The third edition of the DSM, along with its subsequent editions and counterpart editions of the ICD, substantially refined psychiatric classification, greatly reduced national variations in prevalence estimates, improved the diagnostic process, and provided a common language for the field. Nevertheless, these classification systems also have significant limitations. These traditional systems consider all mental disorders to be categories, whereas the evidence to date suggests that psychopathology exists on a continuum with normal-range functioning. Traditional diagnoses generally show limited reliability, as can be expected when arbitrary categories are forced onto dimensional phenomena. Many existing diagnoses are quite heterogeneous and encompass multiple pathological processes. Traditional taxonomies attempt to address heterogeneity by specifying disorder subtypes. However, most subtypes have been defined rationally rather than being derived from structural research, and fail to demarcate homogenous subgroups. Co-occurrence among mental disorders, often referred to as comorbidity, is very common in clinical samples. In terms of nosology, high comorbidity suggests that some unitary conditions have been split into multiple diagnoses, which co-occur frequently as a result, indicating the need to redraw boundaries between disorders. Many patients fall short of the criteria for any disorder, despite manifesting significant distress or impairment that indicates the need for care. The DSM-5 addresses this problem by providing Other Unspecified categories. The core issue potentially responsible for these shortcomings is that construction of traditional taxonomies went beyond evidence available on the structure of psychopathology and was shaped by various other considerations. It appears that this rational approach to psychiatric nosology, not grounded in structural research or an understanding of the etiologic architecture of mental disorders, has failed in some instances to represent psychopathology accurately. Clinically, diagnosis is expected to help in selection of treatment, but the DSM and ICD are imperfect guides to care.

A solution to the shortcomings of traditional taxonomies is emerging in the form of a quantitative nosology, an empirically based organization of psychopathology. Rather than relying on a priori assumptions, a quantitative nosology is defined through the independent work of multiple research groups seeking to understand the organization of psychopathology. The quantitative movement has a long history, beginning with the pioneering work of Eysenck and Overall, who developed measures to assess signs and symptoms of psychiatric inpatients, and identified empirical dimensions of symptomatology through factor analysis of these instruments. Others have searched for natural categories using such techniques as cluster analysis. Similarly, research on the structure of affect helped to identify dimensions of depression and anxiety symptoms. Finally, factor analyses of comorbidity among common disorders revealed higher-order dimensions of psychopathology that inspired a growing and diverse literature. Also relevant are factor analytic studies of normal personality. These general traits show strong links to all common forms of psychopathology; in addition, specific facets are highly informative for understanding certain mental disorders.

A quantitative psychiatric classification operates on two levels. First, it constructs syndromes from the empirical covariation of symptoms to replace diagnoses that rely on untested assumptions, such as the assumption that mental disorders are categories. Second, it groups syndromes into spectra based on the covariation among them. Intermediate structural elements – such as components within syndromes and subfactors within spectra – are similarly elucidated. In line with existing evidence, all of these constructs have been operationalized dimensionally. Hence, if a question concerns a clinical feature common to multiple syndromes, the clinician or researcher may focus on the higher-order dimension. Alternatively, if a specific syndrome is of interest, the higher-order dimension can be controlled statistically to elucidate information unique to this syndrome. This hierarchical organization is an important feature of a quantitative nosology; the multi-level approach allows for a flexible description of a patient depending on the desired degree of specificity.

The NIMH created the RDoC framework to encourage the development of a dimensional research classification system of psychological processes with established neural bases and potential relevance to psychiatric symptoms. This framework is concerned with basic biological processes as much as with pathological behavior, and seeks to link animal and human research, thus largely focusing on constructs that apply across species. As such, the RDoC system holds particular promise for advancing the understanding of biological processes relevant to psychopathology, but its coverage of clinical phenomena is neither highly detailed nor comprehensive. A quantitative nosology goes well beyond the scope of the RDoC in meeting this need and can inform the RDoC framework with regard to key clinical dimensions that need to be considered. The quantitative nosology is driven by clinical constructs and specifically targets shortcomings of existing diagnoses, while also defining clearer phenotypes for basic research. At the same time, a quantitative nosology is limited by its focus on clinical manifestations. The resulting dimensions are descriptive, and their nature is not immediately clear. Validation studies, perhaps conducted within the RDoC framework, are needed to elucidate the etiology, pathophysiology, and treatment response of these quantitative dimensions. Overall, these two efforts approach nosology from different perspectives, but are well positioned to advance toward one another in order to produce a unified system.

