

# Diagnostic and Statistical Mania



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Speaking as a psychotherapist, I would say that my clients come in order to hear from me about their strengths, not their shortcomings. All of us humans want to know *what's right with us*. We also want to know that we are like other people.

In the movie *Shadowlands*, a student at Oxford University recalls his father's remark that people read books to know that they are not alone. Perhaps books, like human relationships, offer us a precious sense of community—reassurance that our feelings are normal and understandable responses to life's challenges.

I find that whenever I can help my clients discover their own resources and recognize their own humanity, they will set and work toward goals that seem right to them, overcoming mental illness and other obstacles that stand in their way. The successful therapeutic relationship lets people hear themselves and each other as they reinterpret a lifetime of experience and set the stage for the realization of future goals.

Does my description of my job seem odd to you? Did you perhaps expect me to tell you about your problems and how to solve them? And what about the diagnoses lurking in that big silver-colored volume published by the American Psychiatric Association? Surely I, the psychotherapist, am part of what the doctor ordered?

Certainly doctors treat physical illness, and many doctors refer people to psychotherapists. Your physician may diagnose influenza, tuberculosis, a broken leg, or any of a huge number of other ills. In each case, there is a precise diagnostic procedure. The doctor may need to make x-rays or MRIs, take a culture, or analyze a blood or urine sample.

With mental issues, however, the situation is different. If you glance through the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (Washington, D.C., 2000; *DSM*), you will see that it deals with symptom

clusters and that the language used is often subjective and relative rather than objective and scientific.

So, for instance, you may read that 313.81 Oppositional Defiant Disorder is:

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

- (1) *often* loses temper
- (2) *often* argues with adults
- (3) *often* actively defies rules or refuses to comply with adults' requests or rules
- (4) *often deliberately* annoys people
- (5) *often* blames others for his or her mistakes or misbehavior
- (6) is *often touchy* or *easily* annoyed by others
- (7) is *often* angry and *resentful*
- (8) is *often spiteful* or *vindictive*

Note: Consider a criterion met only if the behavior occurs *more frequently than is typically observed* in individuals of *comparable* age and developmental level.

B. The disturbance in behavior causes clinically *significant* impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder. [P. 102; *italics added*]

A few questions suggest themselves. Do these criteria communicate special medical knowledge of a medical condition? Isn't this diagnostic label roughly the equivalent of Sorethroatitis? Does it tell you anything you don't already know?

Could the symptoms be part of several completely different illnesses? Does the diagnosis point the way to a scientifically proven "cure" on a par with a course of antibiotics for an infection or a splint for a broken limb?

Maybe there is more to know about the condition in question. Is it possible, for instance, that a rebellious eleven-year-old is struggling with grief in the wake of her parents' divorce and her mother's remarriage? Or an eight-year-old boy may have become angry and uncooperative as a way of getting noticed in a family where older and younger siblings seem to get the lion's share of attention.

You get my drift. The symptoms in question don't occur in isolation. Rather they reflect a complex, many-faceted interaction between the person and his or her environment. I am not saying that medical history, genes, and biological events aren't part of the picture. I am saying that the diagnostic manual grossly oversimplifies, invites comparison with nonpsychiatric medical diagnoses, and, in the process, misleads.

And look at the language in italics. "Deliberately," "often," "easily," "touchy," "significant," "comparable"—all of these words lack precision. Their meaning could vary from one observer to the next, in line with each observer's unique experience and outlook. Still, the description implies a consensus of opinion.

The *DSM* creates pathology. When we say that something is medically wrong with someone, we imply that this person needs fixing. We are also locating the problem within the individual rather than in the situation or the environment, so that the individual rather than society or the community is responsible for any needed repairs. The consequences of this attitude become clear once we acknowledge the research showing that some problems with organic features—paranoid schizophrenia, for example—correlate highly with poverty, high rates of crime, and chaotic, stressful environments.

Second, the *DSM* lets insurance companies limit coverage of mental health services to "mental illnesses" deceptively defined. You, I, and the next twelve therapists know that most people seeking outpatient psychotherapy are grappling with situational stressors, relationship problems, and life stage issues. Before your insurance company will pay for your sessions, however, I must tell it that something is wrong with you. When I do, of course, you run the risk that future coverage may be denied because you had a "preexisting condition." (You also run the risk of being pressured into taking medication to boost pharmaceutical companies' profits.)

Third, the *DSM* facilitates the aggregation of data with limited validity and reliability. So, for instance, a psychologist may administer tests or scales that have been validated with large numbers of people and may determine, on the basis of the scores, that you suffer from clinically significant depression. The psychologist will then treat you with cognitive behavioral therapy (using positive self-talk and eliminating negative messages), which has been demonstrated effective in studies that assigned randomly selected subjects to treatment and control groups. The idea is that a client in distress will necessarily improve if a certain established technique is faithfully followed, regardless of which therapist administers it.

But suppose depression has many different causes and is not uniformly experienced. Suppose the situation of the lonely divorcee at midlife differs

appreciably from that of an overweight teenager suffering from acute acne or the young woman graduating from college and entering the workforce for the first time. (Also suppose that the client is alienated by the time spent taking the test or scale, which leaves him or her feeling more like an experimental subject than someone with a story to tell.)

There has long been a gulf between researchers and practitioners of psychotherapy. The psychiatric community and the insurance companies set great store by so-called best, or effective, practices. Nonetheless, much research exists to show that the relationship between the therapist and the client is key and that the type of therapy used doesn't much matter.

If so, what is the point of best practices beyond an insistence on the therapeutic relationship? And if the relationship *is* the thing, how could it possibly be quantified for replication across settings, across clients, and across therapists? Does it become less important if we cannot validate it using randomization and control groups? Do science and statistics offer the only useful means of evaluating treatment? What are the social costs of exclusive reliance on them?

It is not yet possible to diagnose illness in the brain as precisely as illness in other parts of the body. Until we know more, it is irresponsible not to treat emotional and behavioral problems—and their diagnosis—as socially and culturally constructed, with political implications of which anyone seeking mental health services needs to be aware.

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