

Preserving the Role of Counseling in the Age of Biopsychiatry: Critical Reflections on the *DSM-IV-TR*

Kathryn Z. Douthit
Kathryn.Douthit@rochester.edu

Kathryn Douthit, Ph.D., is an Assistant Professor of Counseling and Human Development at the University of Rochester. Dr. Douthit's areas of interest include critical psychiatry and gerontological counseling. She is currently engaged in a project to assess the ways in which school counselors utilize DSM categories of mental disorder.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association (APA) and serves as a centrally important tool in dissemination of psychiatry's understanding of psychological suffering. The DSM, in its most updated version, the DSM, fourth edition, text revision (DSM-IV-TR) (APA, 2000), contains detailed descriptions of nearly 400 mental disorders and is used in mental health settings, by counselors and other mental health professionals, to assign mental disorder diagnoses to clients whose symptoms match specific disorder criteria detailed in the manual. Among this long list of mental disorders are psychological problems commonly encountered by counselors such as depression, anxiety, and addictions.

In spite of its widespread adoption within the mental health arena, scholars from the counseling community have been sharply critical of DSM. Among the criticisms mounted against the manual are its reliance on the individual psychopathology model (Ivey & Ivey, 1998), lack of attention to social context variables (Douthit, in press), gender bias (Ballou & Brown, 2002), limited cultural consideration (Kress, Eriksen, Rayle, & Ford, 2005), and disregard for developmental forces (Ivey & Ivey, 1998).

Despite these concerns raised by counselors, the psychiatric lens increasingly dominates our understanding of mental health problems. Underscoring the pervasive influence of DSM, Hinkle (1999) warns that counseling will sacrifice its legitimacy in the mental health community if it fails to adopt the language and conceptualization of mental disorder depicted in the manual. He argues that DSM categories provide an organizing structure that in many cases is able to accurately capture the descriptive nature of client distress.

In any event, it is clear that counselors are becoming increasingly immersed in the language and category structure of DSM. It is also clear that in the context of this burgeoning pressure for counselors to become proficient in the use of DSM, forces outside of counseling are shaping the face of the counseling profession. In light of this transforming tide, it is incumbent upon counselors to critically examine the benefits and losses incurred in adoption of the DSM lens. More specifically, we must consider the ways DSM, when used as a structuring device in mental health practice, poses a threat to the preservation of core counseling commitments to diversity, developmentalism, contextualism, prevention, and social justice. If counselors are mindful of how these central elements of counselor identity are fostered or compromised by DSM, they will be well positioned to critically integrate the manual into every day practice without the threat of losing important elements of counseling ideology.

In the interest of fostering critical dialogue around counselor's increasing dependency on DSM, this paper examines several ways in which core counseling values are threatened in the DSM-IV-TR. Although a complete critical examination extends far beyond the scope of this analysis, consideration of the following areas is included: 1) the definition of mental disorder and its relationship to contextualism and social justice, 2) the utility of a multiaxial diagnosis in capturing the essence of developmentalism, contextualism, and prevention, and 3) efforts to incorporate the tenets of multiculturalism into the text.

Defining Mental Disorder

The introduction to DSM-IV-TR clearly defines mental disorder: "Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (APA, 2000, p. xxxi). This characterization of mental disorder suggests that the individual manifesting mental disorder symptoms, if not because of "a culturally sanctioned response to a particular event" (p. xxxi), is experiencing a failure of internal function. For whatever reason, the behavioral,

psychological, or biological mechanisms that normally protect the client from experiencing disabling pain and distress are rendered ineffective and internal conditions thus favor development of a mental disorder.

In some cases, this logic may in fact make inherent sense. Research in psychiatric genetics, for example, shows how the work of individual biology can create conditions that increase the risk of a client developing serious, and sometimes life threatening mental disorder (Douthit, in press). It would follow that if a client has sufficient genetic predisposition for a mental disorder such as schizophrenia, environmental conditions manageable for the typical “nondisordered” individual might result in considerable psychological pain for this biologically vulnerable client. Although there are many insightful critics of the genetic model of schizophrenia (Joseph, 2004), relative to other mental disorders, it provides one of the least contestable, albeit not entirely so, examples of how internal processes predispose clients to psychological suffering.

A more disputable logic; however, can be applied to a child with lead exposure. This child may display diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD) by virtue of the neurological damage caused by the lead (APA, 2000). Environments such as classrooms, which do not pose a challenge for unaffected children, may be problematic for the afflicted child due to permanent neurological injury. By strict definition, ADHD symptoms resulting from lead exposure are an indisputable outcome of an internal biological failure that is consistent with the definition of mental disorder.

But this lead poisoning example also underscores the problematic nature of the mental disorder definition. Most notably, it unveils contextual and social justice concerns that often emerge from the shadows of the individual psychopathology paradigm. It is well established that exposure to toxic lead levels is associated with conditions of poverty. Poor young children, particularly those with calcium deficient diets, when exposed to deteriorating housing containing lead-based paint are particularly vulnerable (National Safety Council, 2004). The focus on failed biology in this case draws attention from poverty as an etiologic agent, engages in a stigmatizing labeling practice, and focuses intervention solely on the individual. Conversely, intervention at the level of unjust social policy, the true source of the mental disorder, is eclipsed and opportunities for promoting prevention through advocacy and other acts of social justice are lost.

Science is making great strides toward showing how social context variables such as discrimination, disempowerment, inadequate housing, violence exposure, poor nutrition, and lack of community resources relate to the root causes of mental disorders such as major depressive disorder, generalized anxiety disorder, posttraumatic stress disorder, and conduct disorder (Douthit, in press). Exclusive focus on internal mechanisms in cases such as these draws attention from pressing social justice issues and the contextual root causes of distress.

