PREFACE (DON'T SKIP THIS—IT MATTERS!)

Ask yourself a few questions. Why do people get mental illness? What—exactly—causes mental disorders? When someone is suffering psychologically, how can we know the best way to treat that person? How is it that we can decode a genome but cannot figure out definitive, clear-cut answers to these questions? Questions like these—as well as our best current answers to these questions—are what this book is about.

This is a book about understanding as much as we can about the etiology and treatment of some of the most common mental disorders and psychological symptoms. Understanding etiology—the study of the causes and origins of diseases or abnormal conditions—is of extreme importance to effective treatment. If you believe a plague is caused by angry gods (as did the author of *The Iliad*), then you "treat" the plague by appeasing the gods. If, as science has demonstrated, plagues are caused by bacterial infections, then effective treatment depends upon antibiotics (and prevention depends upon proper hygiene and/or immunization); that's a big difference. In this text, we use an Integral framework to review empirical and theoretical literature related to the psychological, physiological, cultural, and social aspects of the etiology and treatment of the disorders and symptoms that prompt people to seek the help of mental health professionals. That said, it is *not* a book *solely* about the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (known as the DSM-5). This book is best used as a *companion* to the DSM-5. Although we cover some disorders proper (e.g., Bipolar I Disorder), many distressing symptoms appear in multiple disorders, so you will read about them in multiple chapters. This book is timed to be released soon after the DSM-5. In our research and writing, we have scrupulously studied the DSM-5 Task Force reports and read hundreds of papers on the development of the DSM-5, as well as books put together by the American Psychiatric Association explaining the changes that occurred in the DSM-5. Finally, when the DSM-5 was released, we fact-checked our work against the new manual. Most of the references to the DSM in this book are to the DSM-5 unless otherwise noted. We also have to remember that as of this time—because the DSM-5 was just published—there is little research on DSM-5 diagnoses; most research is based in DSM-IV-TR diagnoses.

Most important, we want to repeat that we have covered cutting-edge research in each chapter on both etiology and treatment. Thus, it really doesn't matter if the DSM label for a disorder has changed. What we know about the causes and treatment of a given disorder does not change just because the DSM label or criteria change. Although we feel we have done a thorough job of following DSM-5 developments, we ask you to keep this in mind. Changes in the DSM labels or criteria do not change the extant empirical research for, or theoretical understanding of, the underlying symptoms and problems for which people seek treatment. We believe that there is no book like this currently on the market, and while we ask a lot of the reader, we also offer a lot, and hope that you find the journey as exciting and informative as we have.

ACKNOWLEDGMENTS

First and foremost, I (Ingersoll) want to thank my friend and colleague Andre Marquis for being willing to do this project with me. I never could have done this without his exhaustive efforts, incisive critiques, penetrating questions, and moral support. I also want to thank the research assistants who have been so helpful to me in tracking down papers and researchers from across the globe. These assistants include Nadine Ndanema, Doreen George-Thomas, Laura McIntyre, and Kevin Blake. Carlene Ortiz from The Centers for Families and Children provided enormous support helping me think through ideas and write in a language students could connect with. Thanks to Paulina Alanisz for her hours of conversations about states of consciousness and cultural identification. Finally, I want to thank Cleveland State University for the release time and technical support to complete this book. CSU has been a great place to work and explore my diverse interests with supportive colleagues and the best students on the planet!

I (Marquis) want to thank Elliot Ingersoll for beginning this project (I doubt I would have initiated such an ambitious undertaking!) and for all of the excellent research he did in preparation for this book. I continue to feel at home in the Counseling and Human Development program at the University of Rochester, and deeply appreciate the support and camaraderie of my colleagues there. I am grateful for the support and friendship of my brother, Ro; my parents; my friend and fishing partner, Brian Connors; and my sister Melinda and her husband Clint. I also want to thank Erica Crane, my wife, for her thoughtful proofreading of my chapters.

We also thank Meredith Fossel and Kerry Rubadue from Pearson who believed in this project and worked hard to get us over many hurdles. Additionally, we want to thank Roxanne Klaas from S4Carlisle Publishing Services who worked so hard on the final pages and was a real trooper with helping us think through last minute changes.

We also would like to thank the reviewers of this first edition: Jenelle C. Fitch, Texas Women's University; Jeffrey Longhofer, Rutgers University; Kathryn Ecklund, Azusa Pacific University; Elizabeth C. Pomeroy, University of Texas at Austin; and Marleen S. Williams, Brigham Young University.

1

Introduction

We are embarking on a journey together—you the reader, and we the authors. We assume you are training to become a mental health practitioner, perhaps a counselor, a social worker, or a psychologist. What is it that you should know about psychopathology? Perhaps most important, we want the reader to understand that this is a book about psychopathology that describes multiple causes and treatments for the most common psychiatric/psychological symptoms that clients present with. That said, this is not a book about how to use the *Diagnostic and Statistical Manual of the American Psychiatric Association*, 5th Edition, commonly referred to as DSM (American Psychiatric Association [APA], 2013a). Rather, this book is designed as a companion to the current edition of the DSM as well as other diagnostic systems for mental and emotional disorders.

The DSM (which we'll cover in greater depth in the next chapter) is a system of categorical psychiatry that provides symptom clusters based on their relationship to one another and the category they are grouped under (e.g., Major Depressive Disorder). The DSM does not attempt to state what causes the disorders (etiology) or the best way to treat the disorders once they are identified. There was an attempt to do this in the DSM-II (APA, 1968), such as describing depression as "endogenous" (more biological in basis) or "exogenous" (triggered by external events). Because researchers failed (and still fail) to find biological markers that would conclusively demonstrate that a case of depression was "endogenous," these attempts at etiology were deleted from DSM-III (APA, 1980).

Thus, studying the DSM by itself is of little clinical value if your work is treating clients rather than matching their symptoms to the ones listed in the DSM. Our primary goal is that this book will help you understand theories and evidence regarding the causes of the symptoms and disorders clients suffer from and, secondarily, various ways to treat symptoms and disorders. Although the DSM edition changes over the years (like the recently released DSM-5), how a disorder is labeled or how many symptoms you must have to be diagnosed with a disorder does not change what *causes* the disorder or *how best to treat the disorder*. While we have just transitioned from DSM-IV-TR (APA, 2000) to DSM-5 (APA, 2013a), the transition has not affected the research on etiology and has had only minimal effect on treatment.

Diagnostic systems for children that you should be aware of include the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, Revised Edition (DC:0-3R; Zero to Three, 2005) and the *Research Diagnostic*

Criteria—Preschool Age (RDC-PA; Task Force on Research Diagnostic Criteria: Infancy and Preschool, 2002). These systems were designed to serve as a complement to the DSM by providing a systematic, developmentally attuned manual to help clinicians identify and classify mental health and developmental difficulties in the first 4 years of life. In addition, there is the *Psychodynamic Diagnostic Manual* (also referred to as the PDM), which is a diagnostic framework that aims to characterize a client's full range of functioning with regard to emotional, cognitive, and social domains (PDM Task Force, 2006). The PDM is also designed to complement the DSM. Finally, there is the *International Classification of Mental and Behavioural Disorders* (ICD-10; World Health Organization, 1992). This manual is the World Health Organization's volume on mental disorders, and the DSM-5 has been designed to harmonize diagnoses in the DSM with those in the ICD. For example, next to each DSM-5 diagnostic code there is a parenthetical ICD code. The ICD-11 is due to be released in 2016. The plan is for these ICD codes to be implemented October 1st 2015, which is why the DSM-5 has both the recognizable (from earlier DSMs) five-digit numeric code (e.g., 296.32) and the parenthetical ICD alphanumeric code (e.g., F32.00). Rather than expecting students to master all these diagnostic manuals, in this book we will summarize the etiology and treatment of mental and emotional disorders including relevant information from these manuals in addition to the ICD and DSM. Finally, we should note that the National Institute of Mental Health (NIMH) announced that it will no longer rely on DSM-5 criteria in research on mental illness. Rather, it is proceeding with its ambitious Research Domain Criteria (RDoC) approach, which was drafted in 2011.[1] These criteria will focus on multiple physiological variables that may cause mental and emotional symptoms. The symptom domains the NIMH will research include symptoms that occur across DSM categories (for example, depression could emerge in Major Depressive Disorder, Persistent Depressive Disorder, or Bipolar I and Bipolar II disorder). The RDoC will include research on genetic, molecular, cellular, and behavioral variables that contribute to symptoms as well as other factors such as brain circuits.

It is important to understand the DSM-5 diagnostic system, and it is strongly recommended that instructors using this text assign the DSM-5 (or the less expensive *DSM-5 Desk Reference* [American Psychiatric Association, 2013b]) to be studied with it. Despite the many controversies surrounding the DSM-5 (Frances, 2013), it is still the most common manual that you will encounter in the field in the United States. What we think you need to understand about diagnostic systems, assessment, and treatment will drive this first chapter and lay the framework for the rest of the book. We hope that by the end of the chapter you will understand that psychiatric disorders are, first and foremost, *very different from* disorders in other branches of medicine. This must be clearly understood if any good is to result from reading this book. We also want to emphasize early on that psychiatry and psychopathology use unique jargon, and you will likely come across new words in reading this book. Keep a dictionary handy, and if you come to a word you don't know, stop, look it up, and write the definition in the margin of the page where the word appears (if you own the book). We will try to define words likely to be unfamiliar to most readers in the footnotes in each chapter.

---

[1] This decision and the links to the RDoC can be found at http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml.

FINANCIAL ISSUES SURROUNDING QUOTES FROM AMERICAN PSYCHIATRIC ASSOCIATION PUBLICATIONS

Upon completion of the DSM-5, the American Psychiatric Association set fees for reproducing any material from the DSM-5 for works like this book. We were quoted a price of $600 for every quote (properly cited) that we originally wanted to use (including criteria sets), which would have been about $30,000. This being prohibitive, we have summarized or paraphrased material from all American Psychiatric Association publications that would have been quoted had the fees not been so high.

