

Describing Relationship Problems in *DSM–V*: Toward Better Guidance for Research and Clinical Practice

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The authors provide a description of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM–IV)*; American Psychiatric Association, 1994) and its limitations, as well as empirical connections between relational processes and mental health. Four types of relational processes are identified, with each type clearly distinguished in terms of its pattern of association with psychopathology. For illustrative purposes, examples are provided along with suggestions of how each might be accommodated in the *DSM–V*. In view of the importance and complexity of the connections between relational processes and mental health, the authors argue that reliable and standardized assessments of relational processes are needed and suggest 6 possible approaches for providing better coverage of relational processes and relational disorders in the *DSM–V*. The article concludes with a discussion of potential concerns about expansion of attention to relational processes in the *DSM–V*.

Keywords: *DSM–V*, diagnosis, family, relationships, psychopathology

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM–IV)* was adopted by the American Psychiatric Association (1994, 2000) to guide reliable diagnosis. Those involved in its development made an explicit effort to use the best available science to inform decisions about nomenclature. This approach continued a revolution in psychiatric assessment begun with the *DSM–III* (American Psychiatric Association, 1980). Since 1980, reliability has improved as a result of the development of empirically informed criterion sets and the application of structured clinical interviews. The result has been enormous

gains in the ease of communication regarding specific problems and in developing science-based recommendations to guide clinical decision making.

Why Have Relational Processes Lagged Behind?

Relational processes have not been the focus of any successful effort comparable to that undertaken for psychiatric assessment more generally, but the resulting limitations of the *DSM–IV* in this regard do not stem from a failure to recognize the importance of relational context for disorders. Indeed, the *DSM–IV* highlights relational processes in the V codes (e.g., partner relational problem, sibling relational problem, parent–child relational problem), lists categories of psychosocial problems on Axis IV (e.g., problems with primary support group, problems related to social environment), and provides the Global Assessment of Functioning (GAF) scale on Axis V and the Global Assessment of Relational Functioning (GARF) scale in Appendix B. In addition, some relational problems have been addressed in supplemental materials, such as the discussion of abuse and neglect and other relational problems in Volume III of the *DSM–IV Sourcebook* (American Psychiatric Association, 1997). Unfortunately, because the research base from this era (i.e., pre-1994) was considered insufficient to support reliable guidelines for assessment or to tie relational processes to particular diagnostic outcomes, relational processes were not given the prominence in the *DSM–IV* hoped

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for by the Coalition on Family Diagnosis, an organization led by Florence Kaslow from 1988 to 1995, representing 15 different organizations concerned with family diagnosis (Kaslow & Patterson, 2006). However, a substantial empirical foundation connecting dyadic relational processes to mental disorders, and a substantial literature on the nature of these relational processes now exists. The current literature suggests a rich network of connections between relational processes and specific diagnostic outcomes. This suggests that conclusions regarding the adequacy of the research base to guide inclusion of dyadic processes in *DSM-V* may be substantially different than those reached for *DSM-IV*.

Should Relational Disorders and Relational Processes Be Included in DSM-V?

The question of whether relational disorders and processes are pertinent to mental illness and should be described in the *DSM* is largely moot; many types of relational problems are already included in the *DSM* and are highlighted as potentially important foci of treatment. However, currently, relational problems are poorly described, and the descriptions provided are not very useful for clinical or research purposes. In addition, pertinent relationship processes that are not in and of themselves disorders are not reflected well in *DSM-IV*. The question that will face the *DSM-V* committees is not whether to include descriptive information about relational processes and issues but how to best include this information and make its inclusion helpful for future empirical and clinical progress.¹ Nonetheless, a subtext of concern regarding the ontological status of relational disorders has haunted the discussion of relational processes for many years and thus bears consideration. That is, if there are “relational disorders,” are these true psychiatric conditions—or something entirely different? This philosophical issue deserves its own extended attention, but it is distinct from the practical issues that animate the need to include description of relational processes in the *DSM*.

