A Response to the Threat of a
Classification Scheme for the Psychosocial Disorders:
Some Specific Suggestions

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Having participated in the development of the American Psychiatric Association's new Diagnostic and Statistical Manual, DSM-II, and being a member of the APA's Committee on Nomenclature and Statistics, which is now looking toward the eventual development of DSM-III, I must candidly state that participating in a discussion of yet another classification scheme is for me a psychosocial stress of great magnitude. Individuals vary in how they respond to stressful situations of this kind. If one chooses not to flee (which might be the most adaptive response), the two alternatives are to discuss general principles involved in classification schemes, or to make specific suggestions to which others can respond. By temperament I choose the latter. Furthermore, it seems to me that the question, "Is a standard classification in psychosocial functioning needed and feasible?" can only be usefully answered after looking at some fairly specific proposals. We obviously don't need a poor classification scheme, and no one is completely satisfied with the one general scheme now available, the American Psychiatric Association's DSM-II.

The proposals that I make are geared to solve specific inadequacies that I believe are inherent in DSM-II for classifying individuals with the kinds of problems, conditions, disorders or illnesses that bring them to the attention of people
who have specialized training in one or more of the disciplines having to do with psychopathology. I make no claim as to their usefulness to individuals who do not have training in psychopathology but who, for one reason or another, are concerned or come into contact with individuals with psychosocial problems. These proposals are presented as an expansion and supplement to the APA classification system of DSM-II because I believe that only chaos would result from introducing a competing system, and that, as bad as it is, DSM-II is a good place to begin.

**Problem:** There is little relationship between specific DSM-II categories and manifest symptomatology.

**Proposal:** In addition to classifying subjects into one or more DSM-II categories, subjects should also be rated as to their current level of impairment in the following areas:

1) **Subjective Distress.** Examples: depressed or anxious mood, feelings of social isolation, suicidal thoughts, somatic concern.

2) **Behavioral Disturbance.** Observable disturbance in motor or verbal behavior. Examples: inappropriate affect, appearance or behavior; excitement; retardation.

3) **Impulse Control Disturbance.** Examples: antisocial impulses or acts, drug abuse, alcoholism.

4) **Reality Testing Disturbance.** Examples: delusions, hallucinations, grandiosity.

5) **Impaired Social Role Functioning.** This would be further specified as: a) occupational role (wage earner or housekeeper); b) parent role (relationship to children); c) spouse or mate; d) student; e) citizen.

The first four dimensions were chosen because there is considerable factor analytic data from many studies employing a wide variety of rating scales that indicates the utility of cutting up the phenomenology of manifest psychopathology in this manner. All dimensions could be rated on the following eight point scale of impairment: unknown, none, slight, mild, moderate, marked, severe, among the most extreme.

Obviously the dimensions would have to be carefully defined and examples of various levels of disturbance provided.

**Problem:** In most instances, DSM-II does not provide information as to the stage of the illness, yet this kind of information has great prognostic significance.

**Proposal:** DSM-II categories of illness should be supplemented by characterizing the current condition as either: 1) exacerbation of a chronic condition; 2) recurrence of a similar previous condition; 3) indistinguishable from past; 4) significant change from any previous condition.

**Problem:** In DSM-II, there is no way to indicate the clinician's judgment of prognosis for recovery, yet decisions as to the need for treatment must logically be based on a discrepancy between prognosis without special attention and with special attention.

**Proposal:** DSM-II categories of illness should be supplemented by a prognostic judgment as to recovery from current episode or condition within one year, both with and without a specific form of treatment. The ratings could be: very good, good, fair, poor, very poor. (This also indicates the need for a standard classification of treatments.)

**Problem:** DSM-II provides no way for specifying the precipitating events or the context in which a condition appears.
Furthermore, there is no way to indicate the level of stress associated with these events, despite considerable evidence that knowledge of stress has prognostic import.

Proposal: Stress of precipitating events associated with the development or exacerbation of a condition should be rated on the following scale: unknown, none, slight, mild, moderate, marked, severe, among the most extreme. Again, examples of different levels of stress would have to be provided. The specific precipitating events can be noted as one or more of the following categories: drug reaction, traumatic incident, someone's death, financial problem, physical illness in family, physical illness of subject, sexual problems, family problems, non-family interpersonal problems, school problems, occupational problems, and other change in life circumstances.

Problem: Several areas in the DSM-II classification lack sufficient specificity. This problem appears most acutely in the section on Disorders of Childhood and Adolescence and Social Maladjustment Without Manifest Psychiatric Disorder.

Proposal: The above two areas should be further subdivided into well recognized groupings that are not now reflected in DSM-II. The difficulty in the "Without Manifest Psychiatric Disorder" group would seem to be the problem of distinguishing the precipitating events or the context in which a condition develops from the classification of the conditions themselves. The following cartoon illustrates this problem, for which I know no solution. The classification problem is whether this lady has a disorder named "Acute togetherness" or whether she has, for example, "Depressive neurosis" precipitated by a change in life circumstances.

If these proposals were adopted, it would mean that at a minimum, each subject would be classified as to the type of disorder (DSM-II plus a few more categories as above), ratings on areas of manifest psychopathology (at least five areas), stage of illness, prognosis (two ratings), stress of precipitating events, and type of precipitating event. Adding on my fingers, this comes to at least eleven ratings per subject! I would think that this kind of multi-dimensional system would be more informative than DSM-II alone, but I must admit to real skepticism as to the feasibility of getting professionals actually to use such an elaborate system routinely. I am further discouraged by my ability to think of yet other axes on which it might be useful to classify subjects—such as extent to which environment suffers, and extent to which environment supports disorder.