THE LAYOUT OF THIS BOOK

This book is designed to introduce you to theories and evidence regarding the etiology and treatment of psychopathology as well as to encourage you to think critically about these theories and data. Thinking critically includes critiques of the DSM and the process used to create it. Although some authors decry the decline of critical thinking in universities and the ascension of what they derisively term "vocational training" (Hacker & Dreifus, 2010), critical thinking is very much alive in our classrooms and the minds of our students. It is the dialogues with students (many of whom are working in mental health fields) that shaped much of our approach here.

The rest of this chapter is divided into six parts. Part I discusses the difference between psychiatry and other branches of medicine. This is important because the DSM is primarily authored by psychiatrists. Even though other mental health professionals have in recent years been part of the task force developing each section, the discipline of psychiatry dominates the process. Of the 33 members of the DSM-5 task force listed in the DSM-5, 79% have M.D. credentials.[2] Part II of the chapter deals with how we define psychopathology and answer the question "what is normal?" Our aim in this part is to encourage you to think critically and broadly about just what constitutes psychopathology and how crucial client variables like cultural identification may affect what is considered "normal." Part III provides an outline of what is sometimes called the "mind/brain problem." In this section we want you to understand that what is considered "mind," what is considered "brain," and the relationship between the two is still unclear (despite the assertions of pharmaceutical-funded researchers who want us to believe that "mind" is nothing more than electrochemical actions in the brain). Again, we include this material to encourage critical thinking. Part IV discusses the place of clinician judgment in using the DSM. Part V introduces and outlines the Integral model, and Part VI provides a case example using that model. The Integral model is subsequently presented as two illustrations in each chapter that are designed to help the reader see "at a glance" the important variables in the etiology and treatment of disorders. Finally, each chapter will have review questions at the end.

---

[2] A list of members of the DSM-5 task force can be found online at http://www.dsm5.org/MeetUs/Pages/TaskForceMembers.aspx and in the DSM-5.

PART I: HOW IS PSYCHIATRY DIFFERENT FROM OTHER BRANCHES OF MEDICINE?

Before going any further, it is important for the reader (who is likely studying or working in a nonmedical mental health profession) to understand the difference between psychiatry and nonmedical mental health professions such as counseling, psychology, marriage and family therapy, chemical dependency counseling, and clinical social work. Psychiatry is a branch of medicine in the United States and other countries. The approach to medical practice in the United States is generally referred to as *allopathic* medicine. The term *allopathy* was coined in 1842 by Samuel Hahnemann, the founder of homeopathic medicine. Allopathic medicine treats disease by introducing remedies that produce effects different from those of the disease under treatment (Webster's New World, 2008). In contrast, *homeopathic* medicine was based in the assumption that drugs or other agents in smaller amounts could produce symptoms *similar to* those of an illness in healthy people and better prepare their bodies to fight disease.[3] Other approaches to medicine historically include osteopathic medicine (which traditionally emphasized the role of the musculoskeletal system in health and disease) and chiropractic medicine (a system of treating disease by manipulating the vertebral column). In the early 20th century, medical education reform was initiated by Abraham Flexner (under the aegis of the Carnegie Foundation) and his so-called "Flexner Reports." In these reports, Flexner established (under great protest from the medical community) allopathic medicine (with its then-new "germ theory") as the most progressive and thus desirable form of medical training. Since then, allopathic medicine has dominated medical training and practice in the United States to the point where osteopathic physicians are basically trained in allopathy and homeopathy has been pushed to the periphery of popular culture.

Why is this important to understand? It is important because psychiatry and the psychiatric diagnostic manual (DSM) list disorders that are radically different from non-mental health disorders in the International Classification of Diseases (ICD) of the World Health Organization in that there is not one disorder in the DSM for which we have found a physiological marker that correlates 100% with any symptom cluster (Practice Management Information Corporation, 2006). It has been pointed out by several sources that as far as biological markers go, psychiatry has failed to find even one for a single DSM disorder (Charney et al., 2002; Paris, 2013). Charney and colleagues (2002) went so far as to note that such a dearth of markers places psychiatry 50 to 100 years behind other branches of medicine. Imagine if your general practitioner was 100 years behind in the practice of medicine; he or she would not know that influenza was caused by a virus.

---

[3] Sometimes, at first glance, students may think homeopathy is similar to vaccination. Homeopathy is *very* different than the idea behind vaccinations. Homeopathy beliefs vary, but generally it is thought that by administering homeopathic agents, the agents stimulate a *vital force* to effect healing, whereas in vaccinations, the intent is to directly affect the immune system to fight a pathogen. There is no scientific evidence for homeopathy's "vital force" through studies of Reiki and acupuncture, but energy medicine and energy psychology continue to explore the possibility. Finally, homeopathy espouses the "law of dilution," which maintains that the way an agent is diluted with water or alcohol (a process called *succussion*) activates the vital force of the agent, and therefore the body will respond to that vital force with its own vital force. As you might guess from this short note, there is scant scientific support for homeopathic practices.

This is a sobering situation at a time when pharmaceutical companies have mistakenly convinced an unwitting public that conditions like depression are unilaterally caused by "chemical imbalances" in the brain.[4] There is no evidence for such a statement but the current laws governing what is called direct-to-consumer drug advertising (which is illegal in every country in the world except the United States and New Zealand) do not prohibit marketing misguided ideas like it. To say that psychiatry may be up to 100 years behind other branches of medicine is to compare psychiatry with medicine at a time when it was almost helpless in the face of the deadliest influenza epidemic in the history of the civilized world (the flu epidemic of 1917–1918). As noted, at that time doctors did not even know that influenza is caused by a virus, and there were many doctors who still contested any germ theory of disease (Barry, 2005).

The truth of our current situation is that we *do not know* precisely what (if any) disease process underlies mental and emotional disorders. In fact, assuming there *is* a physical disease process underlying all of them *may* be an error. Or, as some researchers are investigating, there may be far more variables than we can currently imagine (e.g., see Forsythe & Kunze, 2013, for a discussion of how gut microbes can affect the central nervous system). As you will see in this text, many of the disorders that we cover are what we call *overdetermined*; this means there can be multiple causes across physiological, psychological, and sociocultural aspects of one's life for the symptoms of, for example, depression or anxiety. Other disorders like Bipolar I Disorder or Schizophrenia *seem* to have a physiologic basis but we still do not know exactly what that is.

Given the lack of a definitive understanding about etiology and the fact that we have multiple diagnostic manuals for mental and emotional disorders, the framework we use in this book is the Integral model (Wilber, 1995). We will outline the model later in this chapter, but for now, we want to mention that we use the Integral model for this book because it is an integrative, unifying framework that provides multiple perspectives on symptoms clients are suffering from and thus helps clinicians look at the symptoms from different points of view. This is even more important now because DSM-5 deleted the five-axis diagnosis recording procedure that noted specific psychosocial stressors and global assessment of functioning. Being able to view symptoms from different perspectives increases the chance that a clinician will consider multiple variables related to the client's symptoms (and then treatment) that might otherwise go unnoticed. Why might they go unnoticed? It seems that human beings tend toward a type of attribution error in that if we give something a label, many of us assume that the label explains what the thing *is,* in this case a disease process. In the case of many mental and emotional disorders, the labels *actually obscure* important variables—particularly when the client is a young child.

By way of example, consider depression. It is a set of symptoms present in multiple disorders, including Major Depressive Disorder, Persistent Depressive Disorder (previously Dysthymia), Bipolar I Disorder, Bipolar II Disorder, Post-Traumatic Stress Disorder, and Schizoaffective Disorder. But even depression proper (Major Depressive Disorder) can develop from multiple etiologies. A person may become depressed for no discernable reason and not respond to antidepressant medication

[4] You can view the first author's "TED" talk on this at http://www.tedxcle.com/dr-elliott-ingersoll/.

or be depressed and have a lot of vegetative (physical) symptoms (appetite change, sleep disruption, decreased sexual desire) that respond fairly well to antidepressant medication. Equally, depression may follow the loss of a loved one, giving birth, or suffering a trauma. A person who grew up in a dysfunctional family may develop a negative mindset that increases the chance that he or she will become depressed (what is called a cognitive vulnerability to depression). Other people may be depressed because they have trouble forming healthy relationships, and this seems to be related to having poor relations with their parents early in their lives (what may be called interpersonally-driven depression that results from poor attachment). In each of these examples, the client "hotspots" (what we call *the positive causative factors*) differ. The Integral model, as you will see shortly, provides a framework that helps you map out the "hotspots" by considering possible contributors in several key areas. Before we introduce the Integral model, though, we want to address the concept of psychopathology and normalcy.

PART II: PSYCHOPATHOLOGY

Psychopathology courses are sometimes labeled as "abnormal psychology." What is a "psychology," how do we define it as "normal," and what departure from that makes a psychology "abnormal"? These are the questions we want to explore with you in this section of the chapter. We'll begin with a discussion of normalcy and an idea of what is psychologically "normal." Next, we'll tackle the mind/body problem and the implications this unresolved dilemma has for understanding what is psychologically "normal" and "abnormal." Finally we'll conclude with a discussion of the way this book is structured and an introduction to the Integral model.

What Is "Normal"?

Imagine you are sitting in a coffee shop where you and several other patrons are working on your laptops. At one point a young girl of Indian descent and dressed in a pattu pavadai[5] jumps up with a gasp, points at her computer, and says in a stifled mutter "you made me do this." Is this behavior "normal," "abnormal," or somewhere in between? Most of you are probably thinking "well, it depends." On one hand, if queried the woman may claim that she has just launched a nuclear missile to destroy North Korea because the voices in her head told her to do so. When faced with the reality of what she had done, she muttered that the voices "made her do it." On the other hand, you may find on closer examination that she spilled hot coffee in her lap (accounting for the gasp) while she was engaged in an argument with a relative via the Internet using Skype or some similar software package. In this context her actions and statements take on a new meaning that fall well within the realm of consensual reality[6] or what is "normal." So, what is normal is to a large degree based on the context, and, as developmental psychologist Jerome Kagan (2006) has noted, when we change the

[5] A pattu pavadai is a cone-shaped silk garment that is one of the traditional dresses of southern India for young girls.