One possible approach to reconciling the ontological status of relational disorders with the other constructs described in the *DSM* is to note that the *DSM-IV* describes mental disorders as a classification of diseases people have, not as characteristics of people. Even for severe and chronic conditions, the manual encourages the use of terms such as “individual with schizophrenia” (*DSM-IV-TR*, 2000, p. xxxi), rather than “schizophrenic.” Likewise, the fifth edition of the *Publication Manual of the American Psychological Association* (American Psychological Association, 2001) counsels the use of terms indicating illnesses that people have, suggesting that disorders need not be properties of individuals, merely things that happen to individuals. If this admonition is taken seriously, the distinction between the relationship disorders, currently described as V codes, and individual disorders, described elsewhere in the manual, seems somewhat artificial.

The current article does not address the contentious issue of whether or not relational disorders that confer excess morbidity and mortality, such as abusive parenting or serious and sustained marital discord, should be given equiva-

lent status to other disorders in the *DSM*. Nor is it necessary to resolve this issue to make progress in revising the *DSM* and to improve its coverage of relational processes. Instead, we focus on better specification of relational patterns to complement the structure of the *DSM*, by illuminating ways in which relational processes are central for understanding the etiology and course of mental illness and for guiding effective intervention for persons with conditions currently described in the *DSM*.

What Types of Relational Processes Are Important for Mental Health and Mental Illness?

Relationship Effects on Adult Mental Health

The literature linking adult intimate relationships to mental health outcomes is substantial. There are documented connections between relational processes and the etiology, maintenance, relapse, and optimal treatment of many disorders. Because we cannot provide an exhaustive review, we focus on briefly sampling this literature for illustrative purposes. Serious marital² dissatisfaction predicts increased risk for a major depressive episode in the subsequent year, even after controlling for history of depression (Whisman & Bruce, 1999) or comorbidity (Whisman, 1999). Both marital conflict and physical abuse predict subsequent increases in depressive symptoms among women (Beach, Kim, Cercone-Keeney, & Brody, 2004). The effect of humiliating marital events on depression is substantial (Cano & O’Leary, 2000; Kendler, Hettema, Butera, Gardner, & Prescott, 2003). From a behavioral–genetic perspective, the effect of marital satisfaction is a nonshared environmental effect and is not well modeled as resulting from the same genetic factors that produce the vulnerability for depressive symptoms (Reiss, Pedersen, Cederblad, Lichtenstein, Hansson, Neiderhiser, et al., 2001). Accordingly, disturbance in intimate adult relationships is key for understanding the etiology of depressive symptoms for many individuals and has the potential to supplement genetically based models (Caspi, Sugden, Moffitt, Taylor, Craig, Harrington, et al., 2003).

Marital approaches to treatment have proved useful for alcohol abuse (O’Farrell & Fals-Stewart, 2003), drug abuse (O’Farrell & Fals-Stewart, 2003), and depression (Beach, 2001). There are notable applications of rela-

¹ Additional information about progress in formulating relational diagnoses is available at www.fetzer.org. This site is hosting an ongoing discussion of the role of relational processes in the *DSM-V* throughout 2006 as *DSM-V* workgroups are being selected.

² Most of the research on effects of adult intimate relationships has focused on married, heterosexual couples. It is likely, however, that other close relationships have the potential to produce similar effects under some circumstances. In particular, it may be that long-term committed gay and lesbian relationships or cohabiting heterosexuals have an impact on one another that is similar to that of married, heterosexual couples. Accordingly, the use of the term “married couple” is meant to reflect the preponderance of data and not to exclude other types of dyads prematurely.

tional interventions for individuals with severe mental illness (Miklowitz, 2004). Such treatments are associated with reduced interpersonal stress, greater medication adherence, and lower rates of rehospitalization. As a result of such links, attention to relational problems has increased in the treatment of many mental health problems and is essential for the appropriate management of a number of disorders.

Relationship Effects on Children's Mental Health

Conflict between parents or between offspring and parents may have lasting effects on children. For example, women who were adopted soon after birth and who are at high genetic risk for depression show no evidence of the disorder if reared by adoptive parents without psychopathology or marital difficulties (Cadoret et al., 1996). Similarly, adoptees with a genetic risk for schizophrenia and exposure to specific communication styles in their adopted families are more likely to develop the disorder than genetically susceptible persons raised by families with more clear communication and clear roles (Tienari et al., 1994). These data suggest that an interaction between the relationship environment and particular genetic diatheses may be critical to the etiology of certain major mental disorders (Caspi et al., 2003).

