CHAPTER 22

A Flexible Approach to Psychiatric Classification

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Systems of classification are somewhat like maps of incompletely explored territories; prettiness and popularity may be all we have to go by in making a choice, yet these qualities are no proof of accuracy. For a similar reason the choice between competing classifications in psychiatry is not easy; none has established a clear superiority in usefulness over all others. There exist few standards for recognizing and avoiding classifications that will lead the research worker to go around in circles or will strand the clinician in a desert of false predictions.

"The present status of the classification of behavior disorders is, to say the least, chaotic. There are at least 50 different types of classifications in varying degrees of use throughout the world ranging from those which deny the existence of behavior disorders as entities to those [which] regard all behavioral disorders as manifestations of a single underlying dimension— inability to cope with life's vicissitudes—to those [which imply] that there are differentiable entities in the field of behavior disorders just as there are entities in the field of physical disorders [Zubin, 1967, pp. 375–376]."

It is scarcely surprising that there is a bewildering range of choices in psychiatric classification, since for each purpose (and there are many) a different type of classification may be required. Determination of etiology, prediction of outcome, and selection of treatment are only three of the important aims of psychiatric classification. Furthermore, even when the focus is kept on one purpose alone, such as the detection of etiology, there is little to guide us as to which theoretical model we should adopt as a basis for a system of classification. Zubin (1968) has conceptualized no
fewer than six classes of scientific models that could be hypothetically applied to psychiatric etiology alone. Finally, cutting across the purposive and conceptual frameworks for systems of classification, there is a spectrum of assessment methods, from the intuitive to the statistical, for fitting subjects into a given framework.

In this aura of uncertainty the most graceful position for the clinician’s mind is to be open, though, in the words of G. K. Chesterton, “the object of opening the mind as of opening the mouth is to shut it again on something solid.” Hence the views expressed in this chapter will be tempered with a spirit of flexibility.

A few examples of the available classifications in the area of the mental or behavioral disorders will be reviewed, and their respective merits and demerits will be highlighted in order to demonstrate the value of moving freely from one classification to another as the purpose of the occasion demands. In addition, it will be shown that comparing and contrasting different classifications can lead to each being reciprocally illuminated and sharpened.

To simplify the examples used in this review, the first part of the chapter will emphasize the use of classifications in which the main purpose is to guide the management of the patient, and the data for classification are restricted to descriptive psychopathology. The second part of the chapter will deal with classification in which the main purpose is research into the etiology of psychiatric disorder, and the data include primarily descriptive psychopathology and neurophysiological responses. In the rest of the chapter the discussion will range a little more widely.

Throughout, a pragmatic view will be taken as to the usefulness of classifying psychiatric patients or their disorders. No absolute allegiance is given to any conceptual model, whether of the social-cultural, developmental, learning theory, genetic, internal environment, or neurophysiological type (Zubin, 1967).

THE APPLICATIONS OF CLINICAL, COMPUTERIZED, AND STATISTICAL CLASSIFICATIONS OF DESCRIPTIVE PSYCHOPATHOLOGY; AND THE USEFULNESS OF COMPARING THESE METHODS OF CLASSIFICATION

Clinical Method

Clinical diagnosis in psychiatry has been increasingly under attack, partly on the alleged grounds that it is unreliable (Kreitman, Sainsbury, Morrissey, Towers, & Scrivener, 1961; Ward, Beck, Mendelson, Mock, & Er-
baugh, 1962). By "clinical diagnosis" is meant the pithy label or short set of terms assigned to a patient by a clinician "so as to convey to himself and others as much as possible about etiology, the immediate manifestations, and the prognosis of the patient's condition [Shepard, Brooke, Cooper, & Lin, 1968, p. 13]."

Unreliability of diagnosis may arise for several reasons: the judgments upon which diagnosis is based are often highly subjective; the style of interview may differ between clinicians (Fiedler, 1950); the perception of psychopathology may depend on the training of the interviewer (Sharpe, Gurland, Fisher, & Fleiss, 1969); the vocabulary used to describe a patient's symptoms generally lacks universally accepted definitions (Sharpe et al., 1969); labels may be drawn from different diagnostic systems; and the criteria for placing a patient in a given diagnostic category may differ between psychiatrists from different training backgrounds (Kendell, Sharpe, Cooper, Gurland, Gourlay, & Copeland, 1971). These weaknesses of clinical diagnosis—despite its widespread usage—have until recently militated against its being the optimal method of classification for any purpose.

