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Commentary
Multiple diagnoses on multiple axes—A comment on 'Complex case: The relationship between, and treatment of, DSM Axis I and II disorders encountered in combination' by Janine Stevenson et al.

KENNETH R SILK, University of Michigan Health System, Ann Arbor, MI

The case as presented by Dr Stevenson et al. contains a number of very interesting points for discussion. However, I would like to concentrate on the issue of diagnosis, and the argument made that when cases become very complex, the diagnostic system, as we currently know it in DSM-IV, appears to fail us on a number of issues. The first issue may be that the distinctions between Axis I and Axis II disorders become blurred in that, as in this case, it is difficult to know where the social phobia and other anxiety symptoms end and the avoidant personality disorder begins. Or, in a similar vein in this case, it is difficult to know where the major depression ends and the borderline personality disorder begins or where the borderline personality disorder ends and the eating disorder and other obsessive–compulsive symptoms and behaviours begin. It does appear, as Dr Stevenson et al. write, that having one of these multiple disorders, i.e. meeting the DSM criteria for the disorder, facilitates the development or at least the clinical expression of one of the other disorders. This then leads to multiple diagnoses and multiple disorders, and the roadmap to logical and rational and sequenced treatment can become very complicated, if not downright chaotic.

If the point is pressed, we might find that there really is very little that distinguishes the two axes from each other, no matter how hard the developers of DSM-III tried to suggest that there were real reasons to divide diagnoses between the axes. In 1986, Gunderson and Pollack pointed out that many of the assumptions that we make to distinguish Axis I disorders from Axis II disorders are more myth than reality. And in the 20 years since the Gunderson and Pollack article was written, the distinctions between the disorders on the two axes in terms of genetic predisposition and other biological underpinnings, treatability and types of treatments, and chronicity and course of illness, appear to have become much less distinct, if in truth they have not disappeared altogether (Silk, 1996).

Thus, it appears that it might be useful to put all the diagnoses on the same axis and, perhaps in that way, to give these diagnoses equal weight. While I have no objection to this, I also think that perhaps something will be lost in eliminating Axis

II. In this age of rapid diagnosis and even more rapid treatment, the 'diagnosis' that is often made on Axis II is 'deferred'. In some ways this 'deferred' label may reflect the fact that we are often asked, in a very short time, to make a definitive statement about character structure and the disorder(s) of that structure based upon a single or a very few number of interviews. Many of us hoped that the existence of Axis II might make the hurried clinician pause for a moment to consider, at least, what character structure and what defences and methods of coping this person whom we are currently interviewing might possess from day to day and month to month, and not just for the moment to moment period during which we are examining him or her. But Axis II has not been utilized in this manner, though if Axis II becomes more dimensional and becomes an Axis where defensive and/or major characterological styles and coping abilities (or lack of same) might be listed, then perhaps a great deal of clinically useful and relevant material might be conveyed.

After all, it would appear that the main idea about diagnosis is to communicate information about a patient. But more recently, the idea behind diagnosis appears to be not to convey information, but rather to decide on a treatment. This might be the reason why the number of diagnoses appears to have mushroomed recently into more and more narrow categorical definitions (Blashfield & Fuller, 1996). Yet, while this growth in the total number of diagnoses in the DSM has been occurring, the number of diagnoses attributed to a given individual has also grown, so, as Stevenson et al. write, most of our patients appear to have more than one diagnosis, and these multiple diagnoses appear to come from both axes. Thus, it seems that diagnoses are no longer used to convey information about a patient from one clinician to another; rather they appear to now be utilized in order to tell us which is the correct treatment for this particular patient because the patient has this diagnosis, and we should know, or the pharmaceutical industry has tried to tell us, that this works for this particular diagnosis, though in truth it tells us nothing about what works for a particular patient who might meet the criteria for a specific diagnosis. While this type of thinking may appear to be quite straightforward and useful, it immediately breaks down when a patient has more than one diagnosis, especially if the different diagnoses are supposed to be treated in different ways. We have lost so much in the 25 years when each patient had a formulation that sometimes explained the diagnosis, but mostly tried to formulate the clinical history and the current clinical presentation and symptoms in a parsimonious paragraph or two. If done correctly, these formulations did convey much more information than our current diagnostic system gets across, even when the patient has multiple diagnoses. The formulations told us something about the complexity of the person who was presenting to us in the consulting room, and often made suggestions on how to *proceed along a path to treatment* rather than making a grandiose assumption that arriving at a correct diagnosis will lead us immediately to the correct treatment.

I do not mean to imply that all our patients are this complex. There are many patients who meet the criteria for a single diagnosis and respond well to a specific well-considered treatment, whether that treatment be biological or psychotherapeutic or a combination of both. But most of these patients, especially those that respond well within a short time, never come to us as psychiatrists or appear at hospitals or in speciality mental health clinics. These individuals are treated by their primary care physicians. It is the complex ones—those who do not fit into a given diagnosis or, as in this instance, fit into too many diagnoses—that appear in our offices. And as this case reveals, the current diagnostic system fails to adequately capture and integrate their complexity, and fine-tuning a diagnostic system that has been split into many diagnoses and two axes will not adequately lead us in the direction that we need to go in order to provide comprehensive and coordinated treatment for them. As we move towards consideration of DSM-V, it is time to think about a diagnostic process that conveys the intricacy and uncertainty

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of the complexity of human suffering that we encounter daily in our offices (Kupfer, First, & Regier, 2002).

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Address correspondence to: Kenneth R. Silk, MD, Professor of Psychiatry, University of Michigan Health System, Ann Arbor, MI 48109, USA. Email: ksilk@med.umich.edu

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