Recent animal data also indicate the importance of early rearing environment; for example, poor maternal care by rat dams of their pups within the first 10 days of life influences gene expression (Liu et al., 1997). Poor maternal care leads to changes in glucocorticoid receptor messenger RNA expression in the hippocampus, resulting in enhanced glucocorticoid feedback sensitivity and increased sensitivity to stress. Such changes are the basis for lifetime sensitivity to stress of the maltreated pups (Liu et al., 1997) and set the stage for the offspring's own poor maternal care of their young. Conversely, good maternal care of infant monkeys at risk for anxiety symptoms moderates symptom expression (Suomi, 1999), suggesting that gene-family environment interactions may transform genetic liabilities into genetic assets and that disturbances in primary relationships early in life can change neural systems that control long-term emotional resilience or vulnerability (Gallo, Troxel, Matthews, & Kuller, 2003).

Marital conflict is associated with worse parenting and child adjustment, problematic attachments, and increased parent-child and sibling conflicts. Aspects of marital conflict that have a particularly negative influence on children include more frequent, intense, physical, unresolved, child-related conflicts and conflicts attributed to the child's behavior (Repetti, Taylor, & Seeman, 2002). Marital and parenting problems can be mutually exacerbating and may work synergistically to create a coercive family environment. In turn, marital and parenting problems can interact with genetic liabilities and influence gene expression to influence the etiology of many physical and mental disorders.

How Do Relational Processes Become Intertwined With Mental Health Outcomes?

Relationships often change as a function of psychological disturbance or disease states (Wamboldt & Wamboldt, 2000). In some cases, relationship difficulties are an integral part of a disorder (e.g. Chatoor, Hirsch, Ganiban, Persinger, & Hamburger, 1998; Reid, Patterson, & Snyder, 2002). For example, depressed persons often invite criticism from significant others (Swann, 1996), and perceived criticism from significant others predicts relapse (Hooley & Teasdale, 1989). Depressed individuals may engage in behavior that precipitates interpersonal stress that then feeds back to maintain or exacerbate their depression (Hammen, 1991). In this way, significant others become incorporated into the progression of the disorder. In this context, some relational behaviors that would have been adaptive or benign, or might never have occurred at all in the absence of the disorder, can serve to make a disorder self-sustaining and self-propagating (Pettit & Joiner, 2005). As a result, intimate relationships often become part of the vicious cycle maintaining psychiatric disorder.

Can Nondisordered Relational Processes Also Influence Course of Illness?

Even relatively benign relational processes, such as a partner's role in self-confirmation may serve to maintain pathology under some circumstances (Katz & Beach, 1997). Likewise, criticism is a natural part of everyday functional and dysfunctional parenting relationships. Nonetheless, a high level of critical attitudes in family members resulting in high expressed emotion, predicts a different and more negative course for people with schizophrenia (Butzlaff & Hooley, 1998) or mood disorders (Hooley & Gotlib, 2000) than does a low level of critical attitudes in family members with whom the patient interacts. The dimension of expressed emotion illustrates a relationship process that, although not considered a "disorder," may rise to the level of clinical importance in some contexts.

Preliminary Distinctions

Relational Disorders Versus Relational Risk Factors

The preceding brief overview illustrates that there are many different kinds of relational processes to be considered. Some relationship problems, such as those identified in the current V codes, produce clinically recognizable sets of symptoms, are associated with distress and interference with personal functioning, and could be a focus of clinical attention in the absence of any other disorder (e.g., marital discord). Conversely, other relationship problems may be of clinical interest because they can be risk factors for negative outcomes in the context of an ongoing psychiatric disorder or increase risk for relapse of that disorder even though they are not disorders in themselves, do not typically interfere with personal functioning in themselves, and would not typically be the focus of clinical intervention in the absence

of any other disorder (e.g., expressed emotion). This second type of relational process is not currently highlighted in the *DSM*. Therefore, it may be useful for the revision to distinguish between relational disorders, already included in V codes, albeit in an unelaborated manner, and relational risk factors that are not currently included and may need to be added.