[6] The term *consensual reality* is one way to describe agreements we make, intentionally and tacitly, as to what is "real."

context of something, the psychological meaning of that thing is also changed. Consider how even the following cases of cannibalism, potential suicide, and murder were actually publicly accepted—even celebrated—as a function of context. One man, R. C., ate the flesh of a friend of his; another man repeatedly told friends and family that he was going to drive off a cliff; and another admitted to taking the lives of several people in a series of fights.

> In the first example, R. C. was one of sixteen survivors of an airplane crash in the Andes. He and his companions remained barely alive for ten weeks in the bitter cold and barren wastes of a snow-covered mountain range. Their courageous survival [was] made possible only by their reluctant use of dead bodies for food. . . . The apparent suicide attempt was actually a well-publicized daredevil stunt performed by motorcyclist Evel Knievel. The third illustration refers to the memoirs of a crime-fighting sheriff of a small Tennessee town. (Mahoney, 1980, p. 3)

What we are calling "context" takes into account things like culture, technology, and larger dynamics such as the socioeconomic modes of production within a society and the average person's access to the latest technology. In the 1980s, I (Ingersoll) lived and worked in an inner-city area that had a centralized park. During walks around the park I would frequently encounter people muttering or talking to themselves and occasionally gesturing wildly with their hands while speaking loudly and even shouting. Most of those I encountered in the 1980s were people suffering from Schizophrenia and living on the street or in the mental health group homes that ringed the park area. Today when I walk through downtown Cleveland, it is more unusual to pass a person who is *not* talking to some unseen presence being channeled through a Bluetooth phone remote fashionably clipped onto the person's ear. In this case, the cellular phone technologies available to the average citizen have rendered outdated the notion that anyone walking along talking to herself likely suffers from some mental disorder.

The concept of what is psychologically "normal" is very hard to pin down. We can certainly set parameters that culturally similar people agree upon and say generally that anyone behaving within these parameters is "normal." But then to be culturally accommodating we may further broaden the parameters to include different cultural perspectives and call anyone functioning within these broader parameters "normal enough." But what is "enough"? It is difficult to say what is "normal" regarding physiology let alone psychology. Physiologically, one example is the idiosyncratic response many people have to prescription medications. Whereas in adults idiosyncratic responses are more often the exception, the younger a person is, the more likely the chance that he or she will have an idiosyncratic response to a medication—ask any parent who has given a child an over-the-counter antihistamine for allergies only to have the child bouncing off the walls the entire night rather than feeling sedated from the drug. Even in anatomy what is "normal" varies greatly. Some stomachs hold 12 times as much food as others. In the heart, the number of branching blood vessels differs from aorta to aorta. What is interesting is that *all of these stomachs and aortas fall within the range of what is anatomically "normal."* One criterion we may use to judge the normalcy of an organ like a stomach is whether it functions adequately: If it performs its functions adequately, we should include it in the realm of what is a normal stomach.

But can we apply this criterion of "normal" to psychological states and traits? One of the most speculative and contentious areas in psychology is personality theory. As psychologist Kenny Paris asks students in his abnormal psychology course, "what's a 'normal' person?" Answer: "someone you don't know very well." Surveying thousands of years of efforts to classify typologies of personality has turned up very little material that has predictive or explanatory power, let alone the power to describe what is psychologically "normal" (Ingersoll & Zeitler, 2010). Part of the problem here is that (hard as it is to believe) we still lack a universal definition of what "mind" is and, more important, what the relationship is between "mind" and "brain." If there is such a thing as "the mind," what is it that is functioning "normally" or "adequately" when mind is "healthy"? To even ask the question you need some background on what is called the *mind/brain problem*.

PART III: THE MIND/BRAIN PROBLEM AND THE QUESTION OF DISTRESS OR DISABILITY

"What is mind? No matter. What is matter? Never mind."

George Berkeley

Are "mental" disorders mental, physical, or both? A central issue in answering this question is how we define "mind." At the outset, we are going to "cut to the chase" and tell you this issue has not been resolved. Let's start by having you reflect on your mental experience right now. You are reading. As the late author Kurt Vonnegut stated, reading is hard work. Readers of the English language must create in their minds whole worlds from horizontal lines of 26 phonetic symbols, 10 Arabic numbers, and about a dozen punctuation marks (Vonnegut & Stringer, 1999). How are you doing this right now with your mind? What is the thing you are doing it with? In addition to the work of reading, you are also likely aware of emotions, bodily sensations, and other thoughts. All of these arise in your consciousness, or your field of awareness. Do the things that arise constitute your mind, or is your mind the field of awareness within which all these things arise? Also, if either of these is your mind, does it "come from" somewhere or something like the brain, or can consciousness exist without a brain? You can begin to see what difficult questions these are! Scientists and philosophers who believe your mind comes from your brain are typically called *physicalists* or *materialists* (Churchland, 2002; Koch, 2012).

The materialist typically views the mind as something that "comes from" the activity of the brain. Exactly how this happens *no one has yet been able to explain*. Probably the best effort has been by philosopher Patricia Churchland, who clearly stated ". . . it is the *brain*, rather than some nonphysical stuff, that feels, thinks, and decides" (Churchland, 2002, p. 1). This answer, however, begs another question: How can something "mental" (i.e., nonphysical) feel, think, and decide to affect something physical? Psychologist and philosopher Daniel Robinson has noted that this question has never been adequately answered. We decide to raise our right hand and do it—how do we do that? Robinson notes that if consciousness is nothing more than electrochemical processes, why does it feel so different from electrochemical processes? He further points out that if consciousness is nothing more than physical components

and their processes, we must include the matter and processes of atoms and subatomic particles that we hardly understand at all. Thus, even an exclusively materialist perspective on mind, asserting that the mind derives from the brain, leaves us with an ocean of unanswered questions (Robinson, 2008).

A second (and by no means the last) perspective is sometimes referred to as the *dual-substance approach*, which presumes that consciousness is *not* dependent on a brain for existence. There are many versions of this argument, but one sense of it can be experienced by reviewing the debate about color vision between Isaac Newton and Johann von Goethe. In 1672 Isaac Newton published a series of experiments that postulated a theory of color vision that was physiological in nature. Goethe, who was a respected writer and scientist, took issue with Newton's theory and published his own 1400-page theory of color vision in 1810. Although Goethe seems to have misinterpreted some of Newton's findings, one point he made was with regard to the *experience* of seeing in color. Goethe stated that Newton's theory explained everything about color vision *except* what it was *like* to see in color.

The differences between Newton's and Goethe's theories are sometimes credited as giving rise to a philosophical problem called the "Mary Problem," which was posed by philosopher Frank Jackson (1986). In the problem, Mary is a fictional scientist who was raised in an indoor world of black and white. She has had no access to color stimuli. She has however, through black-and-white television monitors, been able to see the outside world and has studied color vision in depth to the point where there is nothing she has not read on the topic. Being a top-rate mind, she has retained all she has read. The problem is this: In this situation, can we say that Mary "knows" everything there is to know about color vision? Jackson's initial position was that if materialism were complete knowledge, Mary should know everything about color vision. The point of course is that most people would say "no, she doesn't know everything there is to know if she hasn't had the subjective experience of actually seeing in color."

If we take Mary from her black-and-white world into a world of color that she sees for the first time, does she learn something new about color that goes beyond her encyclopedic knowledge of the topic? Many would assert that in fact she does learn something new—she learns what it *feels like* to see color. These experiences of how things seem to us—the subjective qualities of conscious experience—are called *qualia*. You are having experiences of qualia right now as you are reading—what the pages of the book feel like, how your body feels as you sit reading, perhaps (if you live near one of the Great Lakes) a feeling of sinus pressure in your head. All these are qualia and they are intimately related to your experience of mind (whatever that is). If this is the case, then mind or consciousness seems somehow irreducible to the brain, deserving of its own ontological status by virtue of its unique properties.

Metaphysics and the Mind/Brain Problem

Before we go any further we feel it is essential that you understand what we mean by "metaphysics." Many of you may think we are referring to California-style beliefs in "higher" consciousness and yogurt enemas. We are not. We are simply referring to assumptions that underlie any assertion about what you think is real and how to explore it. Such assumptions constitute metaphysical frameworks. Two extreme positions (and there are more than two) that are instructive to the mind/brain problem

reflect different metaphysical assumptions. Briefly, the physicalist or materialist asserts that mind is an epiphenomenon (or side effect) of the brain; this position assumes that all of reality (including your mental states) can be understood by understanding matter and the biochemical processes of the brain. In essence this is the ontological assumption underlying the NIMH RDoC agenda described earlier. The dual-substance argument asserts that matter and mind (or consciousness) are two distinct entities and one is not reducible to the other, although they may be intimately related to, and likely co-arise with, one another. Again, these are just two extreme positions on the mind/brain problem but we shall use them to explain metaphysical assumptions.

All arguments have metaphysical assumptions as their basis. The term *metaphysical* is derived from the editors of Aristotle's works and simply refers to the works that came "after the physics" or *ta meta ta physica* (μεταφυσικά) (or the books that came after the books on physics). As you can see, this is totally unrelated to popular phenomena like supposed psychics or beliefs about reincarnation. The topic of Aristotle's *Metaphysics* was simply what sorts of things exist, what you must *do* in order to acquire that knowledge, the limits of that knowledge, how it changes, and how we might learn about it. Two branches of metaphysics are *ontology* (the study of reality, being, and existence, as well as inquiry into what types of entities actually exist) and *epistemology* (the study of the nature of knowledge, the extent and limits regarding knowledge attainment, and *how* one attains such knowledge). So the two positions on the mind/brain problem just discussed involve different sets of metaphysical assumptions. In the materialist perspective, the ontological assumption about what is "real" is as follows: Only matter (in this case the brain) is "real"; consciousness has no "reality" in and of itself apart from the brain; given that, the best method (epistemology) to learn about consciousness is to study the brain (via empiricism). On the other hand, in the dual-substance position, the ontological assumption is that both brains and consciousness possess realities that cannot be reduced to the other; the epistemological consequences of this are that you can learn about consciousness by studying both the mind (via phenomenology) and the brain (via empiricism).