Transdiagnostic theory aims to identify transdiagnostic factors, or constructs that play a role in the onset and maintenance of several different disorders. Therefore, it has been suggested that rather than examining risk factors for each specific disorder in turn, a more fruitful approach to understanding psychopathology would be to focus on transdiagnostic factors that can contribute to the development and maintenance of various forms of psychopathology.

There are numerous similarities between delusions and overvalued ideas. Moreover, overvalued ideas can transform themselves and reach the state of delusions. They both represent „abnormal‟ fixed states of mind, occupying the consciousness of the individual, absorbing her feelings, thoughts and overall energy to large degree. As such they are noxious and impair the overall cognitive performance of the individual as well as her affective sensitivity. They both have negative consequences, although overvalued ideas could sometimes have some positive ones; it always depends on the given case and context. We are interested in the possible continuum formed by these ideas and specifically at the point where the overvalued ideas are transformed into delusions, and the other way round, when delusions lose their affective power, start to dissolve and are transformed into delusion-like ideas. Thus we hypothesize that they could lay on a single continuum. For proving or disproving this hypothesis we will make conceptual analysis of the two concepts then a conclusion will be drawn, and also some philosophical issues will be addressed as well.

In so far as both beliefs and values are related more or less to overvalued ideas and delusions (delusional ideas) we want to provide a little information concerning their distinction. Veale (2002) provides a clear-cut differentiation between the two notions: beliefs (or inferences, as he also called them), on the one hand, are something that is assumed by the person to be true based on some observation or evidence, values, on the other hand, are supposed to be something that is assumed to be good or important by the individual. Beliefs can be tested and can be subjected to empirical testing or logical evaluation in order facts reinforcing or weakening the given belief to be obtained. These facts or evidences are said to possess objective value. Values though cannot be tested at all. They are normative principles held by the individual. Veale speaks also of evaluation as similar notion to value. Evaluations are a rating of particular things on a scale whose ends are represented by the good and the bad; they are also subjective and personal thus cannot be subjected to any proof, evidence or empirical testing. Both beliefs and values can influence each other. Veale (2002) notes however that „the division between beliefs and values is often confused and has had little impact on psychiatry or psychotherapies. They are however like two sides of a coin.‟

The concept of overvalued idea was firstly introduced and described by Wernicke in 1900. Later, in 1984, it was reviewed by McKenna, and recently again, by Veale in 2002. Unfortunately, there is a partial lack of agreement among specialists about the essence of the overvalued ideas. All clinicians agree however that these ideas represent disorders of thought and psyche.

Overvalued ideas represent solitary comprehensible but abnormal ideas (and beliefs), emotionally charged, that have escaped the control imposed by the reason; these ideas are based on idealized values which, according to Veale (2002), are constituted in such a way that possess an over-rigid importance and totally define the Self of the individual: „such patients are unable to adapt to different circumstances and ignore the consequences of acting‟ (Veale 2002). They could occupy and dominate ones life for prolonged time periods (usually months or years) and influence greatly ones actions; they are neither obsessional nor delusional. An overvalued idea is deceitfulness without a critical attitude from the individual towards it; an obsession is missing – all thoughts and feelings are in accordance with the dominating overvalued idea. Kovalev distinguishes two types of overvalued ideas – 1) ideatorily charged and 2) affectively charged. In the first division are classified ideas with contents like „reflections on the purpose of human life and its meaning, the existence of alien civilizations, writing of treatises about the „world consciousness‟ or „perfections of the theory of relativity‟, etc.‟; other affectively charged ideas are about non-existing or exaggerated physical deficiencies. They may not be as rare as is often thought; usually have poor prognosis, are resistant to any treatment and could be encountered even in healthy individuals. Overvalued idea is thought to lay on a continuum where it stands between the obsession and the delusion; there are possibilities of transformation of an obsession into an overvalued idea and vice versa, and of an overvalued idea into a delusion and vice versa.

In the European tradition the overvalued idea is given the following definition: an idea that is held strongly; preoccupies ones mental life; is ego-syntonic; is developed usually in abnormal personality; is comprehensible given ones past; has content that is regarded as abnormal compared to the general population, but is not so bizarre; causes disturbed functioning or distress; is associated with high degree of affectivity; could lead to repeated actions; could progress to delusion; etc.