General Versus Specific Effects of Relational Processes

It is also important to distinguish between relationship problems with robust consequences for maintenance or progression of a number of disorders (e.g., marital discord and expressed emotion) and those relationship problems that have been shown to have an effect in the context of only a single set of disorders (e.g., partner confirmation processes in depression) or that play a salient role in only a single disorder (e.g., intrusive feeding behavior in the context of feeding disorder of infancy). Because of their different practical implications, general versus specific relational processes may require different treatment in the *DSM*. General relational processes could be described without reference to other specific mental or physical disorders and thus could be described in their own section or on their own axis. This would allow general treatment guidelines and case identification methods to be explicated in an efficient manner and would be conducive to scientific communication and clinical utility. In contrast, specific relationship processes that may be of great importance in one disorder, but of limited relevance for other disorders, would be more efficiently described in the context of that disorder. Rather than place such descriptions in a separate section, these would be more useful if tied to the specific disorder for which they are most relevant, suggesting the value of descriptions embedded in the text of the disorder or reflected in modifier codes for that particular disorder. At a minimum, the variability in types of

relational processes suggests that it may be necessary for a comprehensive diagnostic system to use more than one approach to describe key relational processes and disorders that may have an impact on the etiology and treatment of mental illness.

Four basic categories of relational process potentially requiring different treatment emerge from the above distinctions: (a) disordered and general relational processes, such as abuse or marital discord (i.e., the relational disorders currently described in the V codes); (b) nondisordered and general relational processes, such as high expressed emotion or conflict avoidance in marriage (i.e., relational processes not currently included in the *DSM* that are relevant for treatment and research for many disorders); (c) disordered and specific relational processes, such as intrusive feeding in the context of feeding disorder of infancy or problematic parenting in the context of conduct disorder (i.e., disordered relational behavior that is a component of some psychiatric disorders and that affects treatment and research for particular disorders); and (d) nondisordered and specific relational processes, such as partner verification in depression or low parental monitoring in teen drug use (i.e., relational processes that affect treatment and research for particular disorders; see Table 1). It would be possible for relational processes to move from “specific” to “general” as research regarding the range of effects accumulates. Each of these categories may require different characterization in the *DSM* and, in some cases, it may be appropriate to use more than one approach to capture key relational processes.

Is There a Way to Sort Relational Processes Into Four Categories?

In the proposed scheme, all relational processes of interest could be parsed into one of four categories formed by the crossing of “general versus specific” with “disordered versus nondisordered.” Relational processes would be consid-

Table 1
Examples of Relational Processes Categorized in Terms of Documented Patterns of Effect (General vs. Specific) and Empirically Established Characteristics (Disordered vs. Nondisordered)

Characteristics	Pattern of effect	
	General	Specific
Disordered	Marital discord Child abuse/neglect Intimate partner abuse Parent-child relational problem Sibling relational problem Separation anxiety disorder Reactive attachment disorder	Intrusive feeding in feeding disorder Coercive parenting in conduct disorder Relational problem Sexual desire disorders Sexual arousal disorders Orgasmic disorders Shared psychotic disorder
Nondisordered	Expressed emotion Conflict avoidance in marriage Bereavement Reinforcement of problematic behavior	Partner verification in depression Peer group influence in conduct disorder Low support provision in depression Reassurance seeking processes in anxiety disorders and depression

ered nondisordered until clearly demonstrated to create distress or impairment in the absence of other disorders, to be nonresponsive to self-repair processes or simple provision of information, and to not be merely a response to the aberrant behavior of an individual. Accordingly, an empirical criterion would separate disordered from nondisordered behavior and thus protect against stigmatizing family members or recommendations of premature intervention. Likewise, relational processes would be considered specific until clearly demonstrated to have implications for multiple forms of psychopathology. As new relational processes are considered for inclusion in the *DSM*, there would be a clear set of both defaults and empirical hurdles for inclusion in each category. To clarify the different ways that relational processes might be represented in the *DSM*, we offer a very limited set of illustrative examples. Space limitations preclude more extended treatment, but in each case other examples could have been selected, and additional possible examples are included in Table 1. Because clearly specified criterion sets are critical for specification of categorical or dimensional constructs, and because well-validated criterion sets would be a natural extension of the current V codes, we discuss the important issue of categorical versus dimensional treatment of relational processes below after we illustrate the ways in which each type of relational process might be included in the *DSM-V*.

