

Anticipating the DSM-5

Tina Helm, Manager of Changing Minds, an Auckland-based not-for-profit organisation that recognises and values the diversity of human experience and strives to work innovatively to encourage positive social change, particularly in the areas of mental health and addictions, comments on the DSM-5:

“Publication of the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in May 2013 will mark one of the most anticipated events in the mental health field.” American Psychiatric Association website.

Do you have any comment on this statement?

The document has indeed been much anticipated, mostly due to the debate that surrounds it. While there are groups and individuals who are in support of the latest changes, there are wide and various concerns as to the effects that these changes may have on some groups and individuals.

For example, The British Psychological Association has repeatedly expressed their concerns over the DSM-5, stating that it may “lead to the risk of over-diagnosis and thereby potentially unnecessary and potentially harmful treatment with medication.”

One of the new categories that has caused widespread debate is the inclusion of ‘bereavement’ as a diagnosable “mental illness” in the DSM-5. Many would argue that grief is a fundamental and natural response to loss and that an individual should be able to experience their unique response to this loss without fear of a psychological label imposed on them. Some may feel extreme sadness or depression for a long period of time, some may feel extreme anger, some may feel as though their loved one is with them, some may hear their voice and talk to them, etc. Who is to say what is a “normal” or an “abnormal” response to loss? And should we be granting the medical profession the right to say what is normal and abnormal?

Others would argue that having access to a diagnosis for extreme depression as a result of loss may mean that that person has access to assistance from the medical profession that they otherwise might not have access to.

Given that the DSM is widely used by the psychiatric profession here in New Zealand and the new version is to be launched in May are there likely consequences around stigma and discrimination associated with mental illness that you can envisage?

There can indeed be negative consequences for those who are labelled as “mentally ill.” Just the very nature of being labelled as sick can have an effect on the way that a person sees themselves and lead to internalised stigma. Likewise, if we look at these experiences as an illness and as something described as purely physiological or as something genetic, then we are talking about clinicians potentially giving people a life sentence when it comes to diagnosis – and the efficacy of these diagnoses are still very much disputed across the sector.

On the other hand, when we talk about these experiences as being something influenced by our environment, our social status, our education, our housing, our monetary status, etc., then we can begin to look at new ways of being and at things that we can change in our lives – in our

communities, our living environment, our workplaces, etc. to be able to achieve the things that we would like to achieve in terms of our own personal wellness.

There is also a risk, when we have in mind the BPA's concerns of over-diagnosis, that people may be less willing to discuss their mental health with a health professional for fear that they may be diagnosed with a "mental illness", i.e. the more illnesses we have listed, the more likely you are to get labelled with one.

When you talk about mental health issues on a rigid spectrum of sick and healthy you start getting into the territory of "normal" and "abnormal". We know that a dichotomous approach to the way that we think and talk about people can have negative effects on our communities, particularly for those that are labelled as abnormal. We've seen this in other areas of our lives, such as sexuality. (And it wasn't that long ago that homosexuality was listed in the DSM as an illness and that people were diagnosed and "treated" for this illness, in many cases with dire effects for that individual as well as those around them.) We now know that sexuality exists on a spectrum. This is the same for our mental health in general.

On the flipside, some groups and individuals argue that the release of the DSM-5 will give them greater access to resources and skills to get well.

Some people feel that being given a diagnosis is a positive experience in the sense that if you're struggling with your mental health you may already feel as though you are failing in some way and that you have some kind of personal deficit. Diagnosis can provide a person with an explanation for the things that they are experiencing. Diagnosis can take away some of that anxiety and can provide an individual as well as their friends and family with a context to those experiences. It also means that a person can feel less alone in their experiences as they are able to see that others have experienced similar things and have been able to live through those experiences. Likewise, a diagnosis from a medical professional can provide a person with access to a particular treatment path. You may be given access to resources such as talking therapies or medications, which can assist a person in managing in their struggles.

However, this positive experience assumes that the client and clinician relationship is healthy and non-hierarchical and that the clinician assumes that the client is knowledgeable about their own wellbeing and the things that will make that him or her well. If diagnosis is to be helpful for the individual, it needs to be done in a manner that makes that person feel more knowledgeable about their own experiences and the kinds of tools that may assist them in keeping them well.

