Need of a Classification Scheme for the Psychosocial Disorders

ANITA K. BAHN, Sc.D.

THE PSYCHOSOCIAL disorders of man can be defined as those disorders that interfere with his interpersonal relations, with his capacity to function optimally in social roles (for example, as student, spouse, worker, or citizen), with his other social interactions, and with his ability to live with himself. In its broader definition the term would include not only the interaction of man with society but also of society "pressing" on the individual (*1*).

I want here (*a*) to examine the need for the development of a new classification scheme for the psychosocial disorders, (*b*) to present evidence for the feasibility of developing such a classification, (*c*) to outline some suggested attributes of a classification scheme, and (*d*) to make recommendations regarding the initial steps in its development.

Need for Uniform Data

The term "psychosocial disorders" in itself is one of the most compelling arguments for a classification scheme. It encompasses a wide spectrum of disorders. Dealing with them are professional persons and agencies providing such diverse services as psychiatric inpatient services for the acutely or chronically disturbed; psychiatric outpatient services for the diagnosis, treatment, and pre- or post-hospitalization care of mildly to severely ill persons of all ages; medical services for the alcoholic or narcotic addict or the mental retardate; court and related services for the juvenile offender; psychological school services centering on student adjustment; and welfare and social agency services concerned with family disturbances. The staff of these agencies include such diverse professionals as psychoanalytically trained psychiatrists, neurologists, internists, pediatricians, psychologists, psychiatric social workers, public health nurses, occupational therapists, and school guidance counselors.

Obviously, a single entirely medical or entirely nonmedical terminology is not applicable for such varied backgrounds; yet these interdisciplinary workers must be able to communicate with each other and with the public on the characteristics and problems of their patients or clients and on the services rendered. For broad program planning and evaluation, uniform data are needed for use across agency lines.

The only standard classification now in this field is the medical terminology in the diagnostic and statistical manual of the mental disorders developed by the American Psychiatric Association in 1952 (*2*). Despite its limitations this manual serves as an important anchor in several ways. It is a standard reference defining the term "mental disorders," and it specifies and defines particular disorders.

This classification is used by virtually all psychiatric hospitals and clinics in the United States. That there are difficulties in its general applicability, however, even in this medical setting, is evidenced by the following:

1. Almost 33 percent of children and 18 percent of adult patients are terminated from out-

Dr. Bahn is chief, Outpatient Studies Section, Biometrics Branch, National Institute of Mental Health, Public Health Service, Bethesda, Md.; and lecturer in epidemiology, Johns Hopkins University School of Hygiene and Public Health, Baltimore. *This paper is based on a presentation at a workshop on psychosocial disorders, American Orthopsychiatric Association, Chicago, Mar. 20, 1964.*

patient psychiatric clinics without a diagnosis, in part because some patients leave before a diagnosis can be completed (*3*).

2. Forty percent of the diagnosed patients at child clinics are classified in the "wastebasket" category of "transient situational personality disorder" (adjustment reaction) for which no detailed breakdown is provided (*3*).

3. Many clinicians complain that additional significant dimensions or axes of classification of the patient are not provided, that a more dynamic description of the problem is needed, and that the present classification is not operationally or prognostically useful.

4. Because of inability to select one diagnosis, multiple diagnoses are often reported.

5. Diagnoses from different facilities for the same patient, although made within a relatively short period of time, frequently differ (*4*).

Hopefully, current efforts related to the revision of the psychiatric classification and experiments to objectify and standardize the psychiatric examination and diagnostic protocol will overcome many present limitations. However, two central problems will remain in classification: (*a*) the inability of nonpsychiatric mental health workers to use a medical terminology (the number of such personnel who work with disturbed or maladjusted individuals is likely to increase) and (*b*) limited descriptions of performance in the social role.

What is needed is common reference material of broader scope on psychosocial disorders, which can be used by all mental health workers in this field regardless of specialty. At present, psychosocial disorders are ill defined and have many synonyms and overlapping terms, such as "official and unofficial disorders," "maladjustments," "maladaptive behavior," "predicaments," "incidents," and "dysfunctioning." Knowing what is included or excluded under these terms is difficult. For example, is every divorce or every one-car accident a "disorder" regardless of cause or circumstance, as some studies suggest?

Feasibility of Development

It is recognized that the development of a classification of psychosocial disorders which will be generally acceptable to many diverse professional groups and agencies, useful for a wide variety of etiological, sociological, and experimental studies, and operationally practicable and valuable in case management is not an easy task. Yet there are parallels that offer encouragement.