However, the method of clinical diagnosis has recently been vastly improved. The introduction of structured interviewing (Spitzer, Fleiss, Burdock, & Hardesty, 1964; Wing, Birley, Cooper, Graham, & Isaac, 1967) encourages consistency of interview style; inventories of items for rating behavior ensure coverage of a wide range of symptoms; ratings of discrete behaviors allow the separation of hard from soft data; and definitions of each item of behavior provide a common descriptive vocabulary. Capitalizing on these refinements of diagnostic method, Wing et al. (1967) showed that two clinicians could completely agree in 83.7% of cases on a provisional diagnosis based on the present psychiatric state of the patient. In addition, there is increasing usage of the International Classification of Diseases—the ICD (now the official diagnostic system of many countries, including the United States and the United Kingdom)—and the World Health Organization is working toward a common description of each label in the ICD. Hence clinical diagnosis need not be removed on grounds of unreliability from the repertoire of classificatory methods.

Aside from the issue of reliability, another reason advanced for doubting the value of clinical diagnosis is that heterogeneity and lack of specificity are evident in the symptoms shown by patients in a diagnostic group (Wittenborn, Holzberg, & Simon, 1953; Zigler & Phillips, 1961). However, this criticism may again be more a comment on the practice than on the potential of diagnosis. The relationship between the psychopathology shown by patients and the diagnoses made on them by public mental hospital psychiatrists has been shown to be far stronger in London than in New York (Gurland, Fleiss, Cooper, Sharpe, Kendell, & Roberts, 1970).

Where diagnosis is used to predict response to treatment or long-term
prognosis, it is likely that the more homogeneous are the groups with respect to psychopathology the more accurate will be the prediction. In fact, the definition of clinical diagnosis given at the beginning of this section is consistent with diagnosis based on mutually exclusive categories of descriptive psychopathology. Even then, this value of diagnosis should not stand or fall on whether it is the only determinant of treatment or the only predictor of outcome. There is no doubt “that variables other than diagnosis may be as important as, or more important than, diagnosis in predicing choice of treatment [Bannister, Salmon, & Lieberman, 1964, p. 731].” It is enough that a diagnosis summarizes a large body of information relevant to treatment and prognosis.

Given reliability, there is good evidence that clinical diagnoses can be useful. Organic states have quite different prognoses from affective disorders (Post, 1962; Roth, 1955); phobic neurosis responds less well to deconditioning if there is an admixture of obsessional neurosis (Gelder, Marks, Wolff, & Clarke, 1967); schizophrenics recover sooner and more fully with phenothiazines than with psychotherapy alone (May, 1968), but the same is unlikely to be true with personality disorders of the schizoid type; depressive states benefit from antidepressants (Pare, 1968), and manic states from lithium (Fieve, 1968; Gershon, 1968). These instances only touch on the list of useful predictions to be made from clinical diagnosis.

Whatever the usefulness of diagnosis, some clinicians would feel that conventional diagnosis carries with it certain connotations of an unacceptable nature. The use of the term schizophrenia may be taken to mean that the clinician believes the patient to be suffering from a biological disease and that the proper treatment is one of the somatic therapies. However, the flexible clinician is more pragmatic than theoretic in his approach to classification.

**Computerized Method**

Computer-programmed diagnoses (Glueck, 1965; Spitzer & Endicott, 1968), of either the logical decision tree or the probability model, have the signal advantage of rigid consistency in the criteria of the categories they can offer (although these criteria are by no means universally agreed upon, and two computer programs might give quite different diagnoses to the same patient). The decision tree method is somewhat more flexible than the probability model since “it does not require knowledge or estimates of the base rate of occurrence of symptoms or signs for each diagnosis (which is likely to vary from population to population) [Spitzer & Endicott, 1968, p. 746].” However, observations on or by the patient form the raw material with which the computer must work, and these
observations are not necessarily equally valid for all patients. Patients may relate their symptoms more or less accurately, depending on their education, language difficulty or proficiency, attitudes toward the hospital or toward middle-class psychiatrists, or level of psychiatric sophistication (Dohrenwend & Chin-Shong, 1967). Furthermore, florid symptoms such as auditory hallucinations may not have their usual morbid connotation in cultures with a strong mystical flavor (Kiev, 1964). There is no reason why computer programs should not take these reservations into account (other than the complexity of the task), but so far none of the programs available do so.

