7-1-2006

Beyond the DSM-IV: Assumptions, Alternatives, and Alterations

Shane J. Lopez
University of Kansas Main Campus

Lisa Edwards
Marquette University, lisa.edwards@marquette.edu

Jennifer Teramoto Pedrotti
California Polytechnic State University - San Luis Obispo

Ellie C. Prosser
University of Texas at Dallas

Stephanie LaRue
Dwight D Eisenhower Veterans Affairs Medical Center

See next page for additional authors

Authors
Shane J. Lopez, Lisa Edwards, Jennifer Teramoto Pedrotti, Ellie C. Prosser, Stephanie LaRue, Susan Vehige Spalitto, and Jon C. Ulven

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Current diagnostic processes reflect the limitations and utility of the framework of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV;* American Psychiatric Association, 1994). Clinical information in the *DSM-IV*'s 5-axis system almost exclusively focuses on weaknesses and pathology and is summarized in a flawed categorical system. Hence, the authors describe 3 adjunctive, or alternative, means of conceptualizing behavior; several means of altering the current *DSM-IV* system; and 2 future directions in the diagnosis of strengths.

Traditionally, psychodiagnosis has focused on symptomatology and dysfunction—that which is not working in a person's life. Within the framework of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM-IV;* American Psychiatric Association [APA], 1994) and the later text revision (the *DSM-IV-TR;* APA, 2000), each diagnosis represents a negative syndrome comprising a cluster of symptoms associated with clinically significant impairment or distress. Rather than addressing these syndromes as environmentally or situationally determined, the developers of the *DSM-IV* framed mental disorders as dispositional (i.e., something that is *within* the individual and part of his or her psychological makeup). This focus on negative aspects has occurred at the expense of identifying the strengths of individuals and their environmental resources and of assisting people in their pursuit of optimal human functioning.

In this article, we identify limitations in current psychodiagnostic practices and the *DSM-IV* framework and offer alternative means for conceptualizing behavior. More specifically, we address unsubstantiated assumptions about mental illness and psychodiagnosis that undergird the use of the *DSM-IV*. We then offer three adjunctive, or alternative, means of describing behavior and mental health. Finally, we discuss ways to alter the *DSM-IV*'s five-axis system so that strengths and resources can be detected and described within the existing framework.

Assumptions About Psychodiagnosis and the *DSM-IV*

In this section, we hope to establish that reification of and reliance on the *DSM-IV* system are grounded in the assumption that clinicians are getting the "whole picture" of a client from a diagnosis based on the *DSM-IV* system. This is not the case. Failure to acknowledge the assumptions that undergird the *DSM-IV* system and the associated limitations of this meaning-making tool will perpetuate the disconnect between diagnosis and treatment. (See "Stopping the Madness" by Maddux, 2002, for a detailed deconstruction of illness ideology that served as the intellectual stimulus for this article.)

Assumption 1: Mental Illnesses Are "Facts" and Can Be Classified in Discrete Categories

The *DSM-IV*'s (APA, 1994) and the *DSM-IV-TR*'s (APA, 2000) diagnostic system is based on the assumption that "mental illness" reflects "facts" about people struggling in the world. "Disorders" are created based on reports of complaints and functional disturbances, with arbitrary distinctions being drawn between types of dysfunction. Once these distinctions are made, the cluster of symptoms is given a name and is thereby transformed into a real entity. In this way, it may be said that illnesses are created and do not necessarily re-

Shane J. Lopez, Department of Psychology and Research in Education, University of Kansas; **Lisa M. Edwards,** Department of Counseling and Educational Psychology, Marquette University; **Jennifer Teramoto Pedrotti,** Department of Psychology and Child Development, California Polytechnic State University, San Luis Obispo; **Ellie C. Prosser,** Student Counseling Center, University of Texas at Dallas; **Stephanie LaRue,** Dwight D. Eisenhower Veterans Affairs Medical Center, Leavenworth, Kansas; **Susan Vehige Spalitto,** private practice, St. Louis, Missouri; **Jon C. Ulven,** Counseling, Career and Academic Support Center, St. Cloud State University. Correspondence concerning this article should be addressed to Shane J. Lopez, Department of Psychology and Research in Education, 621 Joseph R. Pearson Hall, University of Kansas, Lawrence, KS 66045 (e-mail: sjlopez@ku.edu).

flect facts about individuals (Barone, Maddux, & Snyder, 1997). Barone et al. suggested that through this process diagnoses and their representative labels are reified, and the cluster of symptoms begins to be recognized more often. Clinicians then diagnose the disorder more frequently, and a disorder takes on a life of its own. It is interesting that some of these diagnoses eventually will become antiquated descriptors because changes in people's beliefs lead to changes in societal norms and values, further reflecting the descriptors' constructivist nature.

