A Critique of the DSM[1]

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As a psychiatrist, I have become increasingly concerned about the inadvertent pathologizing influence in our culture of a major psychiatric document, namely, the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (APA). The impact of this Diagnostic and Statistical Manual (DSM) has been felt far beyond the United States and continues to grow. In my opinion, more open criticism of the document is required to enable clinicians to reflect upon the degree they wish to buy into its assumptions and to participate in extending or in curtailing its influence. What follows are some background comments about the DSM and a brief listing of some of the criticisms that have come to my attention.

Background

The first edition (DSM-I) was published in 1952. It was originally intended to stabilize psychiatric nomenclature in American psychiatry and to clarify the description of mental syndromes. The basis goal was to encourage consistency in communication among clinicians by officially "approving" certain diagnostic terms. The impact of DSM–I was modest but with each new edition, the manual progressively gained more stature.

The key change in DSM-II the second edition which appeared in 1968, was a shift from describing mental syndromes as "reactions" (as was the case in DSM-I) to defining mental syndromes as "illnesses". This move aligned American psychiatry more closely with the rest of medicine. Another focus for DSM-II was to standardize the American classification of mental disorders in relation to the World Health Organization's eighth revision of the International Classification of Diseases (ICD-8). This provided a foundation for more international acceptability and potential influence.

The changes incorporated in the third edition, DSM-III, were extensive. They included "such new features as diagnostic criteria, a multiaxial approach to evaluation, much expanded descriptions of the disorders and many additional categories" (p.7). The priority became one of precision and accuracy in making diagnoses. This was based on the medical assumption that "planning a treatment program must begin with an accurate diagnostic assessment". (p.7) I wonder in what direction the manual might have evolved if, instead, it was based on a humanistic assumption like "planning a therapeutic response must begin with empathy and compassion". But the authors of the manual were much more interested in empirical science than humanism. DSM-III was to be based on "research evidence" as far as possible. Thus, in preparing the third edition, the influence of research investigators with "objective data" increased while the influence of clinicians with therapeutic experience decreased.

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[1] Published in Dulwich Centre Newsletter 1990 No. 3

When it was finally published in 1980, DSM-III was presented to the mental health community as incorporating the best and most up-to-date scientific knowledge that was available. This claim, together with the illusion of objective precision, proved irresistible for most Western clinicians and researchers. As a result, DSM-III was widely adopted and its influence soared. It even was taken up by governments and third party insurance agents. The 1987 revised version, DSM-III-R, acknowledged that "the impact of DSM-III has been remarkable" (p.xviii), and went on to note that it had already been translated into 13 languages. DSM-III-R did not depart significantly from the basic thrust of DSM-III, it simply extended the effort to be more rigorous and precise.

Both DSM-III and DSM-III-R claimed to be based on a predominantly "descriptive approach". They were purported to be "generally atheoretical". Yet, both explicitly articulated a strong and unequivocal individualistic bias: "each of the mental disorders is conceptualized as a clinically significant ... syndrome or pattern that occurs in an individual" so that "conflict between the individual and society ... is not by itself a mental disorder". (p.6 in DSM-III and p.xxii in DSM-III-R) The authors seemed oblivious to the theoretical significance of their individualistic presuppositions. There was no mention of the possibility of another point of view. They simply ignored the body of knowledge based on an alternative assumption, namely that the human behaviour, the mind, and its disorders, may be more fundamentally grounded in social phenomena than individual phenomena.

Interestingly, axes IV and V (severity of psychosocial stressors and highest level of adaptive functioning) implicitly acknowledge the importance of a person's social environment but both axes remain solidly embedded in individualistic assumptions. An important anomaly in DSM-III and DSM-III-R related to this theoretical issue is that when a situation requires clinical attention or treatment, but the evidence of social influence in generating the mental distress is too strong to be ignored, the condition is defined as "not attributable to a mental disorder". Yet the "V codes" are provided to classify it. This contradiction is one manifestation of the inadequacy of the purely individualistic orientation to describing and understanding mental problems.