The development of uniform reporting for some 1,900 outpatient psychiatric clinics in the United States, operating under varied auspices and purposes, represents a large-scale endeavor toward classification (*5–7*). Despite such divergent facilities as after-care clinics of State mental hospitals; clinics in schools, general hospitals, pediatric services, or local health departments; clinics serving alcoholics exclusively; and traveling clinics in rural areas, basic agreements on working classifications and definitions have been achieved (*8–9*). Such terms as "a patient," "termination of service," "treatment," "an interview," and "disposition categories" have been standardized and are reported uniformly, which make possible a nationwide program of voluntary cooperative research on psychiatric outpatient services.

We believe this standardization demonstrates that agreement on axes of classification and terms can be achieved if the objectives are kept clearly in mind; if representatives from different professions, levels of operation, and geographic areas, with divergent views, participate broadly; and if the classifications and definitions developed are not static systems but are periodically reviewed and modified, based on operational experience, new concepts, and changing program needs. Similar achievements have been made in the Model Reporting Area of Mental Hospital Statistics (*10*).

A similar accomplishment is the development of a taxonomy in the field of general medicine (*11*). To quote some of its history (*12*):

> The development of a uniform nomenclature of disease in the United States is comparatively recent. In the late twenties, each large teaching center employed a system of its own origination, no one of which met more than the immediate needs of the local institution. Despite their local origins, for lack of suitable alternatives, these systems were spread in use throughout the nation, ordinarily by individuals who had been trained in a particular center, hence had become accustomed to that special system of nomenclature. Modifications in the transplanted nomenclatures immediately became necessary, and were made as expedi-

ency dictated. There resulted a polyglot of diagnostic labels and systems, effectively blocking communication and the collection of medical statistics.

In late 1927, the New York Academy of Medicine spearheaded a movement out of this chaos towards a nationally accepted standard nomenclature of disease. In March 1928, the first National Conference on Nomenclature of Disease met at the academy; this conference was composed of representatives of interested governmental agencies and of the national societies representing the medical specialties. A trial edition of the proposed new nomenclature was published in 1932, and distributed to selected hospitals for a test run. Following the success of these tests, the first official edition of the "Standard Classified Nomenclature of Disease" was published in 1933, and was widely adopted in the next 2 years.

Today the standard is used by all accredited hospitals and medical institutions. Before its development, however, the task yet to be achieved was on the order of magnitude comparable to what we now face in the area of the psychosocial disorders.

Suggested Attributes of Scheme

While it is not possible to specify all the features that would be desirable or useful in a classification system, certain attributes would appear to be essential. It would seem that initially the nomenclature would need to be multidimensional. Thus it could include not only a typology of underlying pathology but also of overt behavior and manifestations. In turn, behavior may have to be specified in several areas. It should be noted that the reporting of symptoms or behavior alone may not be productive without some attempt at clinical synthesis or diagnosis of the significance of the symptoms in terms of etiology or pathology.

The particular axes or dimensions included in the classification would depend upon their relevancy, state of current knowledge, and feasibility or practicality of use. Some determinations to be made, for example, are whether degree of impairment can be reported with sufficient reliability, to what extent environment is an intrinsic element of psychosocial disorders, is intelligence level adequately standardized, and whether the concepts of family interaction are sufficiently developed.

The minimum standards of "normal" behavior or health for each dimension will have to be spelled out for reference so that deviance or disorders can be identified. A theoretical framework would assist in unifying the concepts of normalcy.

The particular disorders to be included in each area must be clearly delineated. That problems arise from broad nonspecific categories has been noted earlier in the diagnostic category of adjustment reaction. We also have found that certain specific disorders such as alcoholism are more of an operational entity in terms of services received and outcome than some major rubrics such as personality disorders ((*13*, *14*). While certain persons might take exception to some of the inclusive terms, it would be possible to select from this standard reference list specific disorders for particular investigations or to regroup the disorders that turn out to be similar. Summarized classifications could be prepared from this more detailed nomenclature or, for purposes of statistics, separate disorders could be tabulated when warranted because of their frequent occurrence or importance (*15*).

Either there must be well-defined criteria and specifications as to the caretaker agencies qualified to make the determination that a disorder exists or there must be provision for various levels of ascertainment of the disorder.

The disorders will have to be listed and grouped in some logical and functional order along with a well-designed coding scheme to facilitate summarization and selection.