The diagnostics of an overvalued idea is difficult. There is a scale developed by Eisen et al. (1998). It is multidimensional and includes variables like: degree of conviction, perception of others views of beliefs, explanation of differing views, the fixity of the belief, attempts to disprove the belief and insight concerning the belief. A given belief that is to be measured, according to this scale, should be positioned somewhere on the continuum between good, poor (overvalued ideas) and no insight (delusional thinking). Veale (2002) proposes overvalued ideas to be measured on three dimensions: 1) degree of importance attached to the value, 2) the rigidity with which it is held and 3) the strength of identification with the self; overvalued ideas, according to him, occur „when the patient acknowledges the possibility that the belief may or may not be true‟.

The similarities between overvalued ideas and delusions, according to our conceptual analytical research, are as follows: they are both fixed abnormal bizarre and chronic states of mind (thought disorders), based on certain false beliefs that the state of affairs in the world as such and such, that cause negative consequences (e.g. absorbing ones mental energy by dominating ones thought, waste of time, unpleasantness, etc.). They are both multidimensional, characterized by rigidity and ideological remoteness from the current ideology and world-view of society (overvalued ideas basis is however closer to societys than the delusions one), highly affectively charged, treated by identical medications, i.e. antipsychotics and are subjected to transformations. Sometimes a critical attitude could emerge in deluded people whereas persons with overvalued ideas are more plausible to be critical to their overvalued ideas than the deluded ones.

Differentiations between overvalued ideas and delusions are:

1) Comprehensibleness and intelligibility – overvalued ideas, in most of the cases, are comprehensible, understandable and intelligible, when ones past is known, but delusions are not

2) Progression – overvalued ideas could progress to delusions (with some change in the content), but delusions themselves cannot progress to anything superior

3) Prognosis – delusions have better prognosis than overvalued ideas when treated appropriately with antipsychotics; this point however is disputable

4) Psychological reduction – delusions cannot be psychologically reduced whereas some overvalued ideas can, e.g. by ones past

5) Suggestion and correction – delusion cannot be influenced by any suggestions and are not subjected to correction whereas overvalued ideas can

6) Onset – delusions usually have abrupt onset whereas overvalued ideas do develop gradually

7) Insight – delusions and overvalued ideas differ in the degree of insight; according to Eisen et al. (1998) deluded persons do not possess any insight, whereas those with overvalued ideas have poor insight

There are more differences however. For example Mullen (2010) compared two groups of people – deluded and people with overvalued ideas. He concludes that “deluded individuals were less likely to identify what might modify their belief, less preoccupied, and less concerned about others' reactions than those with overvalued ideas”; moreover, delusions, according to him, are more likely to have abrupt onset and are less plausible to be reasonable.

There are numerous and various reasons why overvalued ideas and delusion can be put to lay on a single continuum. As we already have mentioned, they share many of their nuclear characteristics and features. There are possible transformations from the one phenomenon to the other and vice versa. Because of their similarities in fixedness, chronicity, abnormality, negative consequences, multidimensionality, rigidity, affective charge, thought disorder and belief characteristic, ideological remoteness from the ideology of the current society state, treatment, nearly total absence of critical attitude and insight, thought domination and pathology, we can conclude that they lay on a single continuum. Overvalued ideas are just less intense in all these features whereas delusions possess stronger manifestation power; delusions, being a new entity, have some idiosyncratic features as well. Moreover, overvalued ideas are prone to less pathological processes and emerge in less mentally ill persons and personalities, whereas delusions are prone to more mentally ill persons having stronger pathological deviations from the norm. Considering Haralanov et al (2014) and Oepen (1988) accounts, we could propose the following assumption: both these thought pathologies are caused by mesolimbic excess of dopamine which is associated with high level of emotionality and hence are treated with antipsychotics: when the delusion starts to dissolve and loses its affective grounding most probably descends to the state of overvalued idea and then disappears. It is necessary to mention that intense affective states, caused by abnormal cognition, are probably the cause of delusion. However, it is also important to say that not all authors agree on this point: there are hypothesis ranging from complete exclusion of emotions in the genesis of delusions to other that consider a primary underlying affective disorder to be the initial cause. Same could be said for the overvalued idea per se – it descends to the state of obsession (obsession is thought to be the less intense entity on this continuum).

Inferential confusion occurs when a person mistakes an imagined possibility for a real probability. This confusion may occur briefly under conditions of perceptual

ambiguity where imagination may overlap with perception. However, inferential confusion becomes pathological when the person crosses over from the real into the imaginary, treating the imagined possibility "as if'" it were real. We suggest that inferential confusion is a process characterizing different extents of obsessive-compulsive disordered thinking, and that as a process it may account parsimoniously for a variety of "fusion" experiences, particularly wherein the imagination plays a decisive role in rendering nonexistent events or feelings more probable, e.g., imagining myself ill makes falling dl more probable.