Now the important issue here is that *both* of these assumptions are leaps of faith and not science per se. Those championing the materialist position sometimes assert that its primary assumption is "scientific" (minds are "side effects" of brains). This assumption (that the mind derives from the brain) is not *in and of itself* scientific; this is the part most people fail to realize. They assume if something is claiming the mantle of science then it is—in and of itself—scientific. In all cases, though, even science rests on assumptions that are metaphysical in nature, and metaphysical frameworks are not constrained by measurement and observation in the same way that science is constrained. Metaphysical assumptions therefore can neither be proved nor disproved to be scientific. Certainly we may hypothesize that the experience of mind derives from the brain and seek to falsify this hypothesis, but that is different from claiming it is an indisputable "truth."

This may seem like philosophical hair-splitting, but it is important for students of psychopathology because even the most seemingly bias-free method—empiricism—assumes *a priori* that externally observable (empirical) data constitute the most significant form of data; because there are no empirical data that could support that assumption, it can thus be seen as an example of a leap of faith (Marquis & Douthit, 2006). If consciousness turns out to be no more than a side effect of the brain, all mental health disciplines will likely derive their treatments from what we learn from brain

research and the NIMH RDoC in particular. However, presently we must find ways to accommodate information about both mind and brain. We must continue to struggle to account for consciousness, mind, and self-awareness and how all of these interact to create psychological experience. Moreover, even *if* mind and consciousness were discovered to be purely side effects of the brain, that would not negate the fact that people *experience* their minds and consciousness as central to whether they are suffering or flourishing. Thus, we cannot imagine a scenario in which only strictly scientific research on the brain will be needed to help those who are suffering psychological symptoms; the issue of values and how to find meaning amidst one's struggles will always be a central component of helping those with various psychological problems (more on this in the final chapter).

From an Integral perspective, we want to integrate what we learn in neuroscience with what we know about consciousness and the mind. We know that brain affects mind and mind affects brain, but we do not know what the exact relationship is between the two. You will have to come to your own metaphysical assumptions based on your experience. However, the biggest mistake you can make is to assume that any particular position on what the mind is carries the mantle of science is therefore *indisputable*. This is not the case, and, just like when working with a client, you must judge the evidence for yourself and come to your own conclusions.

PART IV: DSM AND THE CONCLUSIONS OF THE THERAPIST

According to the DSM we should make a psychiatric diagnosis only if the presenting symptoms cause marked distress or disability with regard to the different domains of life (e.g., work)[7] (APA, 2013a). This of course requires that mental health practitioners use their minds to exercise discernment and judgment about what constitutes distress and impairment (not to mention the difference between "marked" and "not so marked"). How can we tell if a client's symptoms are "distressing" or "impairing" his or her life experience? Consider the experience of a client suffering from drug dependence who also meets the criteria for Borderline Personality Disorder. This client's life is practically ruled by dependence on alcohol and an inability to regulate emotional experiences. Yet, to hear the client tell it, everyone else is the problem. From the clinician's perspective, the client's life is impaired. From the client's perspective, everyone else is impaired. There are no easy approaches to such situations, and the most effective ones frequently take a great deal of time as the therapeutic relationship is built and the client learns to trust the clinician. That said, our aim is to write this book in a manner that is helpful to clinicians and people training to become clinicians. There is a vast difference between what is statistically significant in field trials of DSM symptom checklists and what the clinician experiences with a client suffering from symptoms. As psychologist Jerome Kagan (2006) has written:

> Experienced therapists have perceptual representations of their patients that are rich with details of the patients' postures, tempos of speech, timbres of voice, facial expressions and modes of dress. By contrast, the representations of patients

[7] It is interesting that in previous DSMs, the judgment about whether or not a person had a mental disorder rested on distress and impairment. In the DSM-5 it is distress and disability. Many clinicians that we have spoken with are still using the construct of impairment, as we are here.

> held by scientists whose knowledge of mental illness comes primarily from questionnaires, often administered over the telephone, lack the rich perceptual structures of the clinician. As a result the two groups do not always agree on which patients are depressed or anxious. . . . The two professionals "know" depression in a different way. (p. 45)

To repeat, this is why we are writing this book with an emphasis on what clinicians experience and what may help them treat clients. Clinicians must use both their knowledge of DSM criteria *as well as* their knowledge of etiology and treatment of symptoms to exercise judgment with regard to what is impairing and distressing clients. Clinicians are presented with a rich array of signals that may be clues to diagnosis and treatment. Given this, we believe that the Integral model provides an efficient way to organize and make use of all the information that clinicians are exposed to in their work as therapists.

PART V: THE INTEGRAL MODEL

The Integral model is a trans-disciplinary theory or philosophy that exists in several forms. For the purposes of our book we use it as an integrative framework. Integrative approaches to psychotherapy allow clinicians to organize as much data about clients and treatments as possible with the aim of maximizing treatment outcomes. The Integral model began as a philosophical model (Wilber, 1995) to unite different forms of knowledge and experience. Wilber maintains that all disciplines or perspectives offer partial truths, and thus what is needed is a model that integrates the partial truths rather than settling for different schools squabbling over who has "*the* truth." The spirit of the Integral framework is that everybody is right about something, but no one is right about everything. Granted there are people who apparently are right about nothing (e.g., the late psychic Sylvia Browne) but trying to find common ground is helpful to establish dialogue. The Integral model has five primary elements: four quadrants or perspectives, lines of development, levels of development, states of consciousness, and psychological types (what is sometimes referred to as psychological styles). In this section of the chapter we will offer a brief summary of these five aspects of the model and discuss how we will use the model in the chapters to come. In addition, we will also introduce a little-used concept in the area of psychopathology: spirituality.

The Four Quadrants or Perspectives

Right now as you read this page you have at least four aspects to your being that can be loosely called (1) your subjective psychological experience, (2) your behavior and physiological functions, (3) beliefs that you share with others (family/culture), and (4) social institutions that you are impacted by and/or participate in. These perspectives or aspects of your being are illustrated in the four quadrants or perspectives in Figure 1.1.

The Upper-Left Quadrant: The Interior of the Individual

What is the "interior" or "inside" of the individual? This refers primarily to the phenomenological experience we all have as sentient beings. This is what we referred to

	INTERIOR (INSIDE)	EXTERIOR (OUTSIDE)
INDIVIDUAL	psychological	medical
GROUP	cultural	social

FIGURE 1.1 The Four Quadrants of the Integral Model

earlier as your subjective psychological experience. For example, as you are reading this you are likely aware of thoughts and feelings as well as bodily sensations. You may have an inner monologue running that sounds like your voice. You may hear music in your mind. Put simply, the interior perspective of the individual is one's experience of awareness and the things that arise in one's field of awareness. This is where most counselors and mental health workers focus in their sessions: How are you feeling today? What's on your mind today? What are you aware of right now? All these questions are asking about a client's interior individual experience. In terms of diagnostic manuals, the *Psychodynamic Diagnostic Manual* includes an "S" axis that is intended to highlight the subjective experience of the client suffering from particular symptoms. For example, the "S" axis for depression describes "styles" of being depressed that are related to two general emotional orientations (*anaclitic* and *introjective*—both discussed in Chapter 3).

Your interior individual experience is usually expressed in first-person "I" language. We say things like "I'm feeling a little anxious today" or "I can't seem to get a certain song out of my mind." Sometimes in counseling sessions clients refer to their first-person awareness in second- or third-person language. A client may say "*you know how it is with anxiety—you have the jitters and you just can't seem to focus*." It is as if the client is pushing away or disowning his or her first-person experience. To counter this, most counselors would direct the client to try using "I" instead of "you" in the statement about anxiety. Throughout this book, we will refer to this interior, subjective perspective as the psychological perspective.

Another way to describe the phenomenological experience pointed to by the interior individual perspective is the term *qualia*, which we described earlier in this chapter. The word *qualia* comes from the Latin language and means "what sort" or "what kind." A contemporary definition of qualia is that it refers to the quality of "what it is like" regarding mental states. In the "Mary Problem" summarized earlier, we might say that Mary knows everything there is to know about color vision except the qualia of color vision—the "what it is like" to see in color. This is critically important in counseling because clients and counselors are usually focused on what the client's psychological state or psychological life "feels like" to the client. As noted in the earlier section on the DSM, many researchers who are not clinicians miss aspects of psychological symptoms because they study them only from a third-person perspective.

They don't really capture, for example, what depression *feels like* for the client. Thus, qualia are the infinite varieties of what the things that arise in our field of awareness feel like to us. *Qualia*, by this definition, *cannot be observed from the outside*; rather, they have to be reported by the client. We can't "know" what your internal experience is unless you share it and we understand what you've shared. In this sense qualia have a hermeneutic quality about them; in other words, they require interpretation and shared understanding.

Qualia are one of the primary dimensions of the mind/brain problem because no one has ever explained how the electrochemical processes in the brain result in qualia; this is what philosopher David Chalmers (1995) terms "the hard problem" of consciousness—how and why we have the qualitative, subjective experience of consciousness at all. In contrast is what Chalmers terms "the easy problem" of consciousness; this is what most neuroscientists devote themselves to—it involves explaining how a specific mechanism in the brain is responsible for a specific function, such as the ability to focus attention, integrate information, deliberately control behavior such as walking, and so forth.

