomania was an evident symptom in what is described as the OCD-Impulse control spectrum; a spectrum that holds no distinct classification, but rather is an encompassing spectrum of symptoms.

Similarly, Fishbain (1987) in a study exploring the relationships between psychological disorders and ICD depressive dispositions noted that depressive neurosis was a primary factor in 42 % of all patients presenting to an outpatient treatment clinic. This led to Fishbain (1987) exerting that perhaps within ICD, the primary diagnostic criteria of ‘impulsion’ is not a direct psychological construct, but rather a facilitator or consequence of a much larger psychological continuum. The continuum described places kleptomania as part of the psychosocial reaction model. In this model, kleptomania and the ICD’s in general are again placed in the spectrum of disorders that are representative of a continuum approach to viewing mental illness.

In applying findings to Wakefield’s (1992) original analysis of the overconclusivness of the DSM and the cause and consequence debate, distinction is not always evident in classification. Goldman (1997), argues that kleptomania within the adolescent population is indicative not of dysfunction, but rather is a response to a troublesome childhood. Therefore, kleptomania becomes a response to an affective environment in the teen, and is a demonstrative way of exhibiting dissatisfaction with lifestyle (Goldman, 1997). Harm then, is not a direct indictor of pathology but rather kleptomania is a consequence of the broader psychosocial spectrum. Moreover, Sarasalo (1996) further adds to this argument by expanding through a psychosocial model of viewing kleptomania. Sarasalo (1996) maintains that although the diagnostic criteria for kleptomania is defined according the DSM as: “recurrent failure to resist impulses to steal items even though the items are not needed for personal use or monetary value (DSM-IV, 1997); low socialisation of the individual can be a reinforcement of over stepping social boundaries. This indeed is plausible when one considers the commodity of kleptomania that includes depression and anxiety, as well as prognosis that begins in early childhood and adolescents. If this is the case, etiology of kleptomania becomes a social rather than psychological dysfunction. As the ICD -10 indicates that kleptomania is a response to a maladaptive environment, classification should therefore focus not what is the psychological underpinnings of kleptomania, but rather what is socially constructing it.

In summary, reports of discussed authors in relation to the criticism of the DSM classification system argue that:

♦ Diagnostic criteria is too broad, therefore comorbidity is high

♦ Comorbidity and differential diagnosis indicates that when treating kleptomania it should be regarded as a secondary symptom of a major psychological or psychosocial dysfunction.

Conclusions:

Contrary to the overconclusivness argument, Livesley et al., (1994) argue that in any classification system there must be some overlap or common thread running through sub-groups of a particular category. Therefore Livesley’s et al., (1994) counter-argument that evidence of discontinuity between different diagnoses and normality would support the DSM’s proposal of distinct diagnostic categories. According to these authors, there may of course, be a wide range of attribute’s within a category, but for the DSM to exist, it is essential that each of the classification subtype’s must be clearly defined and applied only to that specific disorder. Livesley et al., (1994) therefore reject the notion of a spectrum disorder and the overconclusiveness of the DSM. Further support for the exactitude of the current DSM classification system is ascertained in a study by Wittenborn (1981), describing individuals who shared a common diagnosis from one diagnostic category to another. It was found that clients differed greatly from each other in terms of symptom patterns that according to diagnosis had placed then in the same Impulse control disorder category. More simply what Wittenborn (1981) proposes is that overconclusivness is not a result of fault in DSM classification, but rather it is an inevitable process, as many persons share common complaints but their precise symptomolgy that places them within a distinct category is what separates them.

These authors contrary to many perspectives previously presented, argue that the presumed fundamental distinctions between one diagnostic criteria to another, in general has proven elusive for those committed to the current classification system. However, justification for overconclusivness is that most people experience all of the symptoms associated with each disorder in the DSM over some period of time. The difference between the subcategories however, despite the levels of overlap in symptomology, is seen to lie in the degree of persistence of the symptoms which in one subcategory (Wittenborn1981). It is therefore clinical judgement and appropriate use of any classification system that is used to determine the degree of severity, not what or how many categories can be placed upon the one individual. Perhaps this leads one to conclude that although overconclusivness is apparent in many diagnoses, it may be a question of who is over-conclusive, the DSM or user.

In summary however, in terms of the overconclusiveness of DSM criteria for kleptomania, as described by Wakefield (1992), it can be argued that the diagnostic criteria is too broad, reflected through high levels comorbididity with other disorders described. Hence comorbididity and differential diagnosis may include kleptomania and a secondary rather than primary condition. Moreover, the elusiveness of clients who fit neatly into one or another diagnostic category is perhaps most clearly illustrated in previously discussed overlapping subcategories. Thus clients that are described as having, for example Kleptomania with depressive tendencies may alternatively be Depressive with Kleptomaniac tendencies, but such a construct is not described in the DSM-IV or any preceding systems. Indeed this argument again leads to a question of primary or secondary diagnosis and cause or consequence.

Nevertheless, it should be stated that there are many problems associated with the current DSM-IV classification systems for ICD, specifically kleptomania. Therefore, despite the DSM’s attempts at repeated modifications to refine this category, the ambiguity of ICD still remains. However despite this acknowledgement must be given by the clinician that diagnosis at a more detailed level should be based upon a broader socio culture model that utilises classification not as a primary means of diagnosis, but rather as a system that highlights the possibilities in classification.

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