# How About a Diagnostic Alternative for Use in Talk Therapy?

Jonathan D. Raskin August 18, 2014 How About a Diagnostic Alternative for Use in Talk Therapy?2014-08-18T23:26:59+00:00 Alternatives to DSM & ICD, Proposing Alternatives 7 Comments

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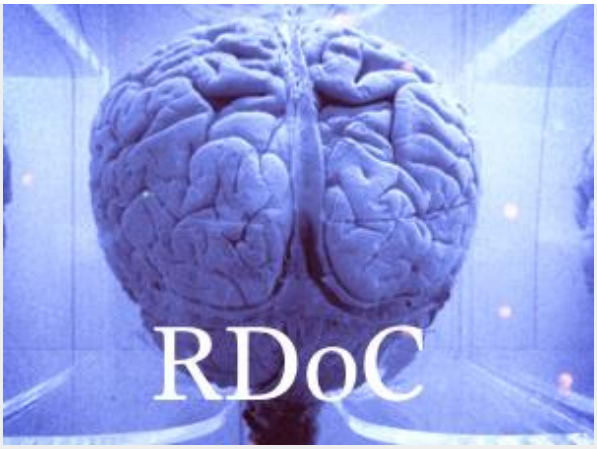
On August 5 and 6, 2014, a group of roughly twenty persons met in Washington, DC for the First Summit on Diagnostic Alternatives. The gathering consisted mostly of psychologists, but social work, counseling, and marriage and family therapy perspectives were also represented. The topic at hand was whether or not to push ahead with developing alternatives to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that could supplement or—in some settings—replace it as a way to understand human distress.

Summit participants readily agreed that the DSM relies too heavily on medical semantics. By seeing human suffering as a function of broken brains, the DSM overlooks the complex and mutually determining interplay of psychological, socio-cultural, contextual, and biological factors in producing it. While the DSM does not completely ignore psycho-social factors, it typically sees them as extraneous variables that influence, but are distinct from, the presumed primary cause of emotional suffering: a dysfunction inside the individual.

The tendency for diagnostic systems to privilege internal dysfunction at the expense of psycho-social and contextual factors is not unique to the DSM. At this year's American Psychological Association convention (which directly followed the summit in DC), there was much talk about shifting from the DSM to the World Health Organization's *International Classification of Diseases* (ICD). To wit, APA is even selling a primer on how psychologists can use the ICD-10. However, moving from the DSM to the ICD isn't much of a shift

because both manuals are conceptually similar, right down to sharing the same diagnostic codes. Both attribute distress to categorical disorders people have and, in doing so, gloss over psycho-social factors. Put another way, the DSM and ICD are merely variations on a theme.



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The other alternative generating buzz at this year's APA convention was the Research Domain Criteria (RDoC) initiative. RDoC's alluring but grandiose mandate is to build a biologically-based diagnostic system of mental disorders from the ground up by identifying brain mechanisms, tracing their functions, and cataloging the behavioral domains they appear to be affecting. The goal is to root diagnostic categories in biological etiology. RDoC is grounded on the presumption that human distress is explicable primarily in terms of biological (usually brain) dysfunction. Unfortunately, its goal of building a taxonomy of human suffering tied entirely to measurable physiological indices may turn out to be a fool's errand (Kirmayer & Crafa, 2014); even its adherents readily admit that their proposed system is years away because the biological knowledge necessary to generate such a system is nowhere near at hand (Grohol, 2013). In its biological idealism, RDoC is even more extreme than DSM or ICD in framing psychological and social-contextual factors as ancillary at best.

Where does this leave psychologists, counselors, marriage and family therapists, social workers, and any other helping professionals who do not see their role as diagnosing and treating diseases, but instead as understanding and remediating psycho-socially embedded problems in living? If we are to develop an alternative system for these professionals, what might it look like? Summit attendees in DC decided the time is now to take up such a task. While we might applaud such an alternative, developing it—much less ensuring its success—is admittedly a very challenging task. Here are a few elements that such a system would likely need to include if it is to stand a chance of catching on:

1. **Places psycho-social factors on equal footing with biological ones**. This is not the same as saying biology is irrelevant. Everything people do is biologically based. That said, biology is not always a unidirectional determinant of emotion and behavior.

Psychological, social, and contextual factors influence biology as much as biology influences them. To be viable, a diagnostic alternative relevant to clinicians must account for the complex and mutually determining interplay of psycho-social and biological aspects of human experience. It is common to hear people say things such as "depression is a brain chemistry issue exacerbated by situational factors"—as if the latter could not possibly have primacy in determining the former. Psychotherapists and counselors know better and need a system that allows them to contextualize psycho-social and biological aspects of human suffering in a more nuanced manner.

2. **Categorizes problems, not people**. One of the attendees at the summit, Jeffrey Rubin, has proposed that we classify *concerns* that clients bring to therapy, not *disorders* they have. Identifying concerns is very different from identifying disorders. Concerns are things such as feeling anxious about one's job, unhappy about one's marriage, emotionally distraught about past abuse, or unable to move past what one saw while fighting in a war. The current diagnostic system encourages clinicians to translate these concerns—which clearly are contextual and not reducible to biology alone—into disorders that afflict people. But therapists and counselors don't actually treat disorders; rather, they talk to people about their concerns—some of which are quite serious and lead to extremely challenging and often intransigent difficulties. Any diagnostic alternative that wishes to better fit with what therapists and counselors actually do must make sure that it classifies problems, not people.

3. **Scientific**. The DSM has been widely criticized for questionable science. RDoC is committed to science, but currently relies more on conceptual speculation about hypothetical "domains" than it does on clear and convincing data. By comparison, there is a great deal of existing literature on psycho-social ways of concretely formulating understandings of emotional distress. More needs to be done, of course. The point is that any useful diagnostic alternative should rely on the best science has to offer.

4. **Collaborative**. Too often, what we call "diagnosis" degenerates into a powerful expert labeling a vulnerable client. Barry Duncan attended the summit and did an eloquent job speaking to the science and practice of collaborative assessment of client difficulties. Clients know more about themselves and their circumstances than we do. A good diagnostic alternative system must make sure that client voices have a prominent role in the process because to leave them out is to ignore a vitally important data source.

5. **Usable across orientations, professions, and constituencies**. Several years ago, a group of psychodynamic therapists produced their own alternative to the DSM: the *Psychodynamic Diagnostic Manual* (PDM). This effort was admirable and marked the first attempt in a long time to offer a non-DSM diagnostic system. However, the appeal of the PDM was limited by its explicitly theoretical nature. Clinicians who did

not identify as psychodynamic were therefore not especially inclined to utilize the PDM. In order to devise a diagnostic alternative with widespread appeal, we must:

a) generate a system that is not bound to any particular theoretical orientation other than one that sees all forms of counseling and psychotherapy as means of using conversation and relational engagement to help clients address their presenting concerns;

b) build a system that involves all relevant constituencies and professions in the process of its creation; this means not just involving representatives of the various helping professions, but also guaranteeing a seat at the table for consumers of services and insurers who cover services;

c) include a practical way for clinicians to code concerns that people bring to the consulting room and provide evidence that we can effectively help people with these concerns, so that insurers see what is being offered as empirically-supported and in their financial interest to cover.

Attendees at the summit in DC were both excited and cautious about the move to develop diagnostic alternatives. It is, admittedly, a daunting task. Yet if it is to ever occur, we must start somewhere. I welcome further thoughts on elements necessary to a successful effort.

## References

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## About Jonathan D. Raskin

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