> The easy problems are easy precisely because they concern the explanation of cognitive *abilities* and *functions*. To explain a cognitive function, we need only specify a mechanism that can perform the function. The methods of cognitive science are well-suited for this sort of explanation, and so are well-suited to the easy problems of consciousness. By contrast, the hard problem is hard precisely because it is not a problem about the performance of functions. The problem persists even when the performance of all the relevant functions is explained. (Chalmers, 1995, p. 201)

In a new Foreword to his landmark book *How the Mind Works*, Harvard psychologist Steven Pinker (2009/1997) writes about some readers' misunderstanding of his work:

> Part of the misunderstanding comes from commentators' failure to distinguish two distinct problems raised by the phenomenon of consciousness. David Chalmers called them "the hard problem" and "the easy problem"; I called them "sentience" and "access," respectively. Without exception, the theories and research of the past decade that claim to attempt to illuminate the hard problem (sentience) in fact illuminate the easy problem (access). And many readers missed what I consider to be the most interesting scientific lesson of the mystery of sentience: that the feeling of mystery is itself a psychological phenomenon, which reveals something important about the workings of the human mind. (p. xi)

We know that changes in qualia may correlate with taking a pill such as an antidepressant, but they are also correlated with things like exercise, listening to music, engaging in sexual activity, playing with a child, or spending time in nature. We doubt that any reader would deny their own conscious experience at this moment while reading this page. We challenge you to seriously contemplate the idea that everything you are experiencing now is solely the result of electrochemical processes that are taking place in your nervous system. Does that feel accurate? If it is accurate, how do you account for the sense of subjectivity you are experiencing? The degree to which you agree or disagree with that assertion is the degree to which you are a believer in either the materialist or a dual-substance position on the mind/brain problem.

Obviously, the manner in which we gather information about another person's qualia can bias the responses given by that person. Many epidemiologic studies are biased simply by the types of persons who respond to such surveys. People who are more preoccupied with their symptoms or who may have experienced secondary gains from their symptoms may be more likely to fill out and return a questionnaire about symptoms. This is the type of bias that various research methodologies aim to avoid, but such avoidance is rarely possible.

The Upper-Right Quadrant: The Exterior of the Individual

What is the "exterior" or "outside" of the individual? Simply put, it is anything that can be observed from the outside or measured and has physical properties. For example, you are engaged in a set of behaviors in reading this book. You are exercising certain muscles in the way you are sitting or holding the book. Your brain cells are firing in areas around the hippocampus, we hope moving some of the book's information from your short-term memory into your long-term memory. So, from the perspective of this quadrant, we would see physical processes and behaviors. Certainly some of these physical processes may be "inside" the individual body (like electrochemical brain processes), but in some sense we can detect their presence by measurement, even if that requires technological equipment like brain-scanning machines.

Of course, this does not necessarily mean we can always measure them accurately. No one would disagree that the neurotransmitter serotonin exists in the brain; however, we have no baseline for what is a "normal" amount of serotonin and thus we cannot speak with accuracy about serotonin balance or imbalance. The most we can say is that some but not all depressed people (about 50%), when given a serotonin-enhancing drug, report feeling less depressed after 4 to 6 weeks. This means that we can *intervene* chemically by giving the person a serotonin-enhancing drug, but that in no way implies that a chemical serotonin deficit was the *cause* of the depression.[8]

The language of the upper-right quadrant is usually third person, and, particularly, "it" language. The idea from this perspective is that one person can behold the "objective" elements of a client with a detached, scientific objectivity so that one studies behavior, blood pressure, serotonin metabolites, and so forth—whatever "it" quality is of interest. Sometimes clients will refer to aspects of themselves as "it." This can be a clue that the client is uncomfortable with some aspect of self and tries to make it "other." For example, in the famous "Gloria" films, when Gloria is with Carl Rogers she refers to her body in the third person, stating that she wants to make love to a man only when she is in love, but her body ("it") disagrees.

We will label this perspective the *medical model perspective* because, as noted, the current allopathic medical model aims to examine objective, physiological variables and understand their relation to symptoms. We will stretch this understanding to also include the behavioral perspective, which seeks to understand human psychological life through behavioral observations. Although strict behavior therapy is less common now than 50 years ago, behavioral interventions live on in our spectrum of cognitive-behavioral theories and interventions and can be very effective. Although

[8] If such an argument were true, the fact that many people feel energized after drinking coffee would mean that the fatigue they had experienced was caused by a lack of caffeine in the brain!

the DSM claims to be "a-etiological," its orientation is closest to the perspective of this quadrant (Douthit & Marquis, 2006). Many DSM symptom sets contain behavioral or physiological symptoms that nicely illustrate the perspective of this quadrant. For example, in Major Depressive Disorder, three of the nine symptoms listed under criteria for a major depressive episode include physiological symptoms such as significant weight loss or weight gain, insomnia or hypersomnia, and psychomotor retardation or agitation.

With regard to psychopathology, the medical model perspective is primarily concerned with the central nervous system and its relation to psychological experiences, including various symptoms. There is no doubt that what we call the human experience of consciousness has strong correlates with brain development and activity, and it may eventually be well demonstrated that consciousness does emerge from brain development (Churchland, 2002). For example, the neurons in the third layer of the brain's cortex undergo a burst of development early in the second year of life. These nerves develop into the corpus callosum, the network of nerves that connect the two hemispheres of the brain. At this same time in development, most children exhibit the first forms of speech, a moral sense, and what we call self-consciousness (Kagan, 1981). These psychological and physiological sets of events are clearly related, but the question that remains is whether one "causes" the other. Are mind and all the things we tie to it, like self-consciousness and morality, nothing more than the brain? What is the relationship? Some neuroscientists make a compelling case that even things like morality are, in the end, nothing more than our brains (Harris, 2010). Others, often working from a philosophical tradition, question the extent to which we can conclude that this is all there is going on (Combs, 2009).

Similarly, we know that we can image brains and show correlations between mental tasks (such as thinking about a drug one is addicted to) and activation of particular brain centers (in the case of thinking about the drug, the pleasure centers the drug activates). The "activation," though, is only a rough approximation of what is happening. In any given brain area, 20–50% of the neurons may be involved in inhibitory processes, so just because those parts of the brain "light up" on a positron emission tomography (PET) scan, we still don't know if the "lighting up" has the overall effect of an excitatory or inhibitory response (Kagan, 2006). Similarly, brain areas may be "activated" for a variety of reasons. The amygdalae (plural of amygdala) are limbic-system structures in the brain that in part mediate emotional experience, but they may be "activated" by anger, fear, or simply surprise (Kagan, 2006). As we pointed out in the discussion of the mind/brain problem, we have yet to come to a clear agreement on what the mind and brain are and whether, in fact, they constitute interacting but exclusive entities or one is merely an effect of the other. There is of course the possibility that all of these are the wrong questions.

The Lower-Left Quadrant: The Interior of Groups

What is the interior of a group? Perhaps the clearest example is the shared beliefs that constitute a shared cultural heritage. The word *culture* comes from a Latin root meaning "to cultivate" but has a multitude of meanings across academic disciplines. In this instance we refer to the shared experiences, beliefs, values, and worldviews of those who may identify with one another based on shared ethnicity, race, sexual orientation, socioeconomic status, ability/disability, religious/spiritual path, age, or sex and

gender. In counseling, psychology, and social work we have made progress in understanding the importance of cultural identification to effective therapy. For example, we know that African Americans share a history of oppression that may incline them to view Caucasians with some suspicion. In some cases this has led to institutionalized racism, as in cases where African Americans were more likely to underutilize mental health services because of well-founded mistrust based on their history of oppression (Suite, La Bril, Primm, & Harrison-Ross, 2007).

Another aspect of the interior of groups involves understanding how groups can share a common language. Shared beliefs or backgrounds lead to *shared signifieds*, as is the case when particular written or verbal signifiers (such as a written or spoken word) trigger particular mental signifieds unique to the group. For example, we would be willing to bet that when confronted with the signifiers "DSM," a majority of the readers of this book would have a thought or image related to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental and Emotional Disorders*. The letters "DSM" in that case would serve as a signifier that evokes a shared signified (a mental image of the actual manual) among most mental health professionals. We would also bet it somewhat unlikely that any 10 engineering majors sitting in a coffee shop would have the same experience when confronted with "DSM" (they may more likely think of an engineering firm—"DSM Engineering Associates"). In this example, "DSM" thus comes to share specific (and different) meanings for students and professionals in different professions. The interior of a group, when it manifests in shared beliefs or signifieds, may result in those who identify with the group forming a sense of "we," and this is frequently the pronoun used to represent this quadrant (e.g. "we believe . . . ," "we agree that . . .").

You can easily imagine the importance of knowing what cultures your client identifies with. For example, you may be seeing a client who was raised in an abusive home and currently struggles to make ends meet. In this case you would want to be aware that people raised in abusive homes and struggling with financial issues are at much higher risk for mental and emotional disorders such as depression. Currently, it is believed that combining a genetic vulnerability to depression with an impoverished environment greatly increases the risk of depression (Kaufman et al., 2004). So in this case, membership in a group that may share some signifiers also increases one's risk of developing certain symptoms.

The training models of the different mental health disciplines may come to serve as a shared signifier for a majority of individuals in those disciplines. For example, the American Psychological Association has long been associated with what is called the Boulder model of training psychologists (Frank, 1984). This model is based on an ideal known as the scientist-practitioner, in which psychologists ideally learn to both conduct research and attempt to apply research findings with clients. As several scholars have pointed out, though, most psychologists are primarily interested in research or clinical work and *rarely* engage in both (Norcross, Gallagher, & Prochaska, 1989; Snyder & Elliott, 2005), so although most psychologists know of the Boulder model, it appears that few identify with it. The debate of counselor identity continues to be a struggle to evoke a shared signified in the mind of the public when individuals hear the world *counselor*. This is one aspect of the "Counseling 20/20" campaign, and part of the problem is that most of the general public is not aware of the differences between the various mental health disciplines. Such differences are harder to make a

case for when in most states the scope of practice covered by state law is the same for counseling, social work, and psychology.

