

HL IB Psychology

Factors Influencing Diagnosis: Classification Systems

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Diagnostic & Statistical Manual of Mental Disorders & International Classification of Diseases

Diagnostic & Statistical Manual of Mental Disorders (DSM-5)

What is the DSM-5?

- The **DSM-5** stands for the **Diagnostic and Statistical Manual** which is now in its fifth edition (hence the -5 in the title), having last been published in 2013 and updated in 2022
- The DSM-5 is a **diagnostic tool** used by any medical professional who is qualified to give a **diagnosis** pertaining to a **mental disorder** e.g. doctors, clinicians, **psychiatrists**
- The DSM-5 is published by the **American Psychiatric Association (APA)** who, at given intervals, **review and revise** the current edition and make recommendations as to what should be removed from or added to the next edition
- Some behaviours or conditions which appeared in previous editions of the DSM have since been removed from more recent editions e.g. **homosexuality** (removed in 1973); **gender identity disorder** (removed in 2012)
- Some behaviours or conditions which did not appear in previous editions of the DSM have since been added to the DSM-5 e.g. **hoarding disorder** and **binge eating disorder** (both were added in 2013)

Hoarding is now considered to be a disorder according to the most recent version of the DSM-5.

How is the DSM-5 different to previous versions of the DSM?

- Previous versions of the DSM (which you may be familiar with via your study of Psychology) used five **axes** to **categorise** the different **dimensions** of mental disorder **classifications** e.g. Axis I grouped **clinical disorders** such as **anxiety**, **schizophrenia** and **depression** together
- The DSM-5 has removed the five axes in a bid to simplify and streamline the manual and the means by which a mental disorder can be diagnosed
- Medical experts had complained that there was very little difference between some of the axes which, they argued, could lead to confusion, **unreliable** diagnoses and, potentially, the patient receiving the wrong **treatment** for their condition
- The DSM-5 uses a **single axis system** i.e. it has combined axes 1–3 into a single axis that accounts for mental and other **medical** diagnoses specifically related to **brain dysfunction** or illness
- The DSM-5 removed the distinct categories it had previously used for mental health diagnoses, medical diagnoses, and personality disorders
- The DSM-5 is organised into three sections:
 - Section I: DSM-5 Basics: a guide for medical professionals on how the manual should be used
 - Section II: Diagnostic Criteria & Codes: the largest section in the manual which comprises **types**, **definitions** and **explanations** of conditions/disorders

Section III: Emerging Measures & Models: information and guidance as to how to apply specific diagnostic tools, the ways in which **culture** may affect diagnosis and an insight into which conditions/disorders may be included in future editions

Evaluation of the DSM-5

Strengths

- The most recent revisions to the DSM-5 reflect **social change** and **socially sensitive** issues e.g. the removal of gender identity disorder means that individuals who do not **conform** to traditional gender roles/identity are not classified as **abnormal**/mentally ill
- The DSM-5 acknowledges that **cultural differences** must be considered when making a diagnosis which should ensure that **ethnocentricity** and **universality** do not interfere with diagnosis

Weaknesses

- As is the case with all diagnostic manuals there is the risk that being given a diagnosis of mental illness can lead to **stigmatisation** and 'labelling' of the individual as 'abnormal'
- The DSM-5 uses broad categories to determine the type of disorder and how it should be treated which tends to lose the individual and the complex nature of their condition in the process which means that it may lack validity

International Classification of Diseases (ICD11)

What is the ICD-11?

- The ICD-11 stands for the International Classification of Diseases which is now in its eleventh edition (hence the -11 in the title), having last been published in 2022
- The ICD-11 is a diagnostic tool used by any medical professional who is qualified to give a diagnosis pertaining to both physical and mental disorders e.g. doctors, clinicians, psychiatrists
- The DSM-5 is published by the **World Health Organisation (WHO)** who, at given intervals, **review and revise** the current edition and make recommendations as to what should be removed from or added to the next edition
- The ICD-11 does not just focus on mental disorders: its scope includes **physical illnesses** and conditions such as **Covid-19**
- The ICD-11 works on a **global scale** (the DSM-5 is only focused on North America), looking at the causes of, the extent of and the consequences of disease and **morbidity** rates across the world
- The ICD-11 uses the data it has gathered to inform worldwide **health initiatives** and research into disease (both physical and mental)

How is the ICD-11 different to previous versions of the ICD?

- Changes to ways in which diseases, disorders and causes of death are **coded** mean that the ICD-11 provides a more **refined and detailed** tool for the classification of both physical and mental illnesses than in previous versions
- This refinement to the coding system means that illnesses can be classified and recorded more specifically and precisely
- The ICD-11 has been translated into 43 languages and makes more allowance for **cultural variations** than did previous versions
- The ICD-11 takes into account the growing importance of **digital technology** and so it has been designed with user-friendly software and a platform which can be accessed globally
- Some behaviours or conditions which appeared in previous editions of the ICD have since been removed from the ICD-11 e.g. **acute stress disorder**; **personality disorders** (these have been combined into just 'personality disorder' singular)
- Some behaviours or conditions which did not appear in previous editions of the ICD have since been added to the ICD-11 e.g. **gaming disorder** and **prolonged grief disorder**

Evaluation of the ICD-11

Strengths

- The global scale of the ICD-11 means that it has wider **generalisability** and application than the DSM-5
- The inclusion of physical illnesses along with mental illnesses means that the link between both mind and body is acknowledged hence it takes a more **holistic** approach than the DSM-5

Weaknesses

- The inclusion of physical illnesses along with mental illnesses could, conversely, mean that the manual is 'diluted' in its approach to diagnosis i.e. it is trying to cover too many bases all at once
- The removal of 'personality disorders' from the ICD-11 could result in a patient being **misdiagnosed** e.g. they may present with **antisocial personality disorder** but their diagnosis would be more generalised under ICD-11 criteria which could result in them receiving insufficient treatment for their disorder

Two Key Studies of Classification Systems

Key Study One: Haroz et al. (2017)

Aim: To investigate the **diagnostic criteria** of the **DSM-5** with regard to possible **culture bias** linked to the diagnosis of **depression**.

