But is it Good for Science?

Joseph Zubin
VA Hospital Highland Drive Pittsburgh

and

Department of Psychiatry, University of Pittsburgh School of Medicine

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The first question that can be raised about a new classification
is cui bono and this symposium has raised such questions as, is it good
for psychology, is it good for the patient, is it good for psychiatry?
Presumably, it must be good for psychiatry since it was developed by a
Psychiatric Task Force. Whether or not it is good for science, is the
burden of this paper.

This is not the first attempt at improving diagnosis. We have
had DSM I, DSM II and, of course, the pre DSM era with attempts at
improvement of diagnosis, and Szasz is not the first to advocate its
abandonment. I am reminded of what Heinrich Klüver wrote me when
I told him of our US-UK study to investigate the diagnostic discrepancy
between the two countries. He wrote:

"I guess something has to be done in re the
diagnostic discrepancies, etc. you speak of. As
things are, attempts are still made, as (A.) Hoche in
Freiburg once expressed it, "To clear turbid solutions
by pouring them continually from one glass to the
other."

Despite these strictures, considerable effort has gone into im-
proving the diagnostic schema. But has it been good for the science of
psychopathology?
Alexander Wolf (1929) has pointed to the importance of classification for science as follows:

"Scientific classification seeks to formulate a scheme of mutually exclusive and collectively exhaustive categories based on the most important characteristics of the things concerned and on the actual relations between them ... The more nearly a classification approaches the aforementioned ideal the better is its claim to be called a natural one; a classification that deviates from this ideal, as usually happens when it is made for some practical human purpose, is called artificial ... In the history of every science classification is the very first method to be employed; but it is much older than science. Every name, indeed almost every word, of a language is the expression of some implicit classification; and language is older than science. The classifications expressed in ordinary language are, however, the result of practical needs rather than of scientific interests, so that science has to correct them even when it starts from them."

The most significant aspect of this statement is the "natural" as opposed to the "artificial" classification, the one which carves nature at the joints vs. the one that carves it along arbitrary lines dictated by values other than natural or scientific. It is in this respect that one must regard DSM III as at least in part artificial. Part of this artificiality arises from lack of knowledge of the location of the natural cleavage in human behavior between the normal and abnormal. In part, however, this artificiality may have crept in because of practical needs rather than scientific interests. Among these was the need to base decisions on a consensus requiring compromise between contrasting points of view. Entrenched clinical practice and such consideration as utility, ease of application, acceptability to practitioners, third party payments, professional considerations and other extraneous influences. This is not to derogate the introduction of biases based on practicality, but these should be