# Psychotherapy and the DSM: What Relationship?

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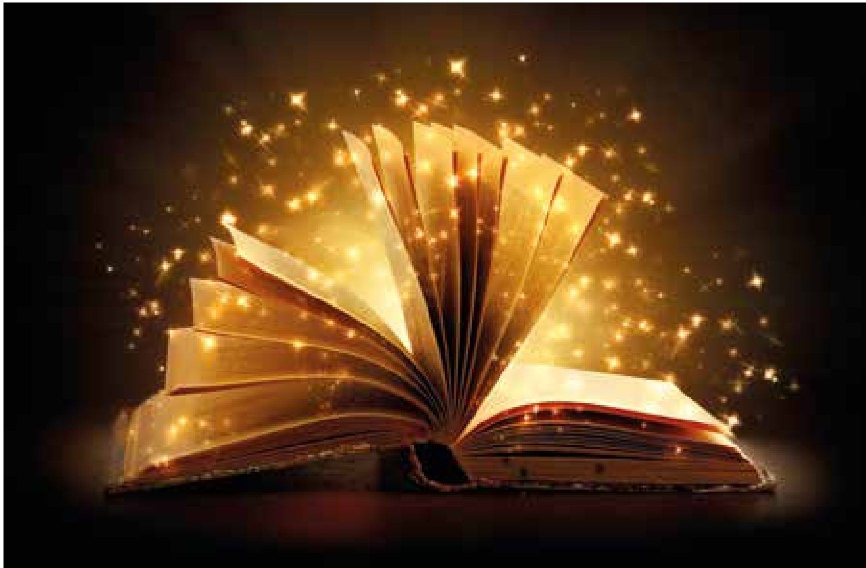

**Abstract**

This article is a response to a previous article "Let's make friends with the DSM" published in the Spring edition of Eisteach, 2016. It looks at the creation of the DSM, its change in direction from having a psychobiological and social construct to becoming the symptom-based construct of today. It takes a critical look at the methodology used in bringing about this current creation, the major concerns surrounding it, and the fallout in relation to mental health that has ensued. The relevance of the DSM for psychotherapists is addressed and the question asked as to the place diagnosis holds or does not hold in the humanistic and integrative psychotherapeutic relationship.

**Introduction**

I would like to respond to the article entitled "Let's Make Friends with The DSM" which appeared in Eisteach Spring 2016. Perhaps it would be useful to look at exactly what it is we are being asked to befriend. The DSM (Diagnostic and Statistical Manual of Mental Disorders) is the standard classification of mental disorders used by mental health professionals in the United States. It has expanded at a faster rate than any other manual in medical history. At its inception in 1952 there were 106 disorders described in the DSM, while the latest publication in 2013, DSM 5, contains around 370 diagnoses.

**Creation of the DSM**

Before the DSM, there were a number of diagnostic systems, with little consensus among the professionals in the area of mental health. The first DSM was published in 1952. It contained 106 what were called 'reactions' which were based on a psychobiological view of mental health and contained a psychodynamic influence. Clearly articulated in the DSM was a group of disorders of psychogenic origin making up the majority of reactions contained in the manual; these were "*without clearly defined physical cause or structural change in the brain.*" (Sanders 2011) This was followed in 1968 by DSM-II which was similar to the first edition, with the addition of 76 disorders. Also, the word reactions was replaced by the word disorders.

Moving on to 1980 and the arrival of DSM-III, there was a distinct shift in orientation towards biological determinants. According to Dr. James Davies, psychologist in University of Roehampton who interviewed Dr Spitzer, chairman of DSM-III, there was a core team of nine people whose task it was to put the manual together. This revision added eighty new diagnoses to the DSM. It also erased the psychoanalytic influence of previous editions, and gave birth to the notion that there were distinctive disorders that could be specifically categorised and distinguished from each other. In so doing, it diminished the significance of psychological and social factors in causing distress. The aim of all of this was to create a sense of an objective truth in relation to mental health and disease, in other words the beginning of a specific

manual which has unfortunately lead to the medicalisation of troubles of the mind/body, spirit and soul. The reality is that the only disorders in the DSM with a proven biological cause are the organic disorders (those caused by disease e.g. delirium, dementia, drug intoxication) and these are in the minority. There are no biological markers for most of the disorders named in the DSM.

With the DSM III "*There was very little systematic research, and much of the research that existed was really a hodgepodge-scattered, inconsistent, and ambiguous. I think the majority of us recognised that the amount of good, solid science upon which we were making our decisions was pretty modest.*" Theodore Millon, psychologist and DSM III task force member.

