

Foreword

The preparation and publication of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has intensified interest in clinical classification among mental health researchers and practitioners throughout the world. As Florence Kaslow details in Chapter 1, family researchers and clinicians, and the many organizations of which they are members, made valiant efforts to clarify and promote concepts concerning the family for inclusion in the published version of DSM-IV. These efforts addressed two questions. First, is there common ground among family practitioners on issues of clinical classification? Second, can family researchers and family clinicians persuade the larger clinical community that they can make an important contribution to a comprehensive system of classification of disorders? The current volume represents the best effort to date to address these questions. As the writer of the Foreword, I want to assist readers in engaging the chapters by encouraging them to formulate and answer questions of their own as they read. Here I report some results of my own engagement.

IS THERE A CONSENSUS ON FAMILY CLASSIFICATION?

This volume divides this question into two parts. First, what concepts and methods are available as a foundation for classification of relationships and their disorders? Second, what are the merits and problems entailed in the process of clinical classification?

Consensus on an Approach to Classification of Relationships

Broadly speaking, the chapters in this book do not—collectively or singly—lay out an explicit system for classifying relationships and their disorders. However, a close reading of all of them suggest that a consensus is emerging nonetheless. Perhaps the most important theme cutting across all chapters is an increasing comfort by family clinicians with systems of classification that focus both on the individual and on relationship systems. For example, chapters on anxiety, dissociative, mood, and eating disorders are organized around concepts and assessments that focus first on the individual and then consider the impact of the individual's disorder on the family. At the same time, several chapters delineate subtle patterns of relationships and relationship disorders to be considered as clinical problems in their own right whether they are associated with classifiable disorders in individual members or not. Some of these family level systems, such as the Structural Analysis of Social Behavior, are exquisitely attentive to intrapsychic functioning.

Having all these chapters in one book helps us recognize the hub of a new consensus on clinical classification. This hub is a flexible system that can give emphasis to disorders of relationships in some cases and disorders of individuals in others and that can strike a relatively even balance between the two in still others. Moreover, the system should allow for changing emphases across the clinical life of a single clinical problem. Reading these chapters suggested to me that a flexible system like this one might be captured by a schema with four very broad

categories. This schema might serve as a useful armature for collaborative research among family researchers and between family and other clinical researchers.

These categories can be arranged to form a series. The first category reflects the clinician's focus on relationship disorders as important in their own right; in using the last, the clinician focuses on the individual disorder, with family problems as a critical but subordinate concern. The other two categories have a mixture of the two. The four categories are: well-delineated disorders of relationships; well-delineated relationship problems associated with individual disorders; disorders that require relational data for their validity; and individual disorders whose evocation, course, and treatment are strongly influenced by relationship factors.

Well-Delineated Disorders of Relationships

The first category captures clinical problems where the clinician attends primarily to relationship problems. Typically, these disorders are the focus of attention because they lead to severe psychological distress for one or more members, they involve physical battery, or they presage the disruptive breakup of the relationship. Because these are the primary focus of concern and are serious in nature, they are termed "relationship disorders."

This level of classification is probably used most frequently when a single individual or a dyad seeks treatment for a problem that they themselves perceive is a relational one and the clinician cannot detect a significant individual disorder in the individual members of that relationship. It is also used when the severity of the relationship disturbance is conspicuous whether the relationship members complain about it or not. The Relationship Conflict Inventory, described in Chapter 24, is one way to approach the assessment of severity. The Global Assessment of Relational Functioning, now located in Appendix B of DSM-IV and alluded to throughout this book, is another. The presence of violence, serious physical or psychological abuse or neglect, or the imminent breakup of the relationship are also clear indicators of a severe disorder of relationships whether they engender complaints or not. Again, in contrast to the next category, this level of classification is appropriate only if there are no discernible mental disorders in any individual involved in the relationship. A third form of clinical presentation for a relationship disorder is when a clinician reframes a disorder that is presented initially as residing within a single individual; this reframing may clarify for the whole family that the index patient's chief (and individual) complaint (or the complaints of others about the index) is embedded in a relational nexus. Chapters 5, 6, and 24 provide concepts and methods for detecting various forms of relationship disturbances.