General and Disordered Relational Processes

Relational disorders are already identified as V codes in *DSM-IV*. Of central importance for *DSM-V* is that the indicator set for each of these disorders be more clearly specified. Given the accumulation of data, specification of reliable and valid indicators should be possible for each of the current V codes. Circumstances under which these disorders should be a focus of clinical attention also may be an appropriate target for clarification in the *DSM-V*. It may be possible to provide guidance about the threshold for considering a problem a relevant target for direct clinical attention rather than merely a background variable for treatment planning. The utility of these descriptions might be enhanced by creating a separate relational disorder category that could underscore the value of continued research on these problems and provide guidance for clinical intervention. More detailed criterion sets for the relational disorders have been proposed previously, with good convergence across prior efforts (First et al., 2002). Below we use parent-child problems to illustrate the initial steps in the process of developing criterion sets for a relational disorder on the basis of the empirical literature. Data pertaining to each proposed relational disorder would have to be reviewed to develop criteria appropriate to that disorder.

Illustrative Example: Parent-Child Conflict Disorder

A large empirical literature identifies correlates of parent-child conflict disorder, including parental depression and substance abuse (Cummings, DeArth-Pendley, Schudlich, & Smith, 2001), and potential indicators have

been identified, including developmentally unrealistic expectations; negative misperception of child behaviors (Wahler & Sansbury, 1990); negative attributional style with regard to the child (Baden & Howe, 1992); overreactive anger and child discipline (Slep & O'Leary, 1998); and inconsistent discipline, low supervision, and rigidity. Associated child behavior may include high levels of noncompliance, disapproval, and negativism. Accordingly, it should be possible to develop an empirically grounded set of criteria that capture the shift from normative, transient conflict between parents and children to the type of parent-child conflict that warrants clinical attention, as well as to define subcategories or additional categories that capture additional problematic features (e.g., child abuse or neglect). Because parenting changes across the life span, it may be necessary to specify different indicators for children of different ages.

General but Nondisordered Relational Processes

The importance of nondisordered and general relational processes (e.g., expressed emotion, conflict avoidance) could be highlighted by creating a separate axis for the description of relational context. Important contextual processes could be better specified, epidemiologists could examine the prevalence and incidence of key aspects of relational context in the general population, and clinical decision making could be better informed. A separate axis would help distinguish between relationship problems that are contextual (i.e., increase the probability of symptomatic exacerbation or relapse despite not being disorders themselves) and those that are disorders (i.e., cause distress and morbidity regardless of the presence of comorbid conditions).

As an illustrative example we discuss "expressed emotion." Expressed emotion is indexed by expressed attitudes toward the identified patient and thus lends itself to reliable, dimensional assessment. High levels of expressed emotion are relatively benign in many family contexts, and in others may be elicited by the presence of physical and mental health problems (Gustafsson, Bjorksten, & Kjellman, 1994). Alternatively, confronted with unusual behavior, family members may misapply strategies that would have been relatively benign in the absence of severe mental illness in a family member, again resulting in high expressed emotion (Hooley & Gotlib, 2000). Accordingly, high expressed emotion is not a relational disorder but nonetheless has implications for treatment because it is an important context that influences the course of illness in many cases.

A substantial empirical literature guides the assessment of expressed emotion and links ratings of expressed emotion to treatment decision making. The best established measurement approach is the semi-structured Camberwell Family Interview (Leff & Vaughn, 1985), conducted with key relatives, without the patient present. Ratings on the five dimensions of Criticism, Hostility, Emotional Overinvolvement, Warmth, and Positive Remarks allows all family members to be classified as high versus low in expressed

emotion. Threshold criteria may be adjusted for different psychiatric problems on the basis of empirical findings.

Specific and Disordered Relational Processes

A third proposal for enhancing the description of relational processes would incorporate a reference to the presence or absence of disorder-specific relational processes through relational specifiers. Specifiers are most often used to describe the course of the disorder or to highlight prominent symptoms. However, specifiers also can be used to indicate associated behavioral patterns of clinical interest. Because the relevance of relational specifiers may be seen clearly in disorders of infancy and childhood, we use feeding disorder in infancy to illustrate the advantages of using relational specifiers to incorporate relationship information into *DSM-V* diagnoses to subtype the disorder and thus provide more appropriate treatment.