Shared beliefs can also function as cultural and social currency, and not always toward positive ends. The aforementioned belief that mental and emotional disorders are "caused by" a chemical imbalance has so misinformed laypeople that they often believe that the optimal treatment for depression is antidepressant medication (Howowitz & Wakefield, 2007; Ingersoll & Rak, 2006). Similarly, many Americans turn to herbal preparations rather than allopathic medicine because they believe that "natural" remedies are safer. In believing this, they ignore the fact that many herbal preparations can prove lethal in the wrong dosage (Astin, 1998).

Other common aspects of shared beliefs that clinicians deal with are those shared by a client's current family or family of origin. Think of a family therapy session initiated because one of two children in the family suffers from depression. The depressed child is 13 years old and has an older sibling who is 19. The parents are a dual-career couple who value competition, material success, and "New Thought" spirituality that focuses on positive thinking. The older sibling is majoring in marketing at a local university and the younger sibling is barely passing his courses. In meeting with this family, the first thing you notice is that the depressed child does very little talking. The parents talk about how you have to "focus on the positive" and "pull yourself up by the bootstraps" when feeling down, and the older brother confirms this is the best approach to depression. Before long, you become aware that the older brother and parents seem to share a worldview that the younger brother doesn't buy into. When you follow up with him in individual therapy, he says "Why should I bother talking? My family already knows the meaning of life." Here is a case in which one member of the family doesn't buy into the family's shared beliefs about competition and success. This variable is likely to play at least as powerful a role in his depression as any purported chemical imbalance.

With regard to diagnostic manuals, previous editions of the DSM (previous to DSM-5) allowed clinicians to code on axis IV psychosocial stressors that may be important to a client's diagnosis, and family tensions often qualify. The Zero to Three task force in charge of authoring the DC:0-3R manual has proposed adding a family axis (axis VI) that would encourage information gathering about family history of mental illness, family structure and available supports, and family culture. Particularly when working with children, no clinician can render effective treatment without some knowledge of the family that forms the context of the child's life. The task force is piloting the family axis as of this writing. Such things can be coded in DSM-5 but there is no axis specific to those issues.

The Lower-Right Quadrant: The Exterior of Groups

The exterior of a group is a little easier to understand. It involves all the things about groups that can be measured or observed from the outside. The group in question may be a family (as in the previous example) a social institution (such as a university), or a social dynamic (such as socioeconomic status as a function of where one lives—urban, suburban, rural, etc.). The lower-right quadrant represents the social perspective. In the family example just presented, the actual structure of the family as well as the way the individuals behave together (systems analysis) would be seen

from this perspective. As you'll see in the next section on Integral diagnosing, there is a great deal of overlap between the two lower quadrants. For example, a family may be deeply involved in Roman Catholicism. In that instance the Roman Catholic Church provides both measurable structure in the institution of the church, such as codes of behavior (lower-right quadrant), as well as shared beliefs and values (lower-left quadrant) about what it means to be Catholic.

In the family example presented earlier, the parents and older brother attend religious services at a nondenominational church that emphasizes a "New Thought" version of Christianity. Needless to say, the depressed 13-year-old does not feel this is a good fit and has recently decided not to attend. Here, the structure of the family, to some extent, conforms to the shared beliefs (those shared by three out of four members). So in a sense this "outside" of the family should mirror what is happening on the "inside" or in the realm of shared beliefs. As noted, for school counselors and school psychologists, these two lower quadrants and what they tell us about the family are crucial to understanding children's mental and emotional symptoms. This is particularly true because the younger the child, the less likely the symptoms will present like those in the DSM, which has been normed on adults (House, 1999, 2002).

The social perspective is also used (in what we'll describe as Integral diagnosis) to list the potential "hotspots" in a client's life that relate to social institutions. For example, clients who are on probation are beholden to parole officers, and this can be an added stressor affecting their symptom profile; similarly, clients without sufficient financial means due to unemployment are vulnerable to a host of mental and emotional disorders that they might not be troubled by if they were enjoying better financial circumstances.

Lines and Levels of Development

The second main element in the Integral model involves developmental dynamics. Despite the fact that school counselors (as well as many other mental health professionals) deal with children ages 5 through 18, there are few psychopathology books for counselors about mental and emotional disorders in children. In addition, the DSM is normed almost entirely on adults (with the exception of neurodevelopmental disorders), but we all know that children and adolescents may suffer from mental or emotional problems that interfere with academic achievement and cause distress or impairment (Skovagaard, Houmann, Landorph, & Christiansen, 2003). This is another reason this book is a companion to diagnostic manuals, including the DC-03. Integral theory attempts to elucidate both stages (also called levels) of development and so-called "lines" of development. In addition to the four perspectives represented by the quadrants, each individual is navigating multiple lines (or different aspects) of development. Right now you have some sense of your intellectual abilities that likely correlate with your cognitive development. In addition, you have a sense of self (sometimes called "ego") that has likely changed as you've grown. You may think of other possible lines of development, such as emotional or psychosexual as well as moral, physical, or artistic.

Although we don't currently have an accurate count of how many distinct lines of development there are, it does appear that the lines we have some empirical support for do not progress at the same rate within most individuals. This simply means

that for most people, some lines of development are more developed than others. A line of development is an aspect of your being that unfolds in a predictable sequence. The various plateaus in the sequence we call *stages* or *levels*. This is a thorny issue in academic psychology because it requires enormous rigor to support the hypothesis of a stage theory. There are many so-called "pop-psychology" theories that claim to have lines of development, but most of these have little or no research to support them. That said there are some stage theories with rigorous support; these include theories of cognitive development, moral development, and ego or "self" development, all of which are clinically helpful.

Most clinicians depend, at least roughly, on their assessment of the client's cognitive development. If we think in general Piagetian terms, it is important to know whether an adult client has access to concrete operational thinking, formal operational thinking, or post-formal operational thinking. A client's level of cognitive ability is important because it guides the manner in which the clinician engages the client. For example, I (Ingersoll) was working with inmates transitioning from prison to halfway group homes. Part of the assessment included a measure of cognition using the Kaufman Brief Intelligence Test 2 (KBIT-2). Prior to reviewing one client's test score, I was discussing with him the list of things he needed to do the first day at the group home. He noted that he had accomplished two of them with one trip. I said "two birds with one stone, huh?" and his response was "*why the f*!* you goin' on 'bout birds?*" The client's cognitive abilities were more or less in a range we would describe as "concrete"; thus, metaphors, allegories, and other formal operational language were not going to be beneficial clinical tools for him.

Simply put, we can refer to a client's level of cognition as what the client is able to be aware of. Within the realm of what a client is aware of are things that he or she identifies with. These we can take as indicators of self or ego development. In this sense one's level of ego development is somewhat dependent on one's level of cognitive development. Cognition can be thought of as the "pacer" for how far a person can proceed in ego development. What we find, though, is that people can be very healthy at all conventional or postconventional ego levels, so growth is not necessary beyond a conventional sense of self. Ego (or self) development was pioneered by Jane Loevinger from the 1950s through the 1990s (e.g., Loevinger, 1998) and continues to be researched today by Susann Cook-Greuter (2000) and others. In this theory, *ego is the story you tell yourself about your life*. The construct of ego proper has three interrelated components. The operative component includes what adults see as the purpose of life, what needs they act on, and what ends they move toward. The emotional or affective component includes how the person deals with emotions and the experience of being in the world. Finally, the cognitive component addresses how a person thinks of her- or himself and the world (Cook-Greuter, 2003).

The nine levels of ego identity range from preconventional to conventional to postconventional. Similar to Kohlberg's terms in his moral development theory, preconventional ego identity means the person is really not aware of, or willing to play by, the conventions of society. As a result we see many of these people in our criminal justice system. Conventional ego identity means that individuals are aware of, and willing to play by, the conventions of whatever society they find themselves in. Finally, people with postconventional ego identities know the conventions of society but make decisions more on their own values and based on context, in contrast to

rigid, universally applicable rules. We are just beginning to see research related to ego development and mental health. For example, there is some evidence that later ego identity is associated with psychosocial adjustment (Lindfors et al., 2007).

The phrase *developmental psychopathology* was coined by Thomas Achenbach in 1974. More recently, Achenbach (2009) has made the point that the categorical approach in the DSM cannot be generalized across age groups, sexes, or cultures. He is one of many who advocate for a dimensional approach to diagnosis, which we discuss in Chapter 2. In general, the past 10 years have seen a dramatic increase in the developmental literature on psychopathology. We are starting to gather evidence that the more severe disorders frequently impair progress on different lines of development. There is strong evidence that severe mental and emotional disorders impair a person's cognition and thus perspective-taking ability (Langdon, Coltheart, & Ward, 2006; Langdon, Coltheart, Ward, & Stanley, 2001; Schiffman et al., 2004). If the relationship described earlier between cognition and ego or self is accurate, then we should expect that disorders/symptoms that interfere with cognitive development will also interfere with ego or self-development.

The only real mention of developmental considerations in the DSM-5 is a half-page summary noting that the aim was to organize the chapters and the manual so that disorders and/or symptoms are presented in what is thought to be a chronological manner. That is, disorders thought to begin in infancy or childhood (e.g., neurodevelopmental disorders) are presented first and disorders thought to arise later in life (e.g., neurocognitive disorders) are presented last. This is really a general caveat, though, and appears to be intended to help guide future research rather than to illustrate the developmental implications of disorders.

States of Consciousness

In addition to the four perspectives reflected in the four quadrants and the developmental dynamics just discussed, the Integral model also emphasizes the importance of states of consciousness. As far as understanding mental and emotional disorders, it is clear that states of consciousness may be relevant as part of the symptoms, as well as part of the "cure." Going back to our example of depression, consider the state of being depressed; for many clients, it is an overwhelming ennui—a pervasive sadness that seems to exacerbate negative thoughts and emotions. With the exception of chronic, long-term, low-grade depression (called Dysthymia), depression is a transitory state. It can be incapacitating but, like all states, it is transitory. The goal of treatment is to figure out the best way for each client to diminish the frequency and severity of the symptoms. How to do this varies from client to client but in the main, treatment may consist of medication, a form of talk therapy, exercise and dietary changes, and perhaps even meditation.