However, one of my major concerns is that there is so little cognizance of the fact that DSM has evolved to become such an authoritative document for classifying and labelling persons with mental problems. It has virtually become "The Bible of Psychiatry" and is being applied religiously by "the faithful". Most mental health systems in North America have adopted it and in many settings it is not possible to receive payment without submitting a diagnosis. Yet, there seems to be so little discussion of how pathologizing this practice of psychiatric labelling is for persons who have already been socially and psychologically traumatized.

The DSM disclaimer, that classifying disorders does not classify individuals (p.6 in DSM-III and p.xxiii in DSM-III-R) does not hold very much credibility in my view. In actual practice, DSM diagnoses are almost always collapsed onto the persons so diagnosed. For instance, "a person with schizophrenia" is referred to as "a schizophrenic", "a person with obsessive compulsive disorder" has come to be known as "an O.C.D." This is often first done by professionals, then by family members,

friends, and the public at large, and eventually by “patients” themselves.

The labelling process initiates permanent stigmatizing patterns of social interaction in the human network of relationships in which a person so labelled is embedded. A person, once authoritatively labelled “a schizophrenic”, is never treated the same again in his or her social network. People simply look at him or her differently. Nor does such a person ever see himself or herself in the same way again. These identity-defining practices follow logically from the theoretical framework out of which the whole DSM system arises, namely, that the disorder is in the person. What is so frightening to me is that the clinicians, researchers, politicians, and insurance agents who use the manual are actively promoting such human classifying practices in our present culture. The resultant damage being done to persons and to social relationships is enormous.

I take the published disclaimer about classifying persons as a disavowal of any deliberate intent to pathologize and stigmatize and, hence, I cite the pathologizing effects of the document as inadvertent. However, the fact that these effects are unintended renders them no less damaging. What is required to mitigate the dehumanizing effects of the document, is the courage to challenge its formidable authority and then to take a stand against the automatic practices that follow from that authority. If one chooses to take such a position, one needs some arguments to undermine the authority of the DSM. What follows are some specific criticisms that I have used to limit its influence on my own habits of thought and clinical action:

Empirical Criticisms

1. The nature of the disorder, its diagnostic criteria, and the boundaries of categories are determined in APA committees, not by the phenomena being described.
2. DSM is unable to encompass many clinical situations (i.e. the “V” codes are inadequate).
3. There is no provision for interpersonal, familial, cultural, or institutional “diagnoses”.

Political Criticisms

1. Constitutive “power in defining the nature of persons can easily be abused.
2 In whose interest is it to label (professionals; patients; other parties such as family members, insurance agents, government; etc.)?
3. DSM promotes the “medical mode” and psychiatric supremacy in the mental health field.
4. Gender bias may be institutionalized (i.e. ”Pre-Menstrual Syndrome” is being considered for DSM-IV), as a heterosexuality bias (i.e. “homosexuality” was included in DSM-II) with reification of traditional stereo-typing.

Humanitarian Criticisms

1. Persons are dehumanized by transforming them into subjects under the scientific “gaze”.
2. Persons are pathologized through labelling, totalizing, and segregating.
3. DSM promotes an “orientation towards inadequacies” by attending to tragedies and personal failures rather than an orientation towards solutions” with attention to *resources* and *competence*.

Pragmatic Criticisms

1. There is an overemphasis on the general syndrome and a de-emphasis with respect to the specific experiences and personal context of the client.
2. DSM promotes a static rather than a dynamic perspective by emphasizing permanent traits rather than transient states.
3. DSM promotes blindness with respect to the interpersonal and cultural factors that contribute to mental health problems.
4. DSM is seldom useful in the determination of a specific treatment plan.

Ontological Criticisms

1. The basic assumption about the nature of mental phenomena seems problematic (i.e. that mental disorders are “in the person” vs “in the interaction between the person and the context” vs “in the coordination of interaction among persons”).

Ironic Criticisms

1. DSM fails to include the diagnosis of the “DSM syndrome” - a spiritual psychosis characterized by a compulsive desire to objectify persons and to label them according to predetermined psychiatric categories.
2. These “victims” of modern psychiatric ideology give priority to knowledge about precise descriptions - over knowledge about healing interactions - as manifest by obsessive preoccupation with pejorative adjectives, inclusion and exclusion criteria, etc.

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A brief summary of this paper was previously published in “The Calgary Participator”, A Family Therapy Newsletter, 1990, p.2-3.