Using Specifiers and Elaborating Embedded Relational Criteria

Relational specifiers: The example of feeding disorder. *DSM-IV* introduced the category of feeding disorder of infancy or early childhood but made no effort to distinguish among subtypes despite preliminary evidence suggesting several variants. For example, children may refuse to eat subsequent to a trauma involving the upper gastrointestinal tract, or their refusal may reflect the interaction of their temperament and an anxious, intrusive feeding style on the part of their primary caregiver. These two subtypes may demonstrate different patterns of dysfunction and respond to various forms of intervention. Accordingly, explicating relational characteristics of the feeding process could play a pivotal role in enhancing diagnosis and treatment.

Elaborate embedded criteria: The example of conduct disorder. In some cases, behavioral patterns of interest might be better captured by elaborating them as part of the symptom criteria for a particular disorder. This may be relevant when an entire category of disorder has prominent relational characteristics but these have been omitted or downplayed in the diagnostic criteria. Accordingly, a fourth proposal for making relational processes more salient would involve better highlighting relational elements implicit in existing disorders. Current diagnostic criteria for conduct disorder, for example, make no mention of the parent-child relationship. However, the relational problems in this disorder may be so central to its maintenance, if not its etiology, that effective treatment may be impossible without recognizing and delineating the relational aspects of the disorder. Elaborating the embedded relational criteria may be critical for enhancing our understanding of treatment response and relapse.

Research on conduct disorders reveals that a coercive, hostile, punitive parenting style is associated with an increased risk for conduct disorder and antisocial behavior. Although this may reflect a shared genetic makeup contributing to coercive behavior in the parent and antisocial behavior in the child (Reiss, Neiderhiser, Hetherington, &

Plomin, 2000), there is little doubt that the interaction pattern is integral to the disorder. Observational data indicate that the parents' desperate efforts to control a child, who is essentially socially unskilled, consist of threats, scolding, and demands (Stoolmiller, Patterson, & Snyder, 1997), which are temporarily effective at best. The child's response to the parents' coercive behavior is aggressive behavior, leading the parent to stop demanding the child's compliance temporarily. This sequence comprises a spiral of negative reinforcement for both parent and child that occurs time and again, maintaining, and perhaps escalating, the child's antisocial behavior and the parent's ineffective response. Interrupting the relational pattern is an efficacious treatment for childhood conduct disorders, although the results for adolescents are less certain (Kazdin, 1998), and no other intervention approach has compiled an equally impressive scientific record. Inclusion of relational characteristics as part of the diagnostic criteria for conduct disorder may be the most appropriate way of recognizing their central role in the psychopathology and treatment of the disorder. Many other disorders may be amenable to similar analyses and might benefit from elaboration of the embedded or implicit relational problems characteristic of the disorder.

Specific but Nondisordered Relational Processes

There are a number of relational processes of importance for one disorder that are not yet known to be of general importance or may have negative consequences only in the context of a specific disorder (e.g., partner confirmation processes in depression). In such cases, it might be most efficient to discuss the relevance of the process in the text of the *DSM-V*. As the text is revised to reflect new findings related to particular disorders, the empirical literature linking particular relational processes, whether disordered or nondisordered, to etiology, maintenance, relapse, or burden of the disorder, could be included.

Other Issues

Categories Versus Continua

Can we avoid the premature categorization that has led to difficulties in the personality disorder area (Widiger & Clark, 2000)? For better or worse, humans are prone to think in categorical terms, gain more (over)confidence in making categorical decisions with increasing expertise, and become more divergent in their beliefs about such decisions over time (Simon, Pham, Le, & Holyoak, 2001), suggesting that professionals are at risk of engaging in premature categorization. As a result, individuals can be induced to provide ratings that reflect categories even when none exist (Beauchaine & Waters, 2003); this should provide a cautionary note as the *DSM-V* revision process begins. All *DSM* workgroups may need to consider whether particular criterion sets tied to categorical variables better reflect the structure of the entities under consideration than do continuous measures. It may be prudent to identify criterion sets

that can be used with or without cutoffs to avoid imposing a categorical structure prematurely.