**Clinical versus Computerized Method**

Computer diagnoses are likely to be most useful when large samples of patients are to be compared between divergent psychiatric settings, but with the patients coming from much the same sociocultural background. On the other hand, clinical diagnosis might be preferred when the assignment of the individual patient to a category is important. When an atypical or unusual clinical picture is observed, it may be necessary to pursue a more refined exploration of the paradoxical symptoms in order to assess the weight of confidence to be placed in them.

"In the interpretations of observations, both wisdom and judgment play an essential part [and] of preeminent importance is judgment; judgment of the integrity of a patient, of his intelligence and the consequent weight to be placed on his statements, of the relative importance of different pieces of evidence; judgment of the value of instrumental and other technical procedures, and of no small moment, judgment of the specialists who carry out these procedures [Cohen, 1943, p. 19]."

Even more important than choosing between computer and clinical diagnosis is the possibility of fruitful interaction between them. Even in settings where individuals must be speedily categorized for clinical triage and reliance is therefore placed on clinical diagnosis, it is valuable to subsample the patients also with computer diagnoses. In this way, the comparability of diagnoses between clinicians and over time can be checked and discrepancies examined more closely. Conversely, when computer diagnoses are appropriate, a quality control can be kept by subsampling with clinical diagnosis, so that the programming of the computer can be modified if a particular diagnostic group is being inaccurately represented.

Glueck and Stroebel (1969) suggest that a close partnership between the clinician and the computer may lead to the best classification of a patient. After experienced clinicians have assigned patients to groups that
they expect to be distinctive, multiple discriminant analysis is used to calculate an optimal set of weights for subsequent classification. The probability of a clinically valid assignment is then determined on a further sample of patients. "Those patients who do not have high probability of membership in any of the available groups require further clinical scrutiny to determine if these are exceptional, uncommon, or highly deviant cases, or if new group categories should be created to accommodate them in the future [p. 5]."

Statistical Method

The application of statistical approaches to the organizing of psychiatric symptoms can enable a system of categories to be derived that are relatively free of traditional diagnostic prejudice. Discriminant function (or canonical variate) analyses can be used to classify patients, for instance, in terms of their response to treatment, while clustering or typological procedures (Lorr, 1966) provide syndromes of psychiatric symptoms that might not have been previously recognized. Both discriminant function and clustering analyses are based on discrete items covering the patient's symptoms and signs and can thus be independent of clinical diagnosis—although, when a clinician provides the discrete observations, a bias may be introduced toward finding clusters of symptoms or patients in accordance with his diagnostic expectations (Kendell, 1968).

In selecting treatment and predicting outcome for patients, discriminant function analysis may or may not be more accurate than other methods of classification (Meehl, 1954). Discriminant function can, after a trial of treatment, determine the features that best distinguish the treatment responders from the nonresponders. However, there is no way of assuring that the results obtained on one sample of patients will apply to other patients who differ in clinical or sociocultural features. Therefore, this statistical approach is most useful when the treatment repertoire is relatively stable and patients are more or less homogeneous.

As mentioned above, typologies derived by factorial analyses and clustering techniques (Moran, 1966; Pilowsky, Levine, & Boulton, 1969) may define groups of patients or disorders already recognizable within the traditional clinical framework or may point to new groups. The argument in favor of adopting such a new classification may rest on proof that a new group has, for instance, a characteristic etiology or treatment response that is more predictable than the one for the old group. Such proof, if forthcoming, should clearly swing the clinician in favor of using the new groupings. However, a quite different line of reasoning may be advanced to press the adoption of statistical typologies, namely, that they
represent discrete syndromes occurring in nature rather than in the clinician's mind. The latter line of reasoning is not convincing. There are many technical weaknesses in numerical taxonomies (Fleiss & Zubin, 1969), not the least of which is the need for a great number of cases gathered without selective bias from a widely representative population and examined with great care by reliable instruments covering a universe of items important to psychopathology. These conditions are rarely fulfilled. In addition, there is no general agreement about the proper statistical treatment of the data and consequently differing typologies may be derived from the same data.