Evidence of the reification of the *DSM-IV* categories can be found when considering the ever-expanding explanatory power of the system. Barone et al. (1997) have indicated that the scope of mental disorders has broadened to include what many would consider problems that are less serious, such as caffeine-induced sleep disorder. Furthermore, the number of clinical diagnoses has increased from 106 in the initial edition of the *DSM* (APA, 1952) to 297 in the recent *DSM-IV-TR* (APA, 2000; Clark, Watson, & Reynolds, 1995; Wright & Lopez, 2002).

Due to their tenuous nature, facts about mental illness and health seem to be best represented by examining the degree of psychological characteristics via a dimensional approach. Examining individual differences in psychological phenomena improves on the current dichotomous categorical system. Although research studies have not yet pitted the dimensional system against the categorical system, evidence from studies of the categorical system indirectly supports the use of an alternative system. Factor analyses of data from a sample of individuals diagnosed with personality disorders and a sample of individuals with "normal" personality functioning revealed that personalities reflected in the two groups were more alike than different (see Maddux & Mundell, 1999, for a review). In addition, neither was necessarily reflective of the criteria-based diagnoses in the *DSM-IV.* Similarly, Oatley and Jenkins (1992) found that "normal" and "abnormal" emotional experiences were not discretely classified. Overall, it appears that looking at problems within the current all-or-nothing categorical system creates false dichotomies and is not empirically supported. The dimensional approach may offer a more valid representation of the "facts" of psychological phenomena.

Barone et al. (1997) acknowledged difficulties in human functioning and clarified that although all people experience problems, these difficulties are best represented as occurring on a continuum. Discrete categories cannot easily explain the inevitable variability of clients' problems. Barone et al. suggested that it is impossible to create a true dichotomy between normal and abnormal functioning, because almost every theoretical orientation acknowledges that it is the degree of the dysfunctional behavior that dictates the distinction between normality and abnormality. Even Freud, who is often criticized for overpathologizing behavior, was clear in his message that it was the degree to which an unconscious conflict or desire might interfere with normal functioning, not the mere presence of that conflict or desire (Barone et al., 1997).

Addressing Assumption 1: Remedying Preemptive Guesswork

Reification turns the unreal into the real. In the present diagnostic framework, the reification of mental disorders directs attention and efforts toward the detection and treatment of illness. Categorically defined mental illness leads scientists and practitioners to carefully gather information to determine a person's "goodness of fit" in a particular category. This commitment of resources to categorizing behaviors leaves few resources for the examination of behavior using other approaches. Because many professionals believe the *DSM-IV* system is a valid tool for making meaning of mental illness and health, its existence may have the effect of preempting consideration of alternative conceptualizations of behavior (Neimeyer & Raskin, 2000). To thwart the preemptive guesswork that comes into play in the diagnostic process, clinicians must be aware of alternative constructions of behavior and must be committed to entertaining the alternatives. These alternatives could be used either in lieu of the *DSM-IV* framework or in conjunction with the *DSM-IV* approach to facilitate a broader understanding of the full range of human behavior.

Assumption 2: *DSM-IV* Diagnostic Labels Promote Understanding

As *DSM-IV* categories currently exist, they describe only the negative aspects of the person's life and do not elucidate human strength or the process of human change (Barone et al., 1997). This is a concern, but it could be remedied by limiting preemptive guesswork and at the same time augmenting the *DSM-IV* conceptualization with additional information. An even bigger, and possibly more intractable, problem is that by using the *DSM-IV* diagnostic system, clinicians become preoccupied with forcing people into negative categories, curtailing their attempts to understand the client (as well as his or her strengths and weaknesses) in a more comprehensive manner. Without purposeful attention toward a more balanced approach, clinicians run the risk of focusing primarily on negative attributes, thus ignoring possible strengths, and therefore may view the client as being unidimensional. By providing a nonholistic diagnostic system, a conflict is created for clinicians, because a diagnosis "label" precludes clinicians from being able to give a full description of clients (i.e., the diagnosis becomes the characterization of the person). A second problem is that although most clinicians can recognize the faults in the *DSM-IV* system (and thus may place less stock in this deficit-based label), they are not the only individuals viewing the diagnosis. Other professionals who may