There was little research to support any of the diagnostic labels, yet their inclusion purports to offer them a validity. Paradoxically, in order to have a diagnosis removed from the DSM, there has to be scientific evidence to support its removal. Research has to prove that the disorder does not exist! So we have the scenario of clinicians putting a case for a diagnosis, arguing and eventually deciding by a vote. The voting method was a show of hands, which of course begs many questions not least the influence of one person on another. DSM-III was the product of opinions of nine people rather than research.

In 1994 the publication of the DSM IV with its 297 disorders was followed by its revision in 2000. The DSM 5 was published in 2013, and while there have been some revisions in diagnoses, the delivery of what was initially promised including a more dimensional view just has not occurred. Most crucially, what still remains is an absence of context, with lists of symptoms predominating. There was much international controversy surrounding this latest edition, with concern expressed in relation to lowering diagnostic thresholds in many disorders (British Psychological Society 2011), to say nothing of the concern regarding its validity in the first place.

### Fallout from the DSM

The DSM has led to the medicalisation of many people's suffering and the concomitant medicating of suffering rather than the understanding of it. We now have huge increases in the diagnosis for example of ADHD, with children being medicated with drugs which have the long term effects of decreasing their physical growth, educational attainments and curiosity (Currie et al 2013). Add to this the on-going concern amongst psychiatrists themselves in relation to the reliability of diagnosis. Studies have shown agreement on diagnosis in experienced clinicians occurs in between 54% to 60% of cases (Beck et al 1962, Williams et al 1992, Aboraya et al 2006). The gap is even wider with non-experienced clinicians. Many psychiatrists themselves are deeply concerned about the DSM. Allen Frances, an editor of DSM-IV is quoted as saying "by use of the proposed diagnostic category, 'psychosis risk syndrome", as well as other newly constructed diagnoses, DSM-5 will take psychiatry off a cliff".

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>
> ***Theodore Millon, psychologist and DSM III task force member.***

### Relevance of the DSM

While it is difficult to see what a 'friendship' would offer, an acquaintance with the DSM has its uses from a number of perspectives. Firstly, our clients may well have been on the receiving end of a diagnosis, and it can be helpful knowing what that diagnosis means at least in medical circles, even when we, as psychotherapists have a different relationship with the whole concept of diagnosis. Indeed, many clients are not served by a diagnosis, and some are significantly harmed. I am thinking here particularly of the diagnosis of bipolar disorder, once a rare disorder, the incidence of which has increased significantly in the United States; its prevalence in the U.S. now being 2.6% of population in 2005 (Kessler et al 2005), The reasons for this are many and would really be the subject of another article, but it is probably not a coincidence that the manufacturers of "mood stabilizers" have experienced significant increases in their sales (Healy 2005). I have seen people who have been misdiagnosed with bipolar disorder and as a consequence, restrict their lives significantly and unnecessarily in order to prevent another manic episode.

Empowering our clients to understand themselves and relate to themselves in the totality of

their humanity is what we are about, and being able to facilitate an individual in this is crucial. Having some knowledge of how psychiatric diagnosis comes about enables us and our clients to question it and look beyond medicalisation, pathologisation and medication. Being acquainted with diagnosis also enables us to have conversations with other mental health professionals, and bring another eye to what are seen simply as symptoms of a disorder, and to challenge the labelling of human suffering.

experiencing extreme difficulty in self-regulation who may have been given a diagnosis of Borderline Personality Disorder. Here we are meeting a person with extreme complex trauma and its attendant challenges. The article by Monica Carsky and Frank Yeomans (2012) entitled "Overwhelming patients and overwhelmed therapists" where they speak of how utterly lost both parties can become where there is a borderline construct in the room names this territory well. Having some knowledge of the chaotic primitive structures our clients

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### Diagnosis and psychotherapy

The question also needs to be asked whether there is ever a role for diagnosis? There is no doubt that the recognition of post-traumatic stress disorder (PTSD) as an entity saved many from being shot in wartime for what had previously been seen as cowardice. As humanistic therapists we are not in the business of diagnosis, diagnosis takes no account of subjectivity or relationship. However, there is something to be said for having a framework with which to work with clients. There is a usefulness to having tentative formulations which are held lightly by the therapist and are constantly open to revision. I am thinking here particularly of the fragile client (Nolan 2012) for example the client endeavouring to live life while experiencing the extreme end of the spectrum of dissociation, Dissociative Identity Disorder, (DID) or the client

may work from can help us stay present, name, understand, and work relationally with the chaos that is present.

At the heart of this debate, is the whole notion of 'psychopathology' and the use of words and categories which dehumanize and pathologise the human condition. So I would say that a friendship is not what a humanistic and integrative psychotherapist would seek, but in the interests of the client, having some knowledge of the DSM can have a value.

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