To my knowledge, there is no reliable data on the incidence or prevalence of relationship disorders of this type. It is possible that severe relationship disorders without evidence of individual psychopathology are very rare, or they might be very common. Those who study individual disorders are now very familiar with the powerful techniques of epidemiology, but family researchers, in general, have been shy about using population-based or community-based epidemiology. This approach to research provides clear concepts, effective methods, and strong inferences about the incidence and prevalence of disorders as well as some of the likely causes of those disorders. Recent advances in epidemiology makes this approach especially suitable for developing and validating classification schemes for relationship disorders. First, epidemiology is focusing more on the social demands for adaptation required by particular communities and assessing individual capacities to respond to these particular demands. Second, a large number of common-use data sets are available to family researchers; increasingly, these contain already-collected data about individuals and their families. Third, tools have been developed to collect very high quality data on relationships in epidemiological studies; these include techniques for observing family interaction process in their own homes. Family-based epidemiology could answer many important questions about the co-occurrence of relationship and individual disorders and help flesh out the ideas advanced in this book and which are reflected in the simple scheme I am presenting here.

Well-Delineated Relationship Problems That Are Associated with Individual Disorders

The second category is used for clinical situations where the relationship is still the primary focus of treatment. The severity of the disturbance may be conspicuous or it may be subtler; relationship members may complain about it or be unaware of it. However, part of the importance of treating the relational problem stems from the likelihood that the problem is evoking or influencing serious disorders in one or more individual members. Clinicians use this level of analysis when they detect both a relationship and an individual disorder *and* the two are plausibly linked either by careful clinical analysis or by valid research data. By using this level of analysis, clinicians commit themselves to evaluate progress in treatment of the relational disorder, not only by monitoring the relationship itself but also by careful assessment of individual disorders even if they elect not to provide individual treatment, such as individual psychotherapy or pharmacotherapy, directed at these disorders. An example is the choice of marital therapy as the only mode of therapy for depression.

A variant in this domain is drawn from the literature on prevention. A relational problem may constitute not only a serious source of distress for individuals who are involved in the relationship but may be a risk for future individual psychopathology in those members or in another member of the family. An example is the treatment of marital conflict in parents of very young children. The children may show no manifest disorder at the time couple's therapy is begun. However, accumulating research data, some of it reviewed in Chapter 12 on childhood depression, suggests that there is a very high likelihood that, if not properly treated, marital conflict will evoke serious psychopathology in the children. By classifying a clinical problem in this broad level, the clinician is reminded to assess the status of these children while evaluating the effectiveness of the therapy directed at the marital couple.

Disorders That Require Relational Data for Their Validity

In this third category, an individual disorder is central in the presentation of the clinical problem to the clinician. However, a full clinical description of the disorder requires relational data. For disorders in this level, part of the set of criteria for reaching a classification decision requires knowledge about one or more key relationships of that individual. Chapter 14 provides interesting examples of this for conduct disorders. Early-onset conduct disorders, a particularly malignant condition if left untreated, probably cannot be adequately defined or classified unless data on the parent-child relationship is a criterion for making the classification. Research data suggest that the most likely characteristic of the parent-child relationship is inadequate parental monitoring and control of these children. This inadequacy does not reside "in" the parent since the conduct-disordered child very frequently is more difficult to monitor and control; nor does it reside "in" the child since parental behavior is such a critical part of the clinical picture. Children with serious conduct disturbances who are not embedded in these inadequate parent-child relationships are rare and may be considered to have a very different disorder. The same principle, of using relationship data as criterion for diagnosis, clearly applies to some forms of severe eating and sleep disorders in infants and toddlers.