not be specifically trained in the system, and who are thus potentially unaware of its faults, may be less apt to view the diagnosis within its systemic context. Again, this may lead to a sole focus on the negative traits the diagnostic label describes. The labels given to these negative categories then serve as a social wedge between "the labeled" and all others.

Static negative labeling can create stereotypical expectations that influence how professionals conceptualize and interact with individuals as well as how these labeled individuals may think about themselves. The application of a diagnostic label can be crippling for a client, taking away autonomy and individuality. Furthermore, once the label of the diagnostic group is applied, the perception of within-group differences tends to be diminished, and between-group differences are enhanced (Wright, 1991). Wright (1991; Wright & Lopez, 2002) asserted that information consistent with the diagnostic label would be remembered more easily than inconsistent information. Thus, by simply applying the negative label, clinicians may tend to seek out information about individual deficits rather than strengths. This process thus decreases the accuracy of a conceptualization of a person's complete psychological makeup.

There are a myriad of negative social consequences associated with a diagnostic label that might obfuscate the true meaning of a categorical tag and bring harm to the bearer of the label. Public knowledge of a diagnosis can result in social alienation, ostracism, loss of employment, harm to family, and reduced social status. These consequences may be due to the fundamental negative bias associated with labeling. Wright (1991; Wright & Lopez, 2002) explained that if something regarded as negative occurs in a vague context and is then made known about an individual (i.e., a diagnosis), then that diagnosis guides the subsequent perceptions made about that person. She noted that clients are able to conceptualize their own behavior as stemming from a number of factors and possess the ability to identify the positives in addition to the problems of their situation. Outsiders, however, may tend to have a more limited view, attributing the behavior to dispositional aspects of the diagnosis—aspects that are independent of the environment.

Negative labels lead the clinician to having a set of negative expectations. Another error that can occur in clinical judgment is the confirmatory bias (Barone et al., 1997). Hypotheses are often formed based on diagnostic categories into which the client is placed. These assumptions are that (a) the client will present with symptoms characteristic of a mental disorder and that (b) the symptoms will cluster and can be categorized and labeled. Clinicians must choose hypotheses associated with an existing set of diagnoses to best account for these assumptions. The tendency is to look for information that supports their hypotheses and results in the application of one of these labels. Again, clinicians may attend more to the negative confirmatory evidence and fail to recognize information inconsistent with their original hypotheses or diagnoses. In this process, clients' strengths are often overlooked. By asking questions designed to elicit symptomatology and omitting questions regarding evidence of optimal functioning, clinicians are often guilty of *expecting* to observe dysfunctional behavior.

Barone et al. (1997) contended that clinicians can also be overconfident in their abilities to diagnose. They may tend to elicit premature diagnoses, because clinicians seek information that supports their hypotheses and they then take this information as confirmation of their original ideas. Because clients have a tendency to agree with whatever the clinician proposes, clinicians may then accept this mutual agreement as further support and feel more confident in their next encounter with a client. At this point, the narrow diagnostic focus becomes a collaborative myth shared by clinician and client.

Addressing Assumption 2: Widening the Diagnostic Focus

Labels provide the common language that facilitates communication; however, the development of a shared view does not guarantee shared understanding. Specific labels communicate different things to different people. Regardless of this lack of shared understanding, the bearers of a particular label are grouped together and their within-group differences are underestimated. Imagine if 20 clinicians were asked to identify 20 children with whom they had regular contact and whom they would label "at-risk." These 20 hypothetical clinicians would identify 400 people who carried the same label. Due to the label, fellow professionals would infer that the 400 children were more alike than they were different, thereby curtailing efforts to gather more information about individual children in the group. This label would then be perpetuated because it was shared with other laypersons and clinicians. Without a comprehensive examination of these children, they have been reduced to a single entity.