At the same time, taxometric procedures (Waller & Meehl, 1998) have been developed to address the question of whether psychological constructs are best characterized as being dimensional only or whether there is evidence of a latent categorical structure superimposed on the dimension of interest, and these approaches may be of use in deciding how best to assess and characterize particular relational processes. If there is evidence of a latent categorical structure, members of the group of interest may be identified as members of the "taxon" and nonmembers identified as members of the "complement." A result of this sort would indicate that the relational process in question could be treated as identifying two categories. Conversely, failure to find evidence of a categorical structure would indicate that the relational processes should be treated as continuous. Meehl's taxometric approach incorporates multiple tests to avoid the false/incorrect identification of a taxon and has been tested in Monte Carlo studies (e.g. Meehl & Yonce, 1996; Waller & Meehl, 1998). Of great importance for relational processes, this approach provides a method for identifying whether a construct is categorical even in the absence of a true criterion measure and also provides an indication of the ideal cut point for correctly identifying members of the taxon and the complement (Waller & Meehl, 1998). Such a strategy has the potential to greatly facilitate the appropriate use of criterion sets for relational processes of interest.

Enhancing Clinical Decision Making

Even with changes that highlight specific relational disorders and relationship dimensions with particular clinical relevance, incorporating relational context into treatment planning will be challenging. Relational processes are often embedded in larger systems, requiring attention to a multi-systemic perspective for the prevention or treatment of many disorders (e.g. Kotchick, Shaffer, Forehand, & Miller, 2001; Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004). It may be useful therefore to provide a guide to thinking about disorders in a relationship context either as an appendix of the *DSM-V* or in a companion volume. In this way, an extended discussion of the issues pertinent to assessing and utilizing information about family and the broader social context that may affect relational processes could be included. This would supplement the multi-axial diagnostic system by addressing difficulties in applying the diagnostic system in the context of ongoing relationship problems or broader systemic difficulties. A guide to relational formulations might also serve as a useful stimulus to training programs and encourage better instruction in family-based approaches to mental health intervention. Providing a guide to relational formulations and social context would suggest that it is crucial to take into account an individual's primary social group and describe its relevance to clinical care. Areas to be highlighted might include level of family conflict about the disorder, family view of the source and likely course of the illness, family view of the patient and the

patient's potential for improvement, family view of treatment and treating agencies, family strengths and sources of support, and family sense of caregiver burden. This material might also address neighborhood effects that influence outcomes of interest (e.g. Cutrona et al., 2005). By providing guidelines for a relational formulation, a number of issues related to need for increased specificity of description, the role of the family in treatment implementation and long-term adherence, and the role of the family as a source of both social stress and social support could be addressed. If a companion volume were provided, these general guidelines could be further elaborated with respect to particular mental disorders and the relationship processes most central to case management. The inclusion of guidelines for a relational formulation is in keeping with the *DSM-IV's* inclusion of guidelines for a cultural formulation.

Concerns

Is Reliable and Valid Assessment Possible?

Current definitions of relationship problems do not include many processes of interest and, for relationship problems that are mentioned in the *DSM*, the definitions provided do not allow for communication of results with the ease customary for other areas dealt with by the *DSM*. This slows research and practice. Data-based criteria for relational disorders, context, specifiers, and embedded diagnostic criteria, as well as greater attention to the available data linking particular relational processes and forms of psychopathology should help correct this problem. Nonetheless, some additional research may be necessary to demonstrate the reliability and validity of particular criterion sets and to determine whether criterion sets are better treated as assessing continuous or categorical constructs, and if categorical, at what point the transition occurs to problematic intensity.

Will These Efforts Undercut Reimbursement Parity for Mental Disorders?

Because neither relational disorders nor relational risk factors will be defined as individual mental disorders, greater attention to relational context is unlikely to influence reimbursement parity. Elaboration of embedded relational criteria and identification of relational specifiers should be neutral with regard to prevalence of reimbursed treatment of mental illness and thus have no effect on the discussion of reimbursement parity. Conversely, to the extent that greater attention to relational context improves treatment or reduces residual impairment, there may be an indirect, positive impact on this discussion. That is, there may be substantial cost offset in some areas as better outcomes lead to reduced long-term expenditures (e.g. Arias & Corso, 2005). Better specification of relational influences on psychopathology along with empirically justified recommendations about the appropriate inclusion of relational interventions could also lead to greater utilization of relationship-oriented interventions. This is to be hoped for to the extent that it leads to more effective treatment, more rapid recovery, reduced

caregiver burden, or decreased relapse. Greater utilization of these interventions might lead some third-party payers to provide coverage or, more likely, to not specifically prohibit coverage of these services. Of course, the *DSM* does not determine reimbursement policies and thus reimbursement of family or other relational approaches to treatment will not be settled by the outcome of deliberations by *DSM-V* committees.