Individual Disorders Whose Evocation, Course, and Treatment Are Strongly Influenced by Relationship Factors

Finally, there is a class where the individual disorder is a continuing and primary focus of clinical attention but additional treatment of the family is essential to promote rapid recovery, reduce morbidity, or prevent relapse. As in the case of relationship problems associated with individual disorders, this approach to classification is supported by abundant research data that link individual physical and psychiatric disorders to family functioning. Chapter 15 on children with life-threatening illness, Chapter 16 on anxiety disorders in adults, and Chapter 28 on adults with depression summarize a great deal of well-known research in this area. The current volume also

has chapters exploring newer areas of inquiry in this domain, particularly the correlation of dissociative disorders, of childhood disorders, and of a range of personality disorders with relational processes.

The level 4 approach to classification differs from level 2 in that the individual disorder remains a central focus of concern and often is the explicit objective of individual-level somatic or psychological treatment. Research data supporting this approach would indicate that family therapy is necessary but not sufficient for patient recovery and for the prevention of relapse. That is why family interventions are important in the treatment plan but are rarely selected as the only mode of treatment. In contrast, if research data supports the effectiveness of the family therapy as sufficient for the adequate treatment of both the relationship and the individual disorder, then the disorder is more suitably located in level 2. Clinicians will vary, when working with problems at level 4, in how they assess the adaptive strengths or psychopathology of other family members as a criteria for the outcome of their interventions. This approach also differs from level 3 because the classification of the individual disorder that is the primary clinical focus, for example Recurrent Major Depressive Disorder, does not require an assessment of current relationships as part of the definition of the disorder itself.

Consensus on the Value of the Classification Process

Chapters 7 and 8 were included specifically to raise questions about the value of diagnostic classification in clinical work with families. In a book of 34 chapters, it might appear as if these chapters reflect a minority opinion. However, at least two more chapters—Chapters 10 and 11, which focus on culture and classification—provide additional cautionary notes on classifying either individuals or families. Culturally uninformed clinicians may be confused themselves and may injure their patients with cultural biases and distortions. I would guess that most experienced clinicians, whether they advocate classification systems or not, are concerned about some of the unintended side effects of classifying families or family process that are raised in these four levels. Thus, these cautionary chapters do not necessarily reflect a minority view but reflect the ambivalence most of us feel about assuming expert status and labeling the families with whom we work.

However, even though it is likely that these concerns about classification are widespread, there is very little research exploring the pros and cons of the process of classification within the interpersonal nexus of family therapy. Fortunately, there are successful precedents in the research literature for approaching this problem. For example, social psychology—and related disciplines—provides a repertoire of concepts and approaches that might be adapted to an important program of research in this area. The most notable line of research was on “experimenter expectancy effects” where hypotheses of researchers were shown to have their own strong influence on the behavior of research subjects. A range of other studies from this tradition documents the powerful affects of attributions, both those of self and those of others, on self-perceived confidence and competence. These approaches could be applied to the family therapy setting.

HAVE WE PERSUADED OUR CLINICAL COLLEAGUES ABOUT THE IMPORTANCE OF FAMILY ISSUES IN CLASSIFICATION?

Since the family field is only now defining a consensus on clinical classification, it may be premature to ask how persuasive we have been to other clinicians outside our field. Nonetheless, as I write this, DSM-IV will have passed the 500,000 mark in sales. It forms an important basis for treatment planning in inpatient and outpatient treatment programs throughout the world. It lies at the core of clinical record keeping, it structures training programs and textbooks, and it is a critical component of reimbursement systems and health care planning. Thus, the content

of its text is a tempting yardstick to measure how seriously our work is regarded by our mental health colleagues. Were we to accept such a metric of our persuasiveness, we might note wistfully that in 886 pages of dense prose, families and relationships get only the briefest attention: A few paragraphs on family troubles are a part of "other conditions which may be a focus of clinical attention" and the Global Assessment of Relational Functioning is provided in an appendix presenting material for "further study."

