Let's Make Friends with the DSM

by Dr Denise Mullen

Introduction

There is a very hefty, intimidating sounding book out there that can make all the difference to your professional life. You might not have encountered it while working on your course, or you may have a passing knowledge of what it offers. But nearly all of us can afford to know this book more thoroughly. It is the Diagnostic and Statistical Manual of Disorders, recognized as the Bible of the psychology world (APA, 2013).

From travelling throughout Ireland these past few years, doing workshops and interacting with a variety of psychotherapists, counsellors and social workers, my hunch is that a wide range of potential clients are being encountered and then lost, largely because of a lack of clear knowledge of how to diagnose properly.

I have heard various reasons why people are reluctant to make use of the DSM; they feel it labels people, or perhaps they practice from a Rogerian perspective and the disorders described by the DSM fall outside their scope… But don't the people coming to our practice expect us to have a wide base of knowledge? We don't need to treat everybody, but we do need to know what they are presenting so that we can clearly define their need and give them the best possible referral. Additionally, if we want to be on board with our psychotherapy and counsellor peers in the EU and the US, then we need to embrace the DSM.

Recently my car broke down on the road, with white smoke billowing out of the exhaust. The man who towed it to the mechanic was certain that I had put petrol in the tank of a diesel engine. He was adamant that the smoke coming from the exhaust pipe could only result from the wrong fuel entering the tank. That is what he told the mechanic, who then spent several days testing fuels and trying to assess the damage done to the vehicle. He also ran a diagnostic test which immediately told him that the problem was a valve in the emission system, not fuel. But because the tow driver was so certain, he continued to test the fuel for contamination. I paid for several days of labour, lost the use of the car for a week and worried ceaselessly that I had ruined the car. When the diagnostic test proved correct, the part was ordered and the car fixed and returned with apologies for the several hundred Euros and time it had cost. Without be-labouring this further, we need the diagnostic equipment (in our case the DSM) in order to assess accurately the presenting issues.

We were probably drawn to the discipline of psychotherapy by a wish to find answers to life's difficulties and a desire to understand familial issues and address our own injuries. Most of us like the pursuit of

knowledge and enjoy the process of learning. If we've stuck it out long enough to earn a diploma and become accredited, then we must have a fair amount of stamina and perseverance. We have encountered difficult client issues and endured some very unusual circumstances that many people couldn't begin to relate to. The groundwork, therefore, is already laid; we have the mental chops, the courage and the curiosity required to be in this field and so are in a good position to take it to the next level.

We have at our fingertips the collective work and knowledge of hundreds of predecessors (Regier, 2009); they've done so much of the hard work for us. We simply need to familiarize ourselves with the material. Have you ever wondered about the clinical differences between distortions, delusion and psychosis? They are clearly defined in the DSM. Have you puzzled over how to distinguish between peculiar traits in a client and a full blown Personality Disorder? Through years of debate in committees and round table discussions, these important differences have been clarified in the DSM (Szalavitz, 2013). During the early years it mirrored primarily a Freudian perspective; over time the committees moved to encompass more of a medical model. They've done the work of removing a judgemental tone and derogatory descriptions which originally peppered the terminology.

History

The beginnings of the DSM date back to the 1840s when a census was taken in the US and attempts were made to collect data on mental illness: then broadly termed idiocy and insanity (Tartakovsky, 2011). Through many iterations the US Bureau of the Census continued to gather statistics and attempted to define the categories of mental disorders. By 1942 there had been 10 editions, but there was still a need for a classification that minimized the confusion between the various diagnostic systems of the day. From a two word description (idiocy and insanity) in 1840 up to 1952 when the 1st edition of the DSM was published, there were 106 disorders defined – in those days with a psychoanalytic slant. With each new edition of the DSM there has been an increase in the number of disorders, and the clarity of descriptions and criteria needed to define them.