This inferential confusion process starts with the person inferring a possible state of affairs, "this object might be contaminated." This possible state is only postulated, not actual, but the person then acts "as if" the possible event or impulse was actually likely to occur. Imaginary possibilities are distinguished from real probabilities not necessarily by their content but by their inferential context wherein plausibility is inferred not from an objective assessment of probability but entirely on the basis of a subjective narrative. The inferential confusion model proposes that there is a critical point when the person with obsessive-compulsive disorder crosses over from the real world of perception into the imagination. This crossover point is identifiable and is reported by clients as a transition from reality to nonreality, sometimes accompanied by different amounts of derealization. This crossover point represents the start of the obsessional process since the obsessional anxiety springs from this meta-cognitive confusion (thinking that an imagined thought or event has a reality value). The subsequent compulsive rituals, neutralization, coping strategies, also result from a confusion that acting in reality can change imagined consequences. Imagination, in this model, is considered an autonomous faculty operating in parallel with perception with some normal overlap, but which processes possibilities rather than reality. Whereas real probabilities are finite, imaginary possibilities are infinite. So the person who confuses the imaginary for the real is likely to be trapped in a spiral of interminable "maybes," chaining on

one from another, but with no reality check, since imagination has replaced reality.

In inferential confusion, obsessions are experienced as ego-dystonic since people with obsessive-compulsive disorder unknowingly act "as if" they have produced unwanted effects, when in fact, in some cases, they are merely imagining the general possibility. Because such patients are unaware of this meta-cognitive confusion, they cannot do anything else other than take these thoughts seriously and act on them "as if"' they were real.

Inferential confusion also ready explains the repetitive nature of the compulsive ritual, or other neutralization, and the arbitrary stopping rules (relying on counting, repeating a phrase, or a "feel" to end the ritual) since the person is trying to change reality on the basis of what is only imagined. Doubt is likely to be increased through carrying out rituals, since such action only reinforces the imagined possibility. The impact of new information is attenuated since the person focuses on an imaginary not a real world and so no feedback from any real action ever definitively resolves the doubt. As part of the absorption in the imagination, the person may begin to experience physical sensations congruent with living "as if" the event was occurring, i.e., feeling bloated and fat, feeling guilty and experiencing sticky hands. The person starts with a possibility "what if I appear fat after eating," "what if my thoughts made an accident more likely," and then lives "as if" the possibility were plausible. In all such cases, imagination trumps perception and the person lives an imaginary story as though it is real. The inferential confusion model would also propose that a fusion experience reflects greater absorption in imaginary possibilities than in other nonfusion experience with obsessive-compulsive disorder but does not represent a separate subtype since this absorption is a continuum.

A special case of inferential confusion may be termed "thought-thought" fusion, where the person confuses the possibility of experiencing a thought with actually experiencing the thought. There is a distinction between entertaining an abstract idea of what is possible and formulating a motivated intention. For example, a client had frequent thoughts chat she might think of cheating on her boyfriend. While putting on make-up or dressing in an attractive way, she thought this might mean she could consider cheating on her boyfriend. Anything slightly associated with female attractiveness or sexual desire became evidence that she might want to cheat on her boyfriend. However, the actual intention to cheat on her boyfriend had never occurred. Another client confused thinking about the possibility of experiencing sexual thoughts with the sexual thoughts themselves. Every time the client was in the company of women, he considered the possibility of having sexual thoughts and that these thoughts might be read and produce an aversive response. In fact, though he never experienced any sexual thoughts, but reacted uncomfortably "as if" the sexual thought had occurred, so confirming the anticipated aversive effect of his thoughts. In other words, he confused possible imagined sexual thoughts with actual thoughts. Mental rituals are likely to be provoked by thoughts such as "I should not think this particular thought" or "I have to avoid thinking of this particular thought" or in the case of self-monitoring "I might think again of this particular thought." Mental rituals such as effacing or replacing the thought reinforce the potential presence of the thought that the patient with obsessive-compulsive disorder wants to avoid. But if, in fact, the actual thought did not occur, then neutralizing activities consist of attempts by this patient not to have a particular thought which has not been experienced. Since trying not to have a possible thought reinforces the possibility of having the thought, the person is caught h a perpetual cycle. The same process would apply to monitoring one's own mental content or the anticipation of the occurrence of an obsession. The thought that one could think again of a particular thought that one wishes to avoid implies its potential presence and could easily be confused with the actual occurrence-of the thought. Thus, inferential confusion does not necessarily always revolve around a confusion between outer and imagined events, and in the case of discrete obsessions can also involve a confusion concerning an actual and imagined cognitive state of affairs.