Widening the diagnostic focus involves consideration of the psychological strengths, environmental influences on behavior, and developmental forces that affect the manifestations of weaknesses and strengths. If the focus is widened, clinical confusion may result because the amount of information needed to make diagnostic determinations may be initially overwhelming; however, ways of incorporating this wealth of information are available.

Assumption 3: *DSM-IV* Diagnosis and Treatment Are Connected

The goal of the use of any psychodiagnostic system is to understand the person's needs and resources and facilitate the implementation of helpful therapeutic interventions. Focus on negative categories does not provide the insight necessary to identify ways of enhancing client adjustment. In fact, the *DSM-IV* (APA, 1994) only has four lines of text (e.g., "to formulate an adequate treatment plan, the clinician will invariably require considerable information about the

person being evaluated beyond that required to make a *DSM-IV* diagnosis" [p. xxv]) that address treatment. This suggests that *DSM-IV* diagnoses offer little information from which a clinician would logically derive an intervention. Ivey and Ivey (1998) contended that the "*DSM-IV* becomes a potential barrier to client growth and change due to the absence of linkages useful for the therapeutic process" (p. 335).

Maddux (2002) pointed out that the utility of a classification system is closely linked to its ability to lead subscribers to the development and selection of effective treatment. This aspect of the *DSM-IV*'s utility has been repeatedly questioned (see, e.g., Raskin & Lewandowski, 2000; Rigazio-DiGilio, 2000). This limited utility may be attributed to the atheoretical nature of the *DSM-IV*. A system that does not explain connections between the environment, culture, behavior, thoughts, emotion, external supports, and functioning can only hint at implications for treatment. The *DSM-IV* system can only "suggest somewhat vaguely *what* needs to be changed, but it cannot provide guidelines for *how* to facilitate change" (Maddux, 2002, p. 20).

Addressing Assumption 3: Connecting Diagnosis, Conceptualization, and Treatment

Neimeyer and Raskin (2000) asked, "How can we conceptualize this client's struggles in a way that is therapeutically useful and still communicate intelligibly with colleagues and case managers?" (p. 4). Assessment and diagnosis serve as the starting points for making meaning of a client's presentation. A comprehensive, and preferably theory-based, conceptualization of all forces that bear on a client's functioning provides a framework for understanding that can lead to the development of a treatment plan that is sensitive to the cultural context of clients.

Alternative Conceptualizations of Behavior

Mental disorders are socially constructed, are based on opinion and value, and have strong negative connotations. Furthermore, the information clinicians do get from *DSM-IV* diagnoses does not necessarily direct them to the treatment selection. Alternative (or adjunctive) conceptualizations of behavior are available, but preemptive guesswork that curtails the use of other systems must be overcome. The systems described subsequently vary in the comprehensiveness with which they address pertinent psychological phenomena. Thus, we would suggest that the developmental counseling and therapy (DCT; Ivey & Ivey, 1998) system and the New Personality (Oldham & Morris, 1995) conceptualization be considered "replacements" for the *DSM-IV* framework. In addition, models of well-being could augment the weakness-focused information gathered in the *DSM-IV* system. Although these alternatives vary in scope, all incorporate a dimensional approach to describing personal characteristics and functioning while at the same time emphasizing the connection between conceptualization and treatment.

DCT

Ivey and Ivey (1998) suggested that one of the first steps toward transcending pathology is to change the language used to describe client functioning. This step includes seeking out and specifically addressing the positive aspects of a client's life. The emphasis should be expanded to include discovery of what is working and ways to capitalize on clients' strengths.

Ivey and Ivey (1998) described DCT as a here-and-now conceptualization of client strengths as viewed within a cultural and historical model. They proposed a developmental approach in order to understand the unique circumstances of each client's experiences and environment that have contributed to current dysfunction, noting that behavior considered pathological within the *DSM-IV* system is often a logical response to developmental history. (Aspects of the developmental focus and the *DSM-IV* diagnostic system are juxtaposed in Table 1.)