Adding to our distress might be the long latency phase that will almost certainly precede the publication of DSM-V. It can now be recognized that DSM-III, III-R, and IV were all part of a relative short cycle of system construction where a classification scheme and specific inclusion and exclusion criteria were worked out. Although there is continuing disagreement on many of the decisions that were made in DSM-IV, its principal authors state that we will be well into the next millennium before a substantial overhaul of DSM-IV will be contemplated, much less carried out. Many of us seniors in the profession wonder if we will still be fit to serve as crew when DSM-V docks for a new load of ideas.

However, there are three good reasons to be cautious about using the volume of DSM-IV text space as a yardstick for measuring the impact of our ideas about relational classification on our colleagues. The first, as I have noted, is that consensus among us on this topic is only just emerging. The second reason is that there are clear limits and problems in DSM-IV. These are widely recognized and the subject of new research plans in which family clinicians and researchers can play a meaningful part. Third, while family therapy has contributed only a fraction of the total text to DSM-IV, it is widely practiced and widely taught. DSM-IV, has stimulated a broad interest in reliable and valid clinical classifications; family therapists and clinicians who work with them will certainly be avid consumers and useful critics of developing family classification schemes whether they are in DSM-IV or not or whether or not these diagnoses serve as a dependable basis for reimbursement.

The Limits of DSM-IV

While it reflects a prodigious achievement in research and clinical consensus, DSM-IV is best regarded as an important base for ongoing clinical research in classification. Its principal authors would almost certainly agree to this. What limits can we define now, what research is appropriate to address them, and where might improved approaches to family classification fit into this process? For illustrative purposes I will mention only three here, although the list of already-recognized shortcomings is much longer.

Classification vs. Diagnosis

First, DSM-IV—despite the big "D" in its initials—is a classification system, not a diagnostic system. Individuals are placed in categories but the underlying causes of their disorders are not systematically delineated by this system. The DSM-III, III-R, and IV cycle was an effort to use the best research available to define patterns of co-occurring symptoms or syndromes. These syndromes were an effort to represent the full range of clinical problems dealt with by the majority of American psychiatrists. During the preparation of DSM-IV, important efforts were made to extend the system beyond the discipline of psychiatry, by including other members of other disciplines on its panels. An important effort also was made to improve the validity of the system beyond the majority of American cultures by drawing on cross-national studies and by providing important information on how culture influences the clinical manifestation of most syndromes. In an appendix DSM-IV also provides a list of disorders that may be relatively unique to particular cultures. However, none of these efforts at extension were intended to address the central causes of the diagnostic syndromes, and in many cases, the causes are unknown or hotly disputed.

My own guess is that the authors of DSM-IV are right; DSM-V will be a long time in coming. However, I also sense that a long latency before its appearance increases the chances that

DSM-V will start a new cycle of manuals, one that reflects a mixture of careful classification, as they do now, but also a growing understanding of factors that influence the development, manifestations, and course of psychiatric disorders. In short, the manuals starting with DSM-V will more closely approximate a diagnostic system where the act of classifying patients is part of understanding the causes of their disorders and how to treat them. Here, family research can play a major role—particularly research that links family process to the development of psychopathology or to the definition of psychopathology itself. This research is likely to influence classification by providing new syndromes that are exclusively relational disorders, better definitions of existing syndromes by adding relational data to criteria sets, and by increasing clarity to diagnosis through clearer data on the family's role in pathogenesis.