**Statistical versus Clinical Method**

It is important for the clinician to be able to make independent decisions about treatment in addition to having the benefit of the discriminant function or typological analysis on a patient. One reason for this statement has already been mentioned, namely, that for some patients who are poor communicators the data derived from discrete items of information may be misleading. Another reason is that clinical judgments, in the present state of technology, may be the quickest method of reaching clinical decisions, particularly if the statistical approach requires feeding data into a computer. Also, in an era of spiraling medical costs it should not be forgotten that computers may be more expensive than clinicians. Above all, it is critical for the clinician to retain his skills in predicting and evaluating treatment in order to be able to detect an unexpected and thought-provoking outcome of treatment.

Many advances in the treatment of psychiatric illness appear to have occurred in such an unexpected manner that it is difficult to imagine how the strict system of observations necessary for statistical techniques could have substituted for the serendipity of the pioneering clinicians. Shrewd observations by clinicians led to the application of electroshock therapy in depressive disorders, the use of phenothiazines in schizophrenia, and the detection of the dangerous effects of cheese ingestion in patients who were taking monoamine oxidase inhibitors (Blackwell, Price, & Taylor, 1967). Iproniazid was a treatment for tuberculosis before it was noted to cause euphoria and was thus tried as an antidepressive agent (Crane, 1956). Imipramine was first tried in schizophrenia but found instead to help depressed patients (Kuhn, 1958).

Another factor making dependence on a rigid and strict system of observations undesirable is that the universe of items relevant to the description of a condition may change over time. The clinician is best situated to note and react to such a change. Ödegård (1967) has described the
disappearance of mutism, posturing, and extreme incoherence from the characteristic picture of schizophrenia and has pointed to the emergence of subtle abnormalities in place of the previously gross symptoms.

Granted that clinical diagnosis and statistical approaches to classification can coexist, that in itself is not enough. Integration is a higher ideal. The clinician can sharpen his own powers of discrimination by learning to recognize in the consulting room the behaviors and constellations of behaviors of the patient which have proved statistically to be most distinctive for prognosis or treatment response. When the identification of statistically derived types of patients appears useful, the clinician may improve his ability to identify these types by checking his own attempts against the statistical analysis based on a patient's discrete data.

Nathan, Robertson, and Andberg (1969) examined the degree to which traditional judgments about the diagnostic significance of psychopathology were matched by the actual behavior of patients in various diagnostic categories. After nineteen common symptoms of affective psychopathology had been evaluated, several unexpected findings emerged. For instance, anxiety did "not reflect sensitive differences in psychopathological conditions, a conclusion which goes directly against traditional psychiatric teaching which emphasizes the utility of anxiety as a prime indicator of the psychoneuroses [p. 241]." Furthermore, the symptoms of depersonalization reflected "acute turmoil and an impending psychotic episode" rather than schizophrenia. On the other hand, elevated mood was a "sensitive measure of a restricted number of psychopathological conditions [p. 241]." The implication of these findings is that traditional diagnostic thinking must be reformulated so as to accord with the facts.

RESEARCH INTO ETIOLOGY: THE APPLICATIONS OF CLASSIFICATIONS BASED ON PSYCHOPATHOLOGY AND ON PHYSIOLOGY AND THE USEFULNESS OF COMPARING THESE TYPES OF CLASSIFICATION

Psychopathological System

The psychopathology shown by a patient is the very stuff that forms the conventional definitions of psychiatric disorder. Thus a classification of psychiatric disorder based on psychopathology might be expected to be useful in the sphere of clinical practice. This expectation is partially fulfilled, for instance, in that psychopathology is a useful prognostic indicator and a determinant of appropriate treatment (Gurland, Fleiss, Sharpe, Simon, Barrett, Copeland, Cooper, & Kendell, 1972).
However, confidence in the validity and potential usefulness of a psychopathological classification would be increased were there more certainty about the relationship between psychopathology and physiology. Different emotions may give rise to the same physiological state. Thus Gelder and Matthews (1968) found it impossible to distinguish between the arousal of a subject (as measured by forearm blood flow) occasioned by performing an annoying task of mental arithmetic and that arising from fearful visualizations of a phobic situation. Furthermore, the same clinical state may result from quite different physical causes, as is seen in the schizophreniform syndromes occurring in disseminate lupus erythematosus, temporal lobe epilepsy, and myxoedema. Conversely, in our ignorance, we must assume that different clinical syndromes may arise from the same underlying physical process. As Hudson (1965) pointed out in the case of Treponema pallidum, the manifestations of disease produced by a single physical agent may vary dramatically between cultural groups.