In framing their approach, Ivey and Ivey (1999) encouraged clinicians to accurately understand the client as a whole. They stated that the "contextual self includes relational di-

TABLE 1

***DSM-IV:* The Contrast Between Traditional and DCT Meaning-Making Systems**

Issue	Traditional Pathological *DSM-IV* Meaning	Developmental Meaning
Locus of problem	Individual	Individual/family/cultural context
Pathology	Yes	No, logical response to developmental history
Developmental and etiological constructs	Peripheral	Central
Culture	Beginning awareness	Culture-centered
Helper role	Hierarchy, patriarchy	Egalitarian, coconstruction
Cause	Linear, biology vs. environment	Multidimensional considers both biology and environment
Family	Not stressed	Vital for understanding individual development and treatment
Treatment	Not stressed	Central issue

Note. *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; APA, 1994); DCT = developmental counseling and theory (Ivey & Ivey, 1998). From "Reframing *DSM-IV:* Positive Strategies From Developmental Counseling and Theory" by A. E. Ivey and M. B. Ivey, 1998, *Journal of Counseling & Development, 76,* p. 336. Copyright 1998 by the American Counseling Association. Reprinted with permission.

mensions of personal and family developmental history, community and multicultural issues, and physiology" (p. 486). Understanding the individual requires gaining information about him or her along numerous contextual dimensions (see Table 1), and developing treatment plans that are sensitive to contextual resources requires an in-depth understanding of the social context in which the client lives.

Specifically, conceptualization within the Ivey and Ivey (1999) system involves building a framework of information. For example, when working with someone who has experienced childhood trauma, Ivey and Ivey would gather information about what they referred to, in the terminology of Masterson (1981), as environmental or biological insults. They would then test hypotheses regarding the connection between the insult and stress and pain and between the subjective experience of stress and pain and sadness and depression (which might occur because of threatened attachment security and safety). Next, the nature of defending against negative mood would be examined, and the current use of defensive structures would be considered. With all these data garnered, personality style and its manifestation in and out of session can be described. How this personality style helps a person navigate current relationships then determines the course of treatment. The developmental diagnostic framework needs to be fleshed out a bit more, but in its current form, it serves as an intriguing meaning-making alternative to the *DSM-IV* system.

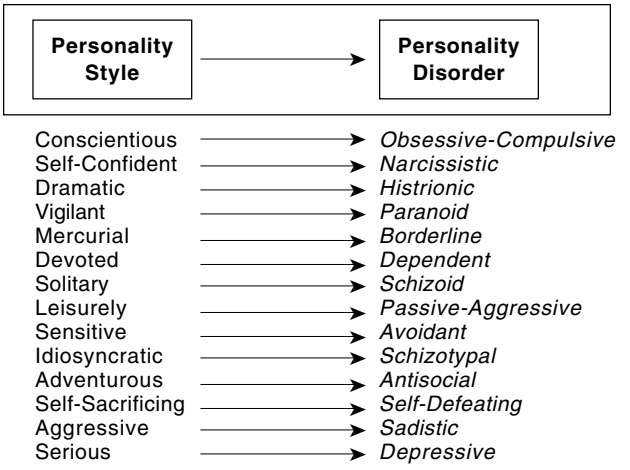

FIGURE 1

Oldham and Morris (1995) Dimensional Conceptualization of Personality Disorders

Note. From J. M. Oldham & L. B. Morris (1995). *New Personality Self-Portrait: Why You Think, Work, Love, and Act the Way You Do.* New York, Bantam. Reprinted with permission.

New Personality Dimension

Oldham and Morris (1995) provided particular support for the dimensional approach with their unique conceptualization of personality disorders. These two authors contended that each of the 14 personality disorders listed in the *DSM-IV* can be viewed as lying on its own continuum of adaptation. Less acute presentations of these personality types lie at one end of these continua, with the actual manifestations of the personality disorders (e.g., borderline, paranoid, histrionic) at the other end. Oldham and Morris posited that an individual may move along this continuum, depending on the environmental and endogenous stressors in his or her life at any one point in time. In this conceptualization, an individual may exhibit behaviors more indicative of the actual disorder at times of high stress, whereas clinical presentation may resemble a less intense version of the disorder in times of less stress. Thus, an individual may meet criteria for histrionic personality disorder during extremely stressful periods but might merely be described as dramatic at times of low stress in his or her life. As another example, someone who may appear to have obsessive-compulsive personality disorder in stressful situations may be described as conscientious on the lower end of the continuum (see Figure 1). These characteristics may, in fact, be quite helpful to the individual on the nondisordered end of the continuum. A person who is conscientious, as described by Oldham and Morris, may find that possessing this quality allows him or her to be responsible and reliable. A person with features of narcissistic personality disorder may find that certain aspects of this disorder allow him or her to be self-confident and therefore able to function at a superior level. It is only when these characteristics become extreme that they are no longer beneficial to the client.