Multiaxial Diagnosis

The multiaxial structure employed by DSM-IV-TR (APA, 2000) allows counselors and other mental health practitioners to assess clients in 5 dimensions:

Attention	Axis I	Clinical Disorders
		Other Conditions That May Be a Focus of Clinical
	Axis II	Personality Disorders
		Mental Retardation
	Axis III	General Medical Conditions
	Axis IV	Psychosocial and Environmental Problems
	Axis V	Global Assessment of Functioning (p.27)

According to the authors of DSM-IV-TR, “the multiaxial system promotes the application of the biopsychosocial model in clinical, educational, and research settings” (p. 27). But does this multidimensional diagnosis actually achieve a view of mental disorder that addresses the psychosocial, i.e., consider the role of context, development, and social justice in disorder etiology? While it is true that the Axis IV diagnosis provides an opportunity for the counselor to highlight significant developmental and contextual forces, that Axis IV designation remains isolated from the Axis I evaluation, which focuses on assigning diagnostic codes for mental disorders. Therefore, if a client is diagnosed with a mental disorder, that disorder is noted on Axis I and retains the character of the definition of mental disorder, i.e., an internal failure of functioning, despite any psychosocial stressor that may be noted on Axis IV. Thus, even in cases where psychosocial stressors can be characterized as severe or extreme, the definition of mental disorder is still applied and the dysfunction is still located within the individual rather than the social milieu. It is the body that fails rather than family, community, or larger social systems.

For example, a child living under conditions of extreme poverty, community violence, and family disarray who displays the symptoms of conduct disorder would still receive an Axis I diagnosis of conduct disorder, and the basic assumption would be that the child is manifesting the failure of internal function. Hence rather than creating an integrated contextualized and developmental view of psychological distress, the multi-axial diagnosis creates a compartmentalized understanding of mental disorder in which context and development can be isolated in an independent category while mental disorder remains a failure of the body.

The primacy of the Axis I, mental disorder diagnoses and all of their attendant mental disorder assumptions are reinforced in clinical practice. Most notably, insurance companies generally offer reimbursement only for services related to Axis I mental disorder diagnoses. Axis I will also accommodate “V” code diagnoses that denote nondisordered conditions related to significant contextual or developmentally relevant conditions, but again, V codes are generally not reimbursable. Thus, any thoughts by the counselor of avoiding the stigmatizing practice of assigning a mental disorder diagnosis is discouraged by reimbursement policies. Additionally, intervention is tied to Axis I diagnoses in that evidence-based, manualized, time-limited, managed care mandated interventions are generally based on Axis I disorder categories. Due to the standardized nature of these types of interventions, customized care in the counseling tradition that aims to accommodate challenging contextual variables, intervene in problems that are clearly developmental, or build an advocacy-based strategy predicated on the principles of social justice is precluded.

Culture and Mental Disorder

Probing the sociopolitical and psychological dimensions of diversity within the counseling relationship has been a centrally important charge of the American Counseling Association (ACA) and is embedded in its code of ethics (ACA, 1995). With culture serving as the nexus of counseling practice and as a fundamental theoretical construct in understanding the change process, discerning the way that culture is understood and operationalized within the DSM diagnostic scheme becomes particularly germane to counselor identity.

In the years leading up to publication of the fourth edition of DSM (DSM-IV) (APA, 1994), significant efforts were made toward integrating diversity issues into the text of the third edition, revised of DSM

(DSM-III-R). These efforts included appointing, through the auspices of the National Institute of Mental Health, an expert multidisciplinary consultation team (Mezzich et al., 1999). Significant additions to the manual included: 1) a description of potential cultural variations in clinical presentation, 2) a description of culture-bound syndromes, i.e., disorders specific to a particular culture, and 3) an outline to aid the clinician in assessing and reporting the impact of cultural forces on client presentation. (APA, 1994)

While these efforts were laudable and advanced the cause of cultural awareness in DSM, members of the consultation team reported several deficiencies. These deficiencies emphasized that although the APA recognized the dearth of multicultural consideration in DSM-III-R, it was firmly entrenched in the notion that its categories of mental disorder were universal, devoid of culture, and atheoretical, and it systematically purged the new DSM-IV of social context consideration. While DSM-IV acknowledged some cultural variation in clinical presentation, it generally attributed much of the range of presentation to individual idiosyncrasy. Perhaps most importantly, any attempt to encourage practitioners to explore their personal bias, become familiar with the meaning of culture and ethnicity, or to understand the cultural foundations of Western psychiatry and the segments of U.S. society that its values represent was rejected. (Mezzich et al., 1999)

In light of these deficiencies, when utilizing the DSM-IV-TR, counselors should be mindful of their own bias, the potential cultural assumptions embedded in categories and criteria, and the cultural diversity inherent in expressions of psychological distress. It is important for mental health counselors to actively seek literature and continuing education venues that challenge the lack of cultural insight in mental health diagnosis.

Conclusion

Counselors have a history of acknowledging sociopolitical and economic inequity, the need for empowerment, and the complex ecological systems in which psychological distress is manifested. These core counseling principles are oftentimes challenged by the content of DSM-IV-TR, but can be sustained through an awareness of the manual's inherent biases. Mental health counselors mandated use of DSM generates conditions that require critical consciousness, self-examination and persistence if the values of the counseling profession are to survive 21st century mental health practices.

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