Participants: 16,130 records were used to form the basis of this research which comprised of 138 studies with data derived from 170 **samples** across 77 nationalities/ethnicities (the total number of participants across the sample is not stated in the original article).

Procedure:

- A review of **qualitative** research on depression across the world conducted between August and December 2012 (updated in June 2015)
- **Statistics** were used to compare features of depression across **nationality, region, gender and context** i.e. qualitative data was translated into **quantitative data**
- Four independent experts **rated** the items from 1–5 on measures such as their **credibility**, lack of **bias** and **transferability** and these ratings were compared with the DSM-5 and other established systems for measuring depression

Results:

- The DSM-5's classification for diagnosis of depression agreed with 7 of the 15 features identified by the experts
- Several other features of depression which occur frequently (e.g. poor concentration) were not given priority by the DSM-5 and thus were not included as a standard way of measuring depression
- The DSM-5 model was found to not adequately reflect the experience of depression at worldwide or regional levels i.e. it is overly **individualistic** and westernised in its approach

Conclusion: The DSM-5 may not be applicable to a range of cultures across the world and may suffer from cultural bias which means that it may lack **validity**.

Evaluation of Haroz et al. (2017)

Strengths

- The results of the study could be used to inform clinicians to be wary of assuming a **universalist** approach and to consider the role of culture carefully when forming a diagnosis
- The large sample size should ensure that the quantitative results are **robust** which should increase the **reliability** of the findings

Limitations

- Using **secondary data** means that the researchers could not be 100% confident that all the studies included in the research had been conducted with care and attention to detail which would affect the credibility of the research
- Translating qualitative data into quantitative data necessarily involves sacrificing meaning, **subjectivity** and context so that the data's **explanatory power** is lost

Key Study Two: Mojtabai (2011)

Aim: To question whether **bereavement-related depression** should be excluded from the DSM-5.

Participants: A **community-based sample** of participants (who were taking part in the *National Epidemiologic Survey on Alcohol and Related Conditions*) from the USA who were tested in two phases (43,093 in phase 1; 34,653 in phase 2).

Procedure:

- The participants were part of a **retrospective longitudinal** study into **grieving** and depression conducted from 2001 to 2002 and from 2004 to 2005
- The researchers used **structured interviews**, using the *Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV* (DSM-4) version to guide the type of questions asked
- The interview schedule described above was designed to as a **diagnostic tool** used to diagnose **mood, anxiety, substance abuse**, and other related disorders
- The researchers measured **demographic** characteristics of the participants including their age at the onset of their depression; if there was a history of depression in their family; if they had used mental health services, and any new depressive episodes they experienced during the 3-year follow up period
- Major depressive episodes were defined as having a duration of at least 2 weeks, during which the participant would have experienced 5 or more of the nine *DSM-IV* (DSM-4) symptoms, particularly **impairment** and/or **distress**
- The **qualitative data** collected via interview was translated into **quantitative data** via a specific **scoring system**

Results:

- Participants with bereavement-related, single, brief depressive episodes tended to be older at onset, were more likely to be African-American, and were less likely to have had impairment, anxiety disorders or a previous psychiatric treatment history
- These participants were also less likely than other participants with bereavement-unrelated, single, brief depressive episodes to experience **fatigue**, increased sleep, feelings of worthlessness, and suicidal thoughts
- These participants also had a much lower risk of developing depression during the follow-up period

Conclusion: The **DSM-5** should exclude bereavement-related depression from the list of depressive episodes requiring treatment as these can be explained by the bereavement itself, they are not signs that a person is prone to depression generally.

Evaluation of Mojtabai (2011)

Strengths

- The use of a longitudinal design meant that the researchers were able to track depressive episodes across time which enabled them to form their conclusion that depression is a natural consequence of bereavement, thus the findings have validity
- Research such as this is important as it can help to inform future revisions and reviews of the DSM-5 which shows that the findings have good **application**

Limitations

- It is possible that participants suffering from depression may not be able to assess their feelings and mood **objectively** which means that the results could lack reliability
- The responses of the participants may have been affected by investigator effects (i.e. they may have liked/disliked the researcher disproportionately) which would in turn decrease the validity of their response



Worked Example

The question is, 'Discuss the use of classification systems in diagnosis'. [22]

This question is asking you to offer a considered and balanced review of the use of classification systems in diagnosis that includes a range of arguments, factors or explanations. Here is an exemplar paragraph for guidance:

Classifying mental disorders can be problematic because to do so requires using diagnostic tools that are standardised and which are in agreement as to what constitutes 'abnormal' behaviour. Mojtabai's (2011) research highlighted one issue with the DSM-IV (now in its fifth iteration as the DSM-5) in that it classified bereavement-related depressive episodes as evidence of abnormal behaviour. A common sense view of bereavement is that it tends to produce low mood, dysphoria, tearfulness etc. in the bereaved person, all of which are understandable features of the grieving process. To label depressive symptoms as 'abnormal' in the context of bereavement means that someone who is progressing through the stages of grief might be told by a clinician that they have clinical depression. This diagnosis could in turn lead to a self-fulfilling prophecy ('They told me I'm depressed, therefore I must be') and to treatment which is not necessarily helpful or appropriate e.g. SSRIs prescribed for long-term use.