This personality continuum can be used to differentiate between individuals possessing more, or less, florid symptomatology in their daily lives. With the current *DSM-IV* conceptualization, an individual must possess a majority of the criteria delineated to be diagnosed as "having" the disorder. An individual who has one less than the specified number of criteria may still be experiencing quite a high level of stress and yet may not receive services because of a lack of a specific diagnosis. The Oldham and Morris (1995) conceptualization leaves room for individuals to be diagnosed according to the degree of dysfunction or maladaption as well as to the degree of positive use of resources. In addition, it may provide more client-friendly terminology to use when discussing personality disorder diagnoses during sessions, allowing clinicians to help clients identify strengths as well as weaknesses in their set of behaviors.

Levels of Well-Being

Conceptualizing individuals based on well-being and positive functioning represents an alternative lens through which to view human behavior. Theories of subjective well-being, such as the model posited by Diener and others (Diener, 1984; Diener, Suh, Lucas, & Smith, 1997), suggest that indi-

viduals' appraisals of their own lives capture the essence of well-being. Objective approaches to understanding well-being have been proposed by Ryff (1989) and Keyes (1998), both of whom provided a useful framework for conceptualizing human functioning.

Ryff (1989) posited that the categories described by proponents of positive psychology can be integrated into six main areas of psychological well-being. Self-acceptance, or holding positive attitudes toward oneself, is a central feature of mental health. Environmental mastery is the second domain of Ryff's model of well-being. This involves the ability to select or generate environments most conducive to an individual's goals. The third aspect of well-being is positive relations with others. This area emphasizes the need for satisfying interpersonal relationships. Having a purpose in life is the fourth essential element of mental health. The fifth element, personal growth, describes the way individuals fully realize and grow toward their potential. Finally, autonomy is the sixth essential element. Autonomous individuals use an internal locus of evaluation; they are independent and self-deterministic. This model of well-being has been investigated in numerous studies, and findings indicate that the six dimensions of well-being are independent, although correlated, constructs. Specifically, Ryff and Keyes (1995) conducted an analysis of the six-part well-being model and found that the multidimensional model was a superior fit over a single-factor model of well-being.

Keyes (1998) suggested that just as clinicians categorize the social challenges evident in an individual's life, so should they assess the social dimensions of well-being. He proposed that these dimensions are coherence, integration, actualization, contribution, and acceptance. His model of well-being addresses both social well-being and intrapsychic functioning, because the individual is able to move from dysfunction to satisfaction in both domains.

Keyes and Lopez (2002) suggested that complete mental health can be seen as a syndrome comprising high levels of emotional well-being, psychological well-being, and social well-being. Individuals with these high levels are said to be "flourishing" (see the criteria in Table 2). Individuals without mental illness but who have low levels of well-being are described as "languishing." (We have found that informal assessment of levels of well-being provides valuable information about the range of functioning between flourishing and languishing.) This conceptualization of incomplete mental health describes a syndrome of symptoms that might be amenable to intervention techniques aimed at increasing levels of emotional, social, and psychological well-being; thus, conceptualization and treatment are well-connected in this model. (For more information about well-being therapy, which is based on Ryff's, 1989, model, see Fava, 1999; Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998.)

It should be noted that the Keyes approach to describing flourishing and languishing incorporates the *DSM-IV* categorical system as well as a new set of categories to describe well-being. Limitations of the categorical system (e.g., categorization does not necessarily promote understanding, categories are not discrete yet they suggest a clear distinction between normal and abnormal behavior, categories can cloud clinical judgment) must be considered when adopting this approach.