The use of mindfulness meditation as one tool for treating depression is relatively new but provides an excellent example of how a depressed state can be treated in part by teaching the client to induce a nonchemical, nonordinary state of consciousness. In this case, the non-ordinary state is focusing attention in the present and learning to view thoughts as passing mental events rather than as realities that you are immersed in. "*Mindfulness* is the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to things as they are"; in mindfulness practice, you learn to watch your thoughts, feelings, and physical sensations (Williams, Teasdale,

Zindel, & Kabat-Zinn, 2007, p. 31). We have told some clients that it is like sitting on a dock by a river. The river is your awareness, and the things that float by (leaves, twigs, etc.) are akin to the things that arise in your awareness. Once you learn to watch what arises in your field of awareness, then you create a psychological space between the you who is witnessing depressing thoughts emerging and the depressing thoughts themselves. In this sense you learn that you are *not* your thoughts and feelings. In some cases this practice seems to stop negative thoughts from fueling depression; in other cases, people still have negative thoughts but they report not being so bothered or disturbed by them. By training themselves to enter states of consciousness in which they can disidentify with their thoughts ("I can watch my thoughts; therefore I am *not* my thoughts"), clients gain the capacity to change their relationship to their thoughts, emotions, and other aspects of their experience such that they are not a victim to them; rather, they develop a sense of freedom—even if the specific thoughts and feelings don't cease. Even if the shift away from depression only lasts a few minutes, it becomes evidence that clients are really not their thoughts and thus have some degree of control over the extent to which they are overwhelmed by the negative thoughts that accompany depression. Like all forms of treatment, this will be helpful for some but not all clients.

In addition to viewing the client's life experience through the four perspectives of the quadrants and understanding relevant developmental dynamics, the Integral model reminds us to note relevant states of consciousness—both those that are related to the symptoms and those related to relief. In some disorders, such as chemical dependency, clients may be using altered states to numb out emotional pain. In such cases, clinicians need to help the client replace a state that poses medical, psychological, and legal risks with one that is generally better for the client. This can be challenging, as the case of Maggie demonstrates. Maggie was dependent on heroin and frequently used it to stifle her panic attacks. Her problems multiplied when the onset of heroin withdrawal would actually seem to cause a panic attack, which would then lead to more self-medicating with heroin. In addition to the risk of putting an illicit substance in her body, she was putting herself at risk for infectious illnesses through needle sharing, and possible legal complications from trafficking illicit drugs. Clearly for people like Maggie, medical intervention (known as "detox") was necessary to help her body wean off the heroin. Following that, a structured, restrictive treatment environment was needed to help her begin to face life without drugs. However, most of Maggie's treatment focused on her states of mind and how to change them while remaining sober.

Types or Styles

The final element in the Integral model is what we call types or styles; it is really a "shorthand" word for personality. Although Integral theorists initially used this construct to refer to psychological typologies, we prefer to view this as a client's style of being in the world because there is little evidence that personality is expressed as exclusive types (Ingersoll & Zeitler, 2010). From the Myers-Briggs Type Indicator to the Enneagram, it seems that, at best, typologies can function only as metaphors—not as valid constructs with reliable psychometric properties. From the time Theophrastus took over the Lyceum from Aristotle (Sandys, 1909), people have tried to "type" personality, and in every instance they have failed. It is this failure that has led us to the factorial approach illustrated in the Five-Factor Model. The controversy over types began, in part, with the work of psychologist Walter Mischel (1968). He published a

critique of all personality assessments (including typologies) and concluded that only a small amount of the variance in a person's behavior can be accounted for by personality tests. Mischel made the commonsense point that human beings are far more complex than most of the subjects in experimental psychology (e.g., rats, mice, monkeys) and that this complexity had not been captured by psychological assessment. This critique rippled through the psychological community and called into question the legitimacy of personality theories and personality assessment.

Given this state of affairs, personality theories are not terribly useful guides in diagnosing and treating psychopathology. The idea of a personality *style*, however, can give some insights into how the person sees the world and what sorts of psychological defenses the person may use. Although we remain skeptical that there is such a thing as a "disordered personality," it is clearly true that some people have personality styles that exacerbate their suffering.[9] Consider the case of Janice, a 26-year-old engineering graduate student who has an excellent academic record but who suffers from consistently volatile personal relationships. Janice grew up in a single-parent household with her mother and was the victim of sexual abuse at the hands of two of her mother's boyfriends. Janice never experienced the safe environment that allows children to develop emotionally. As a result, she has not learned how to set healthy boundaries in relationships and struggles to manage her emotions and the emotions of others. In treatment, I (Ingersoll) talked with Janice about her style of navigating relationships in a way that allowed her to engage my efforts at a therapeutic alliance but not in a way in which she felt I was "damning" the very self she identified with. We may also see that clients manifest particular symptoms with a certain "style," as in the case of anxiety. Anxiety may be experienced primarily as physical symptoms (sweating, racing heart), cognitive symptoms (racing or catastrophic thoughts), or emotional symptoms (fear and a desire to escape anxiety-producing situations).

Spirituality

Another element in the Integral model that rarely shows up in treatments of psychopathology is spirituality. Although popular treatments of psychology are inundated with supposed references to spirituality, mainstream counseling and psychotherapy is really just beginning to integrate this aspect of human experience into topics such as psychopathology. In fact, as recent as 25 years ago, most references to spirituality in the psychopathology literature implied that a spiritual orientation or belief was itself pathological (Wulff, 1996). This has changed to the point where legitimate problems related to one's spiritual life are treated, at least minimally, in the DSM. In the DSM-IV and DSM-IV-TR these were listed under the "V" code "Religious or Spiritual Problem" (Lukoff, Lu, & Turner, 1992). In the DSM-5 the "V" codes are listed alongside the "Z" codes of the ICD-10; thus in the DSM-5 "Religious or Spiritual Problem" is listed as both V62.89 and Z65.8.

In a scholarly approach to psychological topics we have to "operationalize" terms. Operationalizing means that we describe in observable terms what we mean

[9] Psychodynamic diagnosis (McWilliams, 1994) always attends to two interacting dimensions of a client - both the defensive style (i.e., obsessive, dependent, schizoid, paranoid) and the developmental level of personality organization (i.e., psychotic, borderline, neurotic, or "normal"). Thus, a given personality style that manifests in a "normal" or mild neurotic manner is not necessarily dysfunctional; however, any of those same styles will constitute a disorder at borderline or psychotic levels of personality organization, but that is a function of the developmental level of severity rather than the style per se.

when we use a particular construct; in psychotherapy, that usually is through references to what clients are experiencing. For example, anxiety is defined as a negative mood state that can be characterized by somatic symptoms, apprehension about the future, or a set of behaviors (e.g., fidgeting, looking worried). Many studies of anxiety look at only one of these or some combination of two out of three, and researchers admit that anxiety in humans is very hard to measure (Barlow & Durand, 2002). The same can be said of spirituality, and probably the best descriptions of it in relation to psychotherapy state that it is frankly hard to define (Miller, 1999; Wiggins-Frame, 2003).

Spirituality is operationalized in many ways in the psychological literature. In the mid to late 20th century, mental health professionals were just beginning to offer general descriptions of what spirituality meant. Here is a sampling: Spirituality has been described as the ultimate or deepest needs of the self that, when met, move the individual toward meaning and purpose (Bollinger, 1969) and as one's journey toward union with God (Magill & McGral, 1988). Counselor Mel Witmer (1989) described spirituality as a belief in a force or thing greater than oneself. Psychiatrist Gerald May (1988) noted that spirituality has an elusive nature in that it seems paradoxically indwelling yet rooted in something eternal. Counselor Howard Clinebell (1992) described spirituality as living in meanings, hopes, and beliefs about what is ultimately important.

In all of these samples, you'll note the dearth of reference to religion and religiosity. That is likely because William James (1902) set the tone of investigation into the healthy aspects of religion in his famous Gifford Lectures, and Gordon Allport (1950) followed this lead in his book *The Individual and His Religion.* Psychologists from James to Allport thus birthed the construct of religiosity, but in the late 20th century more references were made to "spirituality." Psychologist Carl Thoresen (2007) addressed the complexity of teasing apart religiosity and spirituality. He noted that

> both concepts are complex with several facets or features, some of which are latent, that is, not directly observable but are inferable. . . . Very important concepts remain difficult to articulate and lack complete agreement about how best to define them . . . given this complexity there is no clear consensus on how to best describe, define, or measure spirituality and religion. Both concepts are clearly related to each other and both contain a connection to what is perceived as sacred in life. (p. 5)

In an effort to more clearly specify what is meant by spirituality, many researchers—beginning with sociologist David Moberg (1979)—began looking more at constructs that implied spiritual health or wellness. These included spiritual well-being, spiritual wellness, and spiritual health. As I (Ingersoll, 1994) summarized these efforts, the idea was that because spirituality was described in so many different ways, perhaps focusing on measurable aspects of people who had a spiritual practice would clarify what healthy spirituality meant for clients (and clinicians). These efforts were more precise and led to the development of some scales to measure spiritual wellness but diverged sharply from the manner in which clients described their spirituality. Clients rarely come in, sit down, and say "I had a spiritual experience that is best operationalized by Ellison's [1983] subscale on existential well-being."