Will Relational Processes Engender Negative Reactions From Families of Patients?

Another difficulty confronting greater inclusion of relational processes is the potential perception that greater attention to the importance of relational processes will contribute to family blaming or stigma. It is not without some justification that family members may view efforts to create a category of relational disorders with suspicion. In the past, families have been scapegoated for mental health system failures to adequately treat patients, and relational processes may appear to be another set of conceptual tools for accomplishing the same end. To the extent that the interventions engendered are helpful and nontoxic, it is likely that the enhanced category system will be accepted as beneficial by family members. It will be important to provide characterizations of family functioning that are not inherently stigmatizing. Avoidance of characterization of "ideal" family functioning and a focus on potentially changeable aspects of family functioning may also help prevent negative reactions by family members.

Will Family Researchers and Family Therapists Be Involved in the DSM-V Revision Process?

It is unknown to what extent family researchers and therapists will participate in the dialogue related to relational processes and disorders in the *DSM-V*. Once workgroup selection begins (2006), it may be possible to better gauge the likely influence of family researchers and therapists. In the meantime, there are ongoing discussions within the Division of Family Psychology of the American Psychological Association (Division 43) and by the Workgroup on Relational Processes in Mental Health, supported by the Fetzer Institute in collaboration with the *DSM-V* steering committee. One possible response to the proposals in the current article would be inclusion of individuals with relevant expertise in all *DSM-V* workgroups.

Overall Conclusions and Recommendations

There is widespread, empirically supported clinical use of relational interventions. Myriad treatments for marital and couple conflict disorder have been shown to be effective in controlled clinical trials (e.g. Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). There may be conditions under which analogous techniques can be used for violent couples (O'Leary & Vega, 2006), particularly in the context of drug or alcohol abuse (O'Farrell & Fals-Stewart, 2003). It is likely that a majority of couples used in controlled trials for

treatment of marital conflict had at least low levels of marital aggression (cf. O'Leary, Vivan, & Malone, 1992). Likewise, there is evidence for the effectiveness of parenting interventions (Kazdin, 1998), family interventions in schizophrenia (Butzlaff & Hooley, 1998), and partner involvement in the treatment of alcohol abuse (O'Farrell & Fals-Stewart, 2003) and drug abuse (Fals-Stewart, Birchler, & O'Farrell, 1996). Accordingly, a diagnostic system that provided better guidance regarding when to provide treatment for relationship difficulties and when to utilize relationship-oriented interventions to enhance outcomes would have great clinical benefit. A substantial body of basic research shows that the relational context of disorder is consequential for etiology and treatment decision making. The need to make better provisions for the description of relational context is most obvious when disorders of childhood are focal. However, the effect of relational context on a wide range of outcomes throughout the life span underscores the need to provide relational diagnoses and identify relevant relational processes for adult-adult relationships and possibly for child-child relationships as well. At a minimum, it will be important to better specify the relational disorders, identify empirically supported relational risk factors, and provide relational specifiers for some forms of psychopathology and relational characteristics of some disorders that may lead to greater precision in their characterization.

The four relational processes suggest five ways the *DSM-V* could be improved relative to the *DSM-IV*: (a) devise clear criteria for the relational disorders currently depicted in V codes, perhaps creating a relational disorder category on Axis I; (b) develop an axis devoted to relational risk factors with clear criteria for assessing empirically supported contextual processes that might be the target of clinical intervention, including both family and multisystem contexts; (c) use relational specifier codes to indicate important disorder-specific relational processes; (d) elaborate relationship criteria for existing disorders where appropriate; and (e) describe relevant relational processes in the text associated with the disorder. In addition to these five approaches, it might also be useful to provide guidelines for relational formulations in an appendix or a companion volume to guide clinical use of the new information regarding relational processes. For each option, enhancing the current system could stimulate new research, guide the integration of applied and basic research findings, and inform services. Each relational process could have several well-supported candidates before the *DSM-V* revision process is concluded.

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