Narrow vs. Broad Inquiries in the Classification Process

An important basis for consensus in DSM-IV is the very limited means that are required to make reliable classifications. A single structured diagnostic interview, lasting at most two hours, is all that is required. Two or three very well-developed interviews for adults and good ones for children have been field-tested for major collaborative studies of the epidemiology of childhood psychiatric syndromes. Moreover, for both adults and children in research settings, some of these interviews are designed to be conducted by interviewers with relatively little clinical training. Ironically, this major effort to professionalize the mental health discipline makes it possible for nonprofessionals to do a great deal of its business. As we move from classification to diagnosis, this rather anomalous situation cannot last. Diagnosis will almost certainly require much broader inquiry. Radiology and the clinical laboratory will almost certainly be involved not only to rule out "medical" diagnoses but to rule in certain "psychiatric" diagnoses with radiological or biochemical stigmata. Likewise relational data also will be crucial and must depend on highly skilled clinical observation of interaction patterns and, in all likelihood, more technical forms of data collection. Our field is defining more clearly where these data are crucial additions to the self-report that lies at the center of diagnostic interviews, particularly those conducted by nonprofessionals. The more we explore the importance of these data in reaching valid diagnoses of relational disorders, the more likely they are to be central requirements for a widely accepted diagnostic system.

Dimensional vs. Categorical Diagnosis

In her introductory chapter, Kaslow reports that the DSM-IV task force was concerned that research on family classification could not provide enough data to establish "thresholds" to distinguish illness from health. In Chapter 24, Bodin reports on his effort to design a scale that might indicate relationships which are "cases" because they exceed a conflict threshold. Indeed, the concept of thresholds is central to the DSM-III-IV series of manuals because they distinguish ill persons from the nonill. Family clinicians and researchers are uncomfortable with dichotomization. If they accept the concept of "illness" or "disorder" at all, they are much more likely to conceive of continua of difficulties rather than discrete categories. The Global Assessment of Relational Functioning provides assessment along single continuum of competence to disruption. Will family clinicians and research have to swallow the categorical pill to be included in DSM-V?

This seems unlikely. The categorical approach to diagnosis is already being challenged from two important lines of research. First, researchers oriented toward syndromes have become concerned about "subsyndromal" cases: People who are clearly suffering but fail to meet the DSM-IV thresholds. What should be done with them? One hypothesis was that these relatively mild disorders might be transient disturbances and that a high proportion would remit spontaneously. However, careful research suggests that this is not the case. Individuals in subsyndromal categories often remain the same or get worse unless they are treated; moreover, when one assesses their level of functioning in several spheres of life, they are quite impaired even though their criterion symptoms fail to meet minimum thresholds.

A second research tradition questioning simple dichotomies in classification are studies on the prevention of mental disorders. Here researchers have sought to identify individuals at highest risk for developing full-blown disorders so that preventive interventions can reach them before they fall ill. One strategy has been to identify prodromes of illness. This tactic has shown promise, for example, in preventing first episodes of full-blown schizophrenia in an initial field trial in England. As the enterprise of prevention expands, the search for reliable prodromes will continue. Chapter 14 reports, for example, evidence that the relatively mild disturbance of oppositional behavior in very young children is a reliable prodrome of a much more malignant conduct disorder. Prodromes will invariably be mild versions of the full-blown disorders, mild versions that over time shade continuously into full-blown disorders. Family researchers and clinicians may not have to distort their data and experience to fit into the dichotomous system of DSM-IV. Rather they can participate in an enlarging debate about when categories are appropriate and when continua more closely fit the clinical and research data.

Current Family Practice

It seems abstemious in the extreme for family clinicians and researchers to deny themselves the satisfaction of influencing their colleagues until the DSM-V boat arrives at the dock. The widening world of family therapy practice will have, I suspect, an increasing interest in valid classificatory schemes. Experienced family therapists will be badgered by reimbursement requirements and questioned by their students, and with all their reservations, they will be impressed that DSM-IV is a good tool both for reimbursement and clinical training. Concepts and approaches, such as those in this book, will form an attractive foundation for a systematic approach to classification that could receive wide interest and acceptance among family therapists.

But a deal should be struck. Family researchers should not formulate and disseminate systems of classification unless clinicians agree to participate in field trials of these systems. One can easily imagine that the authors of the chapters and their colleagues in the many organizations that sponsored the proceedings leading up to this book could continue work to develop a consensus document on a clinically important system of family classification. Extensive field trials would test the reliability and clinical utility of these systems. This pattern of transaction, within the family field, may be the most important factor in influencing clinicians practicing outside of it.

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