Physiological System

Physiological behavior could constitute an objective, precise, and rational basis for classifying psychiatric patients or their disorders. To achieve this end, the abnormality of the physiological behavior chosen for testing must either be related closely to the mechanisms underlying psychopathological behavior, or occur exclusively within a class of psychiatric disorders defined on, for instance, clinical grounds. Nothing so pure is yet available for either alternative. Thus, although physiological tests have potential value as diagnostic tools (Zubin, 1966) and as predictors of a patient's response to treatment (Shagass, Naiman, & Mihalik, 1956), in actual clinical practice they are hardly ever used in these ways.

Psychopathological versus Physiological Systems

Important consequences would flow from the achievement of a perfect relationship between a physiological abnormality and a distinct type of psychopathology. There would be a high likelihood of a causal relationship between that physiopathology and psychopathology; the former could be used as an objective measure of the latter; and there would be good reason to expect that type of psychopathology to have a characteristic etiology, natural history, and response to treatment.

Unfortunately, such a perfect relationship has not yet been found in such psychiatric disorders as neuroses and the functional psychoses; therefore we must start with imperfect relationships and try to make them more perfect. One way of doing this follows the lines of an iterative technique (Sutton, 1970; see also Chapter 10, this volume). The iterative technique starts by an examination of the relationship between different classifications
(e.g., physiological and psychopathological) on a given group of subjects. Each classification is then progressively modified so as to improve the relationship on successive groups of subjects.

The initial step in the iterative process might be the choice of a psychopathological classification that is reasonably expected to reduce variance among groups of patients for the physiological behavior under examination. Separation of subjects into schizophrenics and “normals” might constitute such a classification, with reaction time as the relevant index of physiological behavior. Reaction time has been extensively tested in these groups (Huston, Shakow, & Riggs, 1937; Sutton, Hakerem, Zubin, & Portnoy, 1961; Zubin & Sutton, 1970). A noniterative approach would end by assessing the significant differences between the two groups in reaction time (e.g., concurrent validation). The iterative technique goes further and reviews the psychopathological classification scheme in the light of the reaction time results. If there was (as is generally found) considerable overlap between the reaction times of schizophrenics and normals, then both of these groups would be refined with the hope of reducing the overlap. Of course, the success of this venture would have to be tested on new samples of subjects.

Refinement of the clinical classification could proceed by a priori reasoning. Either group may contain patients who have been mislabeled; in that event, consensus diagnoses between clinicians of different persuasion or between psychiatrist and computer may isolate a purer group of schizophrenics or normal individuals (Krieger, 1967). Alternatively the schizophrenics may be sorted into subgroups within which behavior is relatively homogeneous; for instance, if specific symptoms such as affect might determine the reaction time results, the schizophrenics with blunting of affect might be separated from those with depression; or if certain syndromes are regarded as crucial, then perhaps patients with blunting of affect, thought disorder, and delusions of control might be grouped together. There are many variations on this theme, such as separating patients with process and with reactive schizophrenia, those with and without family history, or those in active and in quiescent phases.

Refinement of the clinical classification would also proceed in a more empirical manner than that outlined above. Schizophrenics can be divided into classes in terms of their reaction times, and a search may be instituted for the clinical characteristics that might also distinguish these classes. The search can be imaginatively clinical or mathematically disciplined (e.g., multiple regression analyses). Insights into relevant clinical groups can facilitate the selection of additional cases for the reaction time experiments. In this way, by successive approximations, groups of patients can be defined with increased chances of having a common etiology, natural history, and
treatment response. Thus the iterative process may lead by gradual stages to the discovery of a valid and useful psychiatric classification.