With such a schemata, groups of cases related in several dimensions could be systematically studied. Furthermore, interrelationship of the various disorders, such as mental illness and other psychosocial problems and symptoms, could be more readily investigated in a uniform way through parapsychiatric registers (*16*) or special studies. Along these lines might be mentioned the problem appraisal profile developed by the Outpatient Advisory Committee to the Biometrics Branch, National Institute of Mental Health, which is being used in large-scale trials to supplement the psychiatric diagnoses in clinic reporting (*7–9*).

Recommendations

How to begin? An interprofessional organization, perhaps the American Orthopsychiatric Association, could sponsor the work in this

area. A committee could assist in laying the general framework and guidelines for a new nomenclature. Experts from appropriate specialist fields and service agencies as well as experts in methodology, such as epidemiologists, statisticians, and sociologists might serve on the committee. As previously indicated, a monumental amount of committee and conference work went into the development of the "Standard Nomenclature of Diseases and Operations." The principal point is that a nosological scheme, to have a broad impact, cannot be developed solely by any single professional group no matter how able. However, a number of classifications and approaches already developed and used by various specialist groups and agencies could serve as a nucleus or starting point.

The National Study Group on Coordination of Social Service Statistics, comprised of representatives of national governmental and voluntary organizations, is in general agreement that a taxonomy of psychosocial disorders is necessary and that, despite the limits of our knowledge, there are possibilities of achievement if the task is approached in the right way and with patience. Today would seem an opportune time to begin such a task because of the warm climate of interest in the prevalence, etiology, prevention, and treatment of the psychosocial ills.

REFERENCES

(*1*) Reynolds, C. B.: The social casework of an uncharted journey. Social Work 9: 13–17 (1964).

(*2*) American Psychiatric Association: Mental hospital service: Diagnostic and statistical manual, mental disorders. Washington, D.C., 1962.

(*3*) Rosen, B. M., Bahn, A. K., and Kramer, M.: Demographic and diagnostic characteristics of psychiatric clinic outpatients in the United States, 1961. Amer J Orthopsychiat 34: 455–468 (1964).

(*4*) Bahn, A. K.: Methodological study of population of outpatient psychiatric clinics, Maryland, 1958–59. PHS Publication No. 821 (Public Health Monograph No. 65). U.S. Government Printing Office, Washington, D.C., 1961.

(*5*) U.S. Public Health Service: Mental health clinic statistics; conference report. Public Health Rep 69: 1008–1011 (1954).

(*6*) U.S. Public Health Service: Outpatient mental health statistics program. Public Health Rep 77: 337–340 (1962).

(*7*) U.S. Public Health Service: Outpatient mental health statistics program, 1964. Public Health Rep 79: 435–438 (1964).

(*8*) U.S. Public Health Service: A manual on recordkeeping and statistical reporting for mental health clinics. PHS Publication No. 539. U.S. Government Printing Office, Washington, D.C., 1957.

(*9*) National Institute of Mental Health: Instructions for reporting services to patients by outpatient psychiatric clinics. (Revised.) U.S. Government Printing Office, Washington, D.C., March 1964.

(*10*) U.S. Public Health Service: Progress in reporting mental hospital statistics; conference report. Public Health Rep 76: 925–928 (1961).

(*11*) American Medical Association: Standard nomenclature of diseases and operations. Ed. 5. McGraw-Hill Book Co., Inc., New York, 1961, p. 964.

(*12*) Thompson, E. T., and Hayden, A. C., editors: Textbook and guide to the standard nomenclature of diseases and operations. Ed. 2. Physicians Record Co., Chicago, 1958.

(*13*) Bahn, A. K., Chandler, C. A., and Eisenberg, L.: Diagnostic characteristics related to services in psychiatric clinics for children. Milbank Mem Fund Quart 40: 289–318 (1962).

(*14*) Bahn, A. K., Chandler, C. A., and Lemkau, P. V.: Diagnostic characteristics of adult outpatients of psychiatric clinics as related to type and outcome of services. Milbank Mem Fund Quart 40: 407–442 (1962).

(*15*) U.S. Public Health Service: International classification of diseases, adapted for indexing hospital records by diseases and operations. Revised. U.S. Government Printing Office, Washington, D.C., December 1962.

(*16*) Gorwitz, K., Bahn, A. K., Chandler, C. A., and Martin, W. A.: Planned uses of a statewide psychiatric register for aiding mental health in the community. Amer J Orthopsychiat 33: 494–499 (1963).