TABLE 2

Diagnostic Criteria for Flourishing in Life

Flourishing in Life
A. Individual must have not had an episode of major depression in the past year.
B. Individual must possess a high level of well-being as indicated by the indivdual's meeting all three of the following criteria.
1. High emotional well-being, defined by having 2 of 3 scale scores fall in the upper tertile
a. Positive affect
b. Negative affect (low)
c. Life satisfaction
2. High psychological well-being, defined by having 4 of 6 scale scores fall in the upper tertile
a. Self-acceptance
b. Personal growth
c. Purpose in life
d. Environmental mastery
e. Autonomy
f. Positive relations with others
3. High social well-being, defined by having 3 of 5 scale scores fall in the upper tertile
a. Social acceptance
b. Social actualization
c. Social contribution
d. Social coherence
e. Social integration

DSM-IV Alterations

The *DSM-IV* diagnostic framework comprises five axes: Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention (Axis I), Personality Disorders and Mental Retardation (Axis II), General Medical Conditions (Axis III), Psychosocial and Environmental Problems (Axis IV), and Global Assessment of Functioning (Axis V). Diagnosis and conceptualization within this framework are grossly incomplete because environmental resources, well-being, and psychological strengths are not addressed. Because the *DSM-IV*'s place in the field of psychology is firm, working within this diagnostic framework is, however, necessary. Alterations to the system could serve to emphasize the positive side of human functioning and provide a greater wealth of information that could be incorporated into a more comprehensive conceptualization of personality and functioning.

Broadening Axis IV

When addressing Psychosocial and Environmental Problems (Axis IV), clinicians log the problems that serve to add some context to the psychological disorders diagnosed along Axes I and II. The *DSM-IV* developers indicated that problems experienced would affect the diagnosis, prognosis, and treat-

ment of mental disorders. In essence, the problems might initiate or exacerbate dysfunction.

On reviewing the nine categories of problems listed in the *DSM-IV* (see Table 3), we were struck by the notion that if these everyday problems serve as initiating and exacerbating factors of disorder, then everyday resources could serve as protective factors that would prevent the development of disorder or reduce its impact on an individual. Many of the resources listed in Table 3 can be measured with psychometrically sound tools.

Our recommendation for using a broadened Axis IV is to try to contextualize the view of the client and his or her functioning by considering psychosocial and environmental resources. Listing these resources alongside the problems might facilitate the conceptualization of the ways in which the client copes and solves problems in his or her life.

Reanchoring Axis V

Axis V of the *DSM-IV* was incorporated into the diagnostic system to assess clients' functioning. This is the only axis that does not focus exclusively on pathology, but it remains limited in accurately assessing clients' strengths. It is our contention that Axis V must be reorganized so that it is capable of capturing the absence of functional deficits *and* the areas of optimal living. To create a functioning baseline, the current Global Assessment of Functioning (GAF) level 100 *(absence of symptomatology)* would be rescaled as the midpoint (50) of the GAF scale. Levels 51–100 would be reserved for increasing levels of functioning. The GAF anchors of 1, 50, and 100 would be reflective of *severely impaired functioning, good health,* and *optimal functioning,* respectively. Having this type of assessment built into the diagnostic system would encourage clinicians to recognize, and hopefully use, strengths within clients and their environments.

TABLE 3

Broadening Axis IV of the *DSM-IV* System

Psychosocial/Environmental Stressors	Psychosocial/Environmental Resources
Problems with primary support group	Attachment/love/nurturance with primary support group
Problems related to the social environment	Connectedness/empathic relationships/humor-filled interactions
Educational problems	Accessible educational opportunities and support
Occupational problems	Meaningful work/career satisfaction/self-efficacy
Housing problems	Safe housing with essential elements that foster healthy development
Economic problems	Financial resources adequate to meet basic needs and beyond
Problems with access to health care services	Access to high quality/reliable health care services
Problems related to interaction with the legal system/crime	Contributions made to society via donation of resources and time
Other psychosocial and environmental problems	Other psychosocial and environmental resources

Note. DSM-IV = Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994).

Creating Axis VI

A third option for revising the 1994 *DSM-IV* categorical system is the inclusion of an additional axis. This axis, perhaps titled Personal Strengths and Facilitators of Growth, would present an individual's strengths along dimensions, thereby allowing the development of a more comprehensive picture of the client. In this way, Axis VI would be designed to tap the psychological strengths associated with therapeutic change and positive functioning, thus serving the added function of creating a connection between diagnosis and treatment. To determine a client's position on this axis, a clinician would present the client with a brief packet of measures designed to assess such factors as hope (Adult Hope Scale; Snyder et al., 1991), satisfaction with life (Satisfaction With Life Scale; Diener, Emmons, Larsen, & Griffin, 1985), optimism (Life Orientation Test–Revised; Scheier, Carver, & Bridges, 1994), and personal growth initiative (Personal Growth Initiative; Robitschek, 1998). A cover page would be attached to this packet with three basic questions: (a) What are your specific goals for treatment? (b) Who are the people in your life you will turn to for support while making changes in your life? and (c) What are your personal strengths? After clients had answered these questions, the clinician could then plot the client's scores, from low to high, on a separate continuum for each of the above-listed traits. In this way, a graphic description of these positive characteristics could be seen, thus creating a baseline from which to work in therapy.

