

Protocol for Week 1 – Introduction and theories/approaches to classification**Date: September 15, 2026****Scribes: Sidra Anjum & Angelina Heidebrecht**

A diagnosis is not a disorder; rather, a diagnosis is a classification or label assigned to a pattern. Using Monet's (1899) *The Water-Lily Pond*, Dr. Brankley illustrated how a viewer's perspective of the image can change where they define the boundary of the water, providing an analogy to the boundaries of a diagnosis. It can be difficult to determine the boundary between "normal" and "atypical" functioning, highlighting how context is critical to diagnostic interpretation. This can also raise the problem of reification, where the classification of a disorder can be treated as though it is concrete reality, rather than a diagnostic label.

The class considered three complementary lenses including the DSM description, harmful dysfunction, and CFI/formulation. The DSM provides a shared language for classifying patterns. The harmful dysfunction approach focuses on determining what makes a pattern a disorder. Wakefield conceptualizes a disorder as involving both harm and dysfunction. In contrast, the CFI/formulation approach contextualizes the pattern within the context of the individual. While someone may write a great diagnostic report, without context they fail to capture who the person is, the person's individual experience, what it means and the broader context. The CFI/formulation therefore emphasizes understanding the meaning and context of an individual's experience, rather than only providing a diagnostic label. The same diagnosis can be associated with different experiences and contextual meanings. Further, not considering an individual's experiences can hinder one's ability to create an effective individualized treatment plan and best support the individual. As Langa & Gone discussed, caring for the individual is a critical part of treatment. The DSM recognizes the importance of culture and context, but the class discussion demonstrated how such diagnostic approaches can still minimize the cultural and contextual meaning of the experience's individuals have, as was also discussed by Langa & Gone. This is important because culture shapes judgements of harm. Yet, the DSM is conceptually needed as it provides shared clinical language and communication. The CFI may be of great use adjunctively.

During our in-class discussion, a student asked if dysfunction was interchangeable with impairment. Dr. Brankley noted that something can be impaired but not dysfunctional, and something can be dysfunctional without producing impairment. A further question asked if dysfunction and impairment could be viewed as having a "cause and effect" relationship. Dr. Brankley agreed with this viewpoint and noted that dysfunction would speak more to the causal mechanism (or maintenance), and impairment would be seen as the manifestation or experience of the dysfunction. This distinction is important because it emphasizes the necessity of understanding the mechanisms responsible for impairment.

Points 5 through 6 of the DSM-5-TR's definition of a mental disorder require one to consider the role of society and cultural norms. Not only may cultural norms and the role of society shape what we view as dysfunctional or atypical but may also change what we classify as a diagnosis itself. Over time, the DSM has made drastic changes to some diagnoses including their complete removal, whereas others have remained nearly untouched. Dr. Brankley asked the class to consider how the DSM may look 30 years from now, emphasizing the need for humility and that classification systems should not be considered as fixed representations of reality. The DSM should be treated as the best attempt at explaining reality. One should not take the DSM more seriously than scientific support warrants.

Further, threshold questions must be thoroughly evaluated before a diagnosis. People can hyper fixate on certain events, particularly in forensic settings (e.g., the offence committed), and not evaluate pervasive patterns. A time limited instance does not necessarily indicate that there is

a persistent problem to treat. Additionally, changing diagnostic thresholds can change who gets diagnosed, with errors occurring in both directions (e.g., false positives and false negatives). Proposed changes to any diagnosis must go through thorough field testing, reliability, validity, clinical utility and risk-benefit analysis. Additionally, reliability is not the same as validity, a diagnosis can be applied reliably without demonstrating that it accurately captures the construct it represents. This has implications with the prevalence of the disorder, treatment and the stigma associated with having the disorder.

Four key terms related to a diagnosis and evidence calibration include: (1) Supported, (2) Missing, (3) Plausible, and (4) Contradicted. Missing evidence can be difficult to identify because recognizing that something is absent requires knowing what should be there in the first place (2). This highlights the importance of understanding diagnostic patterns, as familiarity with an expected pattern allows clinicians to recognize when an important piece may be missing. Plausible evidence presents a related challenge. Assessment should be grounded in what you can observe and hear rather than what you think, making it important to continually check for potential biases. Dr. Brankley used black holes as an example: although black holes cannot be directly seen, their presence can be inferred from their effects in space. Similarly, a clinician may observe certain behaviours and infer the presence of something that is not directly observable, referred to as plausible inference. Plausible inference introduces the risk of becoming “an opinion masquerading as evidence” (3). However, plausible inference may be more appropriate when there is a “blank space” left within an otherwise recognizable pattern. Lastly, contradicting evidence allows clinicians to both reflect on their own biases and guide possible treatment planning (4). For instance, if an individual approaches stress in situations where you would expect avoidance, this may alter the course of their treatment plan.

As previously discussed, a diagnosis classifies a pattern, but case formulations help explain it. Dr. Brankley used puzzles as an analogy for case formulations. In the puzzle analogy, a diagnosis is like recognizing the completed picture, whereas case formulation explains how the pieces fit together. Diagnoses and case formulations are not interchangeable, but they are also not mutually exclusive; you can not have a good diagnosis without a good case formulation.

There have been no other pragmatic alternative approaches to the DSM system. The DSM provides a “neutral” approach, largely made up of heuristic values. It remains useful as a shared clinical language and classification system. However, the DSM is not an algorithm, and diagnoses require us to apply case formulation, consider narrative explanations to make connections, and be based on theory.