Experiential avoidance is a process involving excessive negative evaluations of unwanted private thoughts, feelings, and sensations, an unwillingness to experience these private events, and deliberate efforts to control or escape from them. In some contexts, subtle avoidance or suppressed behavior can be viewed as a self-protective strategy to prevent seemingly disastrous consequences. Examples include trying not to show signs of anxiety during a job interview, controlling feelings of boredom during a conversation with a valued person, or worrying in order to control fears about the anticipated threat of confronting a transgressor. In these contexts, experiential avoidance is a relatively benign short-term strategy to manage emotional expression; the negative consequences such as energy expenditure and not being a fully engaged participant from moment to moment may be minimal. Attempting to control anxiety and fear works as long as an individual can still live in a way that is coherent with their core sense of self, and effort and progress can be made toward personally meaningful goals. Experiential avoidance becomes a disordered process when it is applied rigidly and inflexibly such that enormous time, effort, and energy is devoted to managing, controlling, or struggling with unwanted private events. This struggle, in turn, gets in the way of movement toward valued goals, diminishes contact with present experiences, and thus yields impairment in functioning. The unwillingness to remain in contact with negatively evaluated private events, and chronic attempts to alter the form of these events or contexts in which they arise, are proposed to be a stronger contributor to psychopathology than the content (e.g., intensity, frequency, negative valence) of private psychological and emotional experiences.

In clinical and non-clinical samples, experiential avoidance is strongly correlated with measures of general psychopathology and specific measures of anxiety and depression. In response to inductions of acute emotional distress (via panicogenic CO 2 inhalation and hyperventilation challenges), healthy individuals endorsing greater experiential avoidance reported more panic symptoms and perceived uncontrollability, even after accounting for other risk factors such as anxiety sensitivity. These studies demonstrate that experiential avoidance amplifies anxiety symptomatology in individuals with no history of anxiety-related disorders. Thus, there is evidence that experiential avoidance is not merely a concomitant or consequence of anxiety-related pathology, rather it is a psychological vulnerability for anxiety pathology. The paradox of experiential avoidance is that attempting to hide or inhibit unpleasant thoughts, feelings, and bodily sensations serves to increase the frequency and distress of these same experiences and a sense that one is being inauthentic or disconnected from oneself. Moreover, chronic emotional avoidance interferes with the pleasures of being fully immersed in any activity, resulting in less frequent positive events and dampened positive emotions. Rigid attempts to avoid negatively evaluated private experiences apparently lead to more frequent and intense episodes of psychological distress and interference with meaningful life activities. All human beings will have moments of pain and suffering. This includes experiencing the full spectrum of human emotions, including intense, potentially disturbing states such as panic attacks, and a range of evaluative thoughts including self-doubts about the ability to perform in a particular situation and feeling that one should/ought to be better or present oneself more favorably. The content and form of these events are part of being human and living in the present moment; they are not necessarily problematic or dysfunctional (e.g., thoughts such as I am a loser or I am a banana are just thoughts). Moreover, taking action toward valued goals requires contact with a full range of emotional content, some of it quite painful. This is where

experiential avoidance tends to get people into trouble.

In this system, undesired psychological content must be managed first in order to do what is important in life. Here struggle with, and avoidance of, unwanted private events predominates, and the ability to engaged in valued directions is disrupted (Hayes et al., 1999). Such experiential inflexibility, in turn, can yield fusion of a sense of self with thoughts, feelings, and actions, such that an individual is unable to differentiate private emotions, thoughts, images, and memories from the sense of self (e.g., ‘‘I am worthless’’). In this example, worthlessness must be fixed, the self must be fixed, in order to do what matters. As a consequence, effort and progress toward personally meaningful goals is sacrificed because of an unwillingness to experience and let go of the struggle with unwanted private events. After all, in terms of movement toward the attainment of important goals, potentially unwanted events such as anxious feelings and thoughts can be necessary ingredients. With this conceptualization, experiential avoidance is defined as a core toxic diathesis underlying several other psychological vulnerabilities.