By 1980 when the DSM-III was published there was a huge shift away from a psychodynamic orientation and a movement toward empiricism (specific data proved by observation or experiment) (APA, 2016).

The DSM identifies traits and lists specific criteria needed to diagnose accurately the individuals we have coming to see us. It is not a subjective rendering; neither is it solution oriented. It largely spells out what we are looking at and is our best source of help in sorting pathology in order to unlock, manage, and understand what we are encountering. In the most recent edition: DSM-5, there is a new inclusion of "tools and techniques to enhance the clinical decision-making process, understand the cultural context of mental disorders, and recognize emerging diagnoses for further study" (Ferranti, 2013).

However, because the list of traits can be so daunting and many of the words so off-putting, many people are reluctant to dig in deeply and make practical use of it. The truth is, it is an essential tool for moving forward professionally, especially since so many psychotherapists have not had instruction courses on working with personality disorders. If only to define our true scope of practice, in order to know when we should refer a client, we need a working knowledge of the DSM. Otherwise we could find ourselves operating from a vague grasp of a few terms, throwing around diagnostic labels such as "narcissist," "borderline," and "psychotic," inaccurately and unhelpfully, if not dangerously. Traits described within the diagnostic category, such as entitled, lacking empathy, grandiosity, dissociative, abandonment issues, impulsivity, etc., could be used without knowing where they fit. A similar analogy would be that of an engineer attempting to construct a bridge without the benefit of carefully drawn blueprints. Scary to think of crossing the river on that bridge!

With the advent of the internet, some lay people are outdistancing counsellors and psychotherapists as they look online and search out the criteria. Just this week I received an email from a family member of a client I had yet to meet and they said the individual met 8 of the criteria for borderline personality disorder and I ought to be made aware of this. Another situation comes

to mind, from the early days of my training. I was working as a Psychological Assistant (a pre-licensed Psychology student, while completing my PsyD), in a psychiatric hospital in Southern California. A woman was assigned to me with a disorder I had only encountered in a classroom setting: trichotillomania (APA, 2013). I could barely pronounce it, let alone cope with her needs and underlying causes. She was hospitalized because of the extreme nature of her condition. Nearly all her hair follicles from the neck down were destroyed from her incessant plucking with tweezers. She had nowhere left to pluck except her eyebrows and scalp and had already damaged much of the hair on the back of her head. The first source I turned to was the DSM, which grounded me and led me to a number of questions to ask her. This gave us a beginning point; she felt I had a basic grasp of her condition as the DSM indicated specific tendencies. This led to an uncovering of the genesis of her disorder, which built a relationship between us. I ended up seeing her for over a year after she left the hospital. She made significant progress and began to deal more openly with the extreme anxiety that led to such an expression of her desperation.

So, this is an invitation to you to become the expert, to overcome any areas of confusion and insecurity about the various mental disorders and become close friends with the book that can make a great difference in your measure of confidence: The Diagnostic & Statistical Manual of Disorders. You can buy it online, new or used. Because the criteria change minimally from one revision to the next, it is nearly as useful to buy a used copy of an old edition and do the homework on what has changed. You can also find the DSM online at www.psychiatryonline.org. If the book looks huge, imposing and scary to wade through... then don't. Look at what you specifically need: is it a clear definition of depression or adjustment disorder, or exactly what constitutes a diagnosis of narcissistic personality disorder? Casually look at the descriptive portion, allow room for the stuffy sounding words and keep going. Then look at the list of criteria and, more importantly, how many need to be ticked in order to warrant the diagnosis? Then take a client that you feel meets a lot of the criteria and carefully attempt to match their specifics with the listed descriptions. This practical, do-able exercise will teach you a great deal in a short period of time. There is also the option of attending the workshop I will give in September in Dublin for the IACP. It will be a full day on the use of the DSM, using an interactive and creative approach that will keep people engaged throughout. However you decide, whatever is best for your style, I hope you will crack the cover of that marvellous volume and discover a world of help in your chosen profession.

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