An outstanding example of the iterative technique may be found in the work of Satterfield (1969). He subdivided a sample of depressed patients into three groups on the basis of the recovery functions of their auditory evoked responses. The two extreme groups (hyper- and hyporecovery) differed also on other aspects of their evoked potentials, suggesting "a basic neurophysiological difference" between these groups. Satterfield further examined their responses to electroconvulsive therapy and their family histories of depressive disorder. These features again distinguished the groups, "lending weight to the validity of the notion that these may indeed be two different kinds of depressive disorder [p. 25]." Following up this notion, Satterfield explicated a rationale for expecting the hyper-recovery group to respond best to psychic energizers and the hyporecovery group to respond best to tranquillizers, and promises a replication study followed by a comparative trial of the effectiveness of the drugs mentioned above.

The iterative technique could also be usefully applied to the controversy about whether there is continuity or discontinuity between certain diagnostic categories. This is particularly relevant to classification of the affective disorders. Clinical approaches alone have not settled this issue, and statistical treatment of clinical ratings has failed to provide a definitive solution. An iterative approach linking clinical with biochemical and psychological measures might provide evidence for or against the continuum hypothesis of neurotic and psychotic depression.

Court (1968) builds on such an approach in urging that mania may be a severer form of the psychotic process underlying depression. He presents equivocal clinical evidence of a continuum (e.g., depression may sometimes shift to mania without an intervening period of normality; additional stress may sometimes provoke mania in a depressed patient; electroconvulsive therapy and lithium may be effective in both conditions). To support this clinical evidence he quotes Coppen (1965), who states that "manics show the same shift in residual sodium as do depressives but with a more extreme departure from normality [p. 1138]." Court derives similar support from simple reaction time experiments, both his own and those of Lundholm (1922). He moves to the clearly iterative technique when he indicates that only some types of depressive disorders may lie on this continuum. The clues he presents for differentiating these depressive disorders are the response to lithium and the level of urinary 17-hydroxycorticosteroids (Bunney & Mason, 1965). This interplay of concept, clinical observation, treatment response, and physiological or psychological measures lies at the heart of the iterative process.
A wide-ranging strategy for the initial steps in the iterative process has been adopted by Ralph Gerard and his coworkers (Gerard, 1964). This multidisciplinary group of researchers carried out a seven-year program entitled The Schizophrenia and Psychopharmacology Joint Research Project. They examined 208 male patients at the Ypsilanti State Hospital, about half these patients being independently diagnosed as schizophrenic by three psychiatrists. The patients were given approximately 400 separate measures, including psychiatric rating forms, ward behavior inventories, psychological test batteries, and physiological and biochemical tests. Patients were divided into five subgroups by clinical means. Gerard reports:

“At least two kinds of schizophrenia (paranoid and non-paranoid) that had been separated on the basis of clinical criteria were also separated by our tests. It was very satisfying to find that in many respects our results do fit in with clinical subgroups, while differing in useful ways [1964, p. 331].”

However, these workers did not stop here. By successive factorial screening of the schizophrenic sample, and using measures only from the areas of psychology, physiology, and biochemistry (i.e., excluding psychiatric data), seven subgroups of patients were derived. According to a psychiatrist with this project (H. von Brauchitsch) “the seven groups . . . appeared to present well defined and easily recognizable clinical entities [p. 332].” Gerard concludes that after seven years of study, by a team that included at its peak more than 40 scientists, there emerge from the amassed data “seven clear subgroups” of schizophrenia, and “anyone who does research or theorizing in the future . . . can advance from this base [1964, p. 333].”

OTHER ASPECTS OF FLEXIBILITY IN CLASSIFICATION

There are times when change may be required, not in the way of classifying patients but in the labels given to the various classes. A diagnostic label may have connotations that reflect past usage rather than current knowledge. For instance, as late as the 1920s in the United States, “schizophrenia” was extensively used only for patients with a poor prognosis (Lewis, 1966). Although there is wide recognition today that schizophrenia has improved in prognosis since the introduction of the term [mainly with the advent of somatotherapy around 1934 and of pharmacotherapy around 1955 (Ödegård, 1967)], it is still possible that a patient with a benign form of schizophrenia might be handicapped in obtaining early release from hospital because a pessimistic attitude, based on the earlier views of schizophrenia, pervades the staff. Moreover, the
expectation that schizophrenia will follow a slow course of only partial recovery may lead to a self-fulfilling prophesy. As Szasz (1966) persistently warns us, psychiatric diagnoses may be “swung as semantic blackjacks [p. 148].” In these circumstances a change in the name of his disorder may be beneficial to the patient.