As the field of psychology shifts to a balanced model focusing on mental illness and mental health, clinicians and researchers must move beyond traditional deficit diagnosis. The modifications to Axes IV and V and inclusion of an Axis VI are potential directions for growth.

Future Directions

Challenging faulty assumptions about psychodiagnosis and the *DSM-IV* system remedies the preemptive guesswork that keeps clinicians mired in one incomplete explanation of functioning. Alternative conceptualizations help clinicians to transcend pathology and entertain the full range of psychological functioning. Finally, alterations to the 1994 *DSM-IV* system could provide a revised framework within which clinicians and researchers can make sense of human behavior.

Recent developments in classifying the full spectrum of human functioning hold much promise for rounding out the view of the pathology-to-optimal-functioning continuum. In this last section, we discuss Wright's (1991) approach to

developing a comprehensive conceptualization of a person's weakness and strengths and of the influence of environmental stressors and resources. The Values In Action (VIA) Classification of Strengths is also described.

Wright's Four-Front Approach

One useful framework for assessment and diagnosis is Wright's (1991; Wright & Lopez, 2002) four-front approach. In this approach, clinicians gather information about (a) strengths and assets of the client, (b) deficiencies and undermining characteristics of the client, (c) resources and opportunities in the environment, and (d) deficiencies and destructive factors in the environment. Clinicians can use multiple methods, including observation, interviews, informal assessments and standardized measures, to gather this information and should attempt to include the four-front data that are gathered in reports and clinical records. Using this balanced approach to psychodiagnostic assessment helps to counteract deindividuation and other clinician biases, and it also encourages clinicians to actively look for clients' personal strengths as well as environmental resources.

Regarding the future of this approach, Wright (1991) called for the creation of four separate diagnostic manuals— a manual for each of the four fronts. We believe that a fifth manual would be necessary to guide the clinician in the incorporation of data and the connection of conceptualization and treatment. Although it might be cumbersome, five manuals would cover all the bases of diagnosis. If the arduous task of constructing the five-manual set is undertaken, the development of a single, condensed volume highlighting the four-front approach and its application should follow.

VIA Classification of Strengths

The VIA Classification of Strengths (Peterson & Seligman, 2004) serves as the antithesis of the *DSM-IV* and holds the most promise for fostering further understanding of psychological strengths. Peterson and Seligman made the point that although members of the counseling field currently have a similar language to use in speaking about the negative side of psychology, they have no equivalent terminology to use in speaking about the strengths of individuals. The VIA Classification of Strengths provides them with this common language and, at the same time, encourages a more strength-based approach to diagnosis and treatment (treatment manuals focused on enhancing strengths would accompany the diagnostic manual).

In support of a less unilateral classification system, the VIA Classification of Strengths describes the individual differences of character strengths on a continuum and not as distinct categories. In this way, Peterson and Seligman (2004) contended that their classification approach is sensitive to the developmental differences in which character strengths are displayed and deployed. Six categories are delineated in the VIA Classification of Strengths system—wisdom, courage, humanity, justice, temperance, and transcendence—and these are thought to represent universal and cross-cultural virtues. This classification system may become the gold standard for classifying the positive aspects of human life.

Concluding Remarks

Diagnosing along the *DSM-IV* axes is a standard practice in clinical work. The five-axis framework and its related codes provide a common means of communication among clinicians and between clinicians and third-party payers. This diagnostic system, however, is limited in numerous ways, and it does little to encourage a focus on human strengths and environments as resources and does not foster a connection between diagnosis and treatment. Hence, we hope that the recommendations to go beyond the *DSM-IV* provide clinicians with ideas needed to enhance diagnosis.

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