Additionally, the current model of "mental illness" diagnosis and the areas in which funding is funnelled means that there isn't necessarily access to those wellness tools that are outside of pharmaceutical interventions. There are many who advocate for "alternative approaches" to be considered so that people have access to tools such as: talking therapies, meditation, music and arts therapies, massage, acupuncture, etc. Many people find the medicines prescribed for mental health issues to be highly addictive and to have a number of seriously negative and long-lasting side effects. Some advocate for the use of medication to be seen as a more immediate intervention, but that other tools should be available for people to maintain wellness in the long-term.

How 'scientific' is diagnosis of mental illness? I think the mental health community will cite instances of people who have received multiple diagnoses?

If you look at John Read's discussions on simplistic biological and genetic answers for why a person can develop mental health issues, you'll find plenty of evidence to suggest that diagnoses are not as scientific and fool-proof as may be advocated by the medical profession. He discounts much of the science behind these approaches, as being unsubstantiated and at this stage only a series of theories.

Unfortunately, a biological or genetic approach doesn't necessarily take into account a person's life experiences. John Read argues that trauma and abuse are the main triggers for mental health issues to occur in a person.

John Read still takes "science" into account and examines the brain patterns of people living with mental health issues. Stress caused by trauma can change the way in which you brain develops.

We know that there is not currently any science that definitely explains the causes of mental health issues, and therefore that there is no definitive science that proves the "truth" of diagnoses.

One other inherent issue with the diagnostic approach is that we can forget indigenous experiences and explanations around some of what the medical profession label as "mental illness". For example, for Maori, the experience of hearing voices may be explained in a way that can be quite positive, and that is even celebrated. A person who can hear voices may be seen as possessing an openness and access to a spiritual level that others may not have the same access to. Moreover, our tupuna are ever present in our lives and there are times when Maori talk to their ancestors. This is not seen as an illness and simply should not be classed as something scary or abnormal when you are coming from this particular framework. There are other examples of differing approaches when we look to the Pacific, Native Americans, different Asian approaches, and in many other indigenous cultures throughout the world. The DSM could be seen as something quite dismissive when it comes to these alternative non-Western viewpoints.

Are there times when the DSM is a useful tool for clinicians? What dangers do you see in it?

Yes, certainly – the DSM is supposed to be used by clinicians – by clearly defining terms different patients can be discussed and compared in order to gain a greater understanding of mental health as a whole. Many (but not all) of the problems with the DSM are derived from improper use, principally by the layperson who intentionally or not, uses a medical term as a descriptor of a person or as an insult. Other examples of misuse can also occur in a medical setting – essentially the connection between asserting a diagnosis and assigning a treatment path is not strict or indeed in any way clear. As for many people their first contact will be with a GP and only after that a specialist service or clinician, there is a very real possibility that GPs are reaching for a pharmaceutical intervention as a result of an assumed connection between a DSM 'diagnosis' and the availability of a drug which supposedly treats that diagnosis. And it is not only GPs who may be tempted to adopt a two dimensional (diagnosis/drug) approach. Psychiatrists are also prone to prescribe first and ask questions later. Most of the objections to the DSM are based on the fact that it is supposed to increase our understanding of people, and yet actually allows very little room for the individual. A diagnosis is not a person. In order to properly help and heal someone we need to be able to

understand them, and the first place we should be looking is at the person and not at a diagnostic manual, irrespective of the number of revisions the authors' release.

Writing in the British mental health magazine, Open Mind, David Pilgrim argues that the principle of diagnosis is inherently flawed and should be abandoned and replaced by unique and context formulations about experience and behaviour.

David seems to be very aware of the tension between a diagnosis and the individual. To transpose the logic we could say that a diagnosis is like using general terms to try and say something quite specific. If clinicians are prepared to accept that the DSM is a mechanism for speaking generally and not a precise tool for determining treatment then its utility can be preserved, however that is not its current usage and we would certainly support a move to 'unique and context formulations about experience and behaviour'.

Changing Minds advocate for a movement beyond the current technical paradigm to explain "mental illness" to examine social, environmental, physical, and other causal effects on mental health-related problems. This relates also to the types of treatments available to people. There is a push from many mental health service-users toward a stronger focus on social support and care opportunities for those experiencing mental health issues, rather than purely pharmacological interventions.