When Not to Adopt a Flexible Approach to Classification

Up to now, this chapter has proposed a flexible approach to classification and one that is open to change. There are advantages, however, to setting limits to such flexibility. Longitudinal studies on the prevalence of psychiatric disorders cannot be pursued if diagnostic criteria change over time. Also, communication between psychiatrists, either within or between countries, is made more difficult by an unstable system of classification. For certain purposes, therefore, it may be necessary to adhere to a rigid and arbitrary diagnostic system.

When Not to Classify Patients

Finally, it is willingly acknowledged that there are aspects of psychiatric treatment that clearly do not hinge upon gross classification of the patient. When one treatment mode, such as psychoanalysis, is favored above all others, there is less need to resort to gross classification. The same holds true when all disorders are held to be maintained by the same mechanism or to arise from the same etiology, such as conditioned maladaptive responses. “What is the new look of diagnosis?” asks Salzinger (1970). “The new look says to look where the behavior is! . . . There are only three basic concepts to be learned and they are discriminative stimulus, response class, and consequence of the response (that is, reinforcement) [p. 26–27].” In these instances it is more pertinent to elicit and classify at a discrete level the unique features of the patient’s life history that enable application to his condition of psychoanalytic or learning theory methods, as the case may be.

Some behavioral analysts, such as Kanfer and Saslow (1969), argue that each patient must be treated in the light of his unique experiences. Categorization of the patient, by conventional diagnoses or symptom classification, is of little help in predicting the outcome of treatment.

“Therapeutic intervention can be based on a comprehensive knowledge of two sets of variables which maintain problematic behaviors: those inferred from the patient’s history, and those in his current situation. . . . This approach sacrifices the taxonomic features of the usual diagnostic enterprise for greater specificity and heavier contributions of the obtained observations toward direct use in the therapeutic intervention [Kanfer & Saslow, 1969, p. 443].”
Yet Cooper, Gelder, and Marks (1965) have shown, and Gelder et al. (1967) have confirmed, that isolated phobias respond better than agoraphobias to treatments based on learning principles. The response to desensitization may depend as much upon the type of disorder treated as upon the particular method (of desensitization) employed (Gelder & Marks, 1966). Furthermore, parts of the assessment technique suggested by Kanfer and Saslow might be misleading if given to a patient during an affective disorder. For instance, one step in assessment, the motivational analysis, deals with how a patient ranks “various incentives in their importance to him [Kanfer & Saslow, 1969, p. 426].” This ranking, whether made by the patient or by independent observers, would seem to require cautious interpretation if the patient is affectively disordered. Finally, it seems premature to assume that a classification based on symptoms cannot be a useful initial guide to treatment, especially of the pharmacological variety. Nevertheless, it is well to bear in mind that the determination of treatment requires more than classification of the patient. Flexibility in the choice of classification extends to opting to minimize classification of the patient in certain circumstances where treatment is better approached from a unitary viewpoint.

SUMMARY AND CONCLUSIONS

This chapter is based on the premise that, for the present, the most useful approach to psychiatric classification is to be flexible. Flexibility means choosing one or more classificatory methods (e.g., clinical, computerized, or statistical) or systems (e.g., psychopathological or physiological) that suit the purpose of the moment (e.g., prognosis, selection of treatment, or detection of etiology), and making a different choice for other purposes at other moments.

Flexibility also means a willingness to modify classifications so as to improve their usefulness. In this chapter a way is described of highlighting the aspects of a classification that need refinement by contrasting one method or system of classification with another. One example given is that computer diagnoses can reveal inconsistent criteria in clinical diagnoses; conversely, clinical diagnoses can detect inappropriate grouping of patients by the computer. A more elaborate process for sequentially contrasting and modifying classifications (“the iterative process”) is also described.

Finally, in pursuing the theme of flexibility in classifying psychiatric disorders, this chapter paradoxically mentions occasions that call for a rigid approach to classification, such as when studying changes over time in the prevalence of psychiatric conditions. Also mentioned are occasions
that require minimizing classification in order to treat each patient according to his unique characteristics.

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