In the last 10 to 15 years, it seems that a second round of efforts has been made to more clearly operationalize both religiosity and spirituality. The gap between spirituality and religion continues, as psychologist David Wulff (1996) explained:

> sensing that the words *religious* and *religion* fail today to denote certain positive inward qualities and perceptions but, to the contrary, seem increasingly to be associated with prejudicial attitudes, violence, and narrow social agendas, people in various walks of life are choosing to use the terms *spiritual* and *spirituality* instead. (p. 47)

Psychologists Scott Richards and Allan Bergin (2000) noted that

> . . . by spiritual, we also mean those experiences, beliefs, and phenomena that pertain to the transcendent and existential aspects of life . . . the transcendental relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation, that strives for reverence, awe, and inspiration, and that gives answers about the infinite. (p. 13)

These same two authors, 3 years later (Richards & Bergin, 2000), owned the Western biases in the previous description and added a full-page table of the differences between Western and Eastern worldviews. Bruce Scotton (1996) differentiated spiritual and religious when he wrote that

> *Religious* refers to the belief system of a specific group, whose members usually gather around specific contents and contexts that contain some transpersonal elements. *Spiritual* refers to the realm of the human spirit, that part of humanity that is not limited to bodily experience. *Transpersonal experience* in addressing all human experience beyond the ego level, includes spiritual experience but also includes embodied human experience of higher levels. (p. 4)

Most recently, authors have focused on the difficulty of defining words like *spirituality* and *religion*, with some authors devoting entire chapters to the problem (Aten & Leach, 2009; Sperry & Shafranske, 2005). Psychologists Brian Zinnbauer, Kenneth Pargament, and Allie Scott (1999) conducted an analysis of the panoply of definitions and asserted that spirituality and religiousness had been polarized by contemporary theorists in three ways. The first was the polarization between organized religion and personal spirituality. The second was substantive religion in contrast to functional spirituality. The third was negative religiousness in contrast to positive spirituality. The authors then integrated these constructs, concluding that the polarizations unnecessarily constricted the definitions. Their solution is twofold. First, they noted that there is a need to resolve the tension between remaining pluralistic enough to include the varieties of spiritual and religious experiences while also allowing researchers to be specific enough to carry out a coherent research program. Second, they felt there had to be a way to distinguish between spirituality and religion without polarizing them. To accomplish these aims, they endorsed Kenneth Pargament's description of spirituality as "a search for the sacred" and his definition of religion as a search for significance in ways related to the sacred. In these definitions, spirituality is central to religion and religion can be the culturally shaped vessel that ideally nurtures the search for the sacred.

To recognize the complexity of this issue, we will draw on many of the previous descriptions of spirituality throughout the book and will include them when they are

relevant to certain symptom sets (for example, there are types of depression described in mystical literature called a "dark night of the senses" or "dark night of the soul"). We will include spiritual considerations when we are able to, although there is limited literature to draw upon in this arena. In some cases we will, following philosopher Robert Solomon (2002), simply describe spirituality as a thoughtful love of life.

PART VI: CASE EXAMPLE: PULLING TOGETHER AN INTEGRAL DIAGNOSIS

At this point we have introduced all the elements of the Integral framework that we will refer to in this book. For the most part, though, we will focus on the four perspectives offered by the quadrants and how these can help us in the process of diagnosing. One approach that we recommend, and that we both use in our private practices, is to complement our DSM diagnoses (which we'll discuss more in depth in the next chapter) with what has been called an Integral assessment and diagnosis (Ingersoll, 2002; Marquis, 2008). To demonstrate one way to use this model, consider the following case.

Katie is a 29-year-old, African American mother of three children (ages 9 months, 3, and 4). She identifies as an Evangelical Christian (meaning a belief in the historicity and general inerrancy of scripture, the exclusive divinity of Jesus of Nazareth, and a Calvinist emphasis on personal conversion). This client was originally seen at an agency for financial counseling and was subsequently referred for personal counseling. She stated that she had been "wrestling with strong demons" and said she had been meeting with her pastor about them. The "demons" were feelings of fear about the future, her children's welfare, and her husband's drinking problem. Her husband had been drinking more alcohol (unusual for him) almost every night and becoming sullen and distant. Katie thought he was drinking because of their financial problems but also feared he was drinking because she was not as good a wife as she should be. Her husband had also snapped at her verbally several times a week—also uncharacteristic of him.

Katie discussed times when she felt "attacked" and was beset with heart palpitations, sweating, chest pain and nausea, and a frightening feeling that she was going crazy. She had four such attacks in the 3 months prior to the evaluation. She said she constantly worried about having these attacks and that they were going to cause her to go crazy. As a result of the attacks, she started seeing her pastor for counseling and had tripled her prayer time. She was dismayed that she still had the attacks despite her prayer and was growing increasingly despondent because she was starting to doubt her religious convictions because her prayer time had not resulted in any appreciable lessening of her symptoms. In her religious faith community, traditional gender roles were the norm and she felt that her husband's behavior may have been her fault.

She agreed to let the therapist speak with her pastor, and he noted that Katie's life was stressful and he hoped that their sessions gave her comfort and some ways to access the power of the Spirit to help her. The pastor noted that she didn't seem to feel any better in the 2 months that she had been seeing him, and he stated that he was

glad she was seeking additional help. Katie was relieved that her pastor supported her work in counseling, as she felt that her anxiety was interfering with her ability to perform daily tasks. Because of increasingly pervasive religious doubts, she was also ambiguous about her pastor's ability to help her with her problems. Katie presented cognitively as someone who has access to formal operational thinking. Her sense of self was very conventional in that, up to this point, she felt her religious faith was a complete guide for how to live her life.

Katie had no history of mental health interventions and her physician had confirmed that she also suffered from Irritable Bowel Syndrome (IBS). She had no medical disorders that would mimic anxiety and there was no evidence of any drug use/abuse. In the third session with Katie, she revealed an experience late one night when she was up worrying about the family's problems. She said she was suddenly "overwhelmed" by a sense of peace. For about an hour she said she felt on the one hand as if she were merely watching her fears—like they were someone else's—but that she didn't feel "numb" to them. She said she wondered if this had been a state of grace. Whereas her counselor suggested she was dissociating due to stress, Katie felt there was something more to the experience because it was comforting. The experience has not recurred.

DSM-IV-TR and DSM-5 Diagnoses of Katie

Under the DSM-IV-TR (APA, 2000), Katie's five-axis diagnosis would have been as follows:

Axis I: 300.01 Panic Disorder Without Agoraphobia
R/O V62.89 Religious or Spiritual Problem
Axis II: V71.09 No Diagnosis on Axis II
Axis III: 564.1 Irritable Bowel Syndrome
Axis IV: husband's drinking problem, financial stressors
Axis V: 58

Under the DSM-5 (American Psychiatric Association, 2013a) the five-axis diagnosis has been eliminated, leaving us with a nonaxial system. Using the DSM-5, clinicians can list what used to be on axes I, II, and III together (again mirroring the ICD-10) and then make additional comments about psychosocial factors and assessment of functioning (formerly axes IV and V) (American Psychiatric Association, 2013a).

So from the DSM-5 perspective, Katie's diagnosis would look like this:

F41.0 Panic Disorder; R/O Z65.8 Religious or Spiritual Problem. Client's husband appears to be abusing alcohol and the couple is experiencing financial stress. Some third-party payers will switch to numbered lines for diagnoses with the change to ICD codes. In that format all relevant issues (including psychosocial stressors) are listed like this:

1. F41.0 Panic Disorder
2. R/O Z65.8 Religious or Spiritual Problem
3. Relational stress due to spouse's alcohol use.

	Quadrants/Perspectives	
	INTERIOR (INSIDE)	**EXTERIOR (OUTSIDE)**
INDIVIDUAL	Questioning her faith Feels persecuted by demons Fear of losing her mind Questioning her worth Concern about secular counselor	Physiological symptoms of anxiety Panic attacks Irritable bowel syndrome Increased religious behaviors (prayer)
GROUP	Norms of the faith community Breakdown in communication w/husband	Structure of the church Creditors' interest rates and demands for payment

FIGURE 1.2 Integral Summary of Katie's Case

Doing away with the five-axis format will likely minimize many of the contextual elements the multi-axial system represented. It is for this reason that we feel it is more important than ever to have some integrative system that is complementary to the DSM diagnosis, as this approach will capture what used to be captured in axes III, IV, and V; the Integral quadrant approach provides this.

Complementary Integral Diagnosis Related to the Quadrants

Using the four quadrants, Figure 1.2 illustrates how the material from the written case about Katie fits into the elements of the Integral framework.

DEVELOPMENTAL TASKS Katie and her husband have recently had a third child and, in addition to the added financial stress, are having to find a new family rhythm.

STATES Clearly Katie is suffering with states of anxiety but has also had one state that was nonordinary for her and was, by her description, comforting. Katie also experiences a great deal of distress due to her perception of the woman's role in the family. She feels stress because she believes it is the woman's job to keep up family morale.

TYPES OR STYLES Katie appears to have a conventional, conservative sense of self that, until recently, has been more or less embedded in her church community. While she is questioning some aspects of her faith, the community still plays an important role with regard to her sense of self. We also see that Katie has a "style" of being anxious that manifests in physical symptoms.

Now we will discuss what we placed in each quadrant. The idea of using the four-quadrant diagram is to be able to catch, "at a glance," what the "hotspots" seem to be for the client's experience. Recall that each quadrant is simply one aspect of a person's life experience.

Exterior Individual Quadrant—The Medical Model Perspective Katie is clearly suffering from many physiological symptoms of anxiety, given the confirmation from her physician that she is otherwise healthy. Her behavior of increasing her prayer time is a logical response given her worldview, which, however, may cause distress depending upon her expectations and subsequent results. She also has the diagnosis of IBS. The objective signs tell us that Katie's predominant "style" of anxiety is physical, and this informs the shape the intervention will take. Her IBS is likely exacerbated by the stress and anxiety she is experiencing. One important aspect of the treatment must be to decrease the frequency and intensity of the panic attacks and objectively measure these to assess the effectiveness of treatment as it progresses.

Interior Individual Quadrant—The Psychological Perspective Katie feels like she is being persecuted by demons—a construct that makes sense from, and generates more anxiety in, her worldview. It is important to understand that the way she talks about "demons" reflects her worldview rather than what some might think is delusional thinking. She harbors some apprehension about secular counseling. She fears that she is losing her mind and her faith all at once. She also is questioning her worth as a woman, largely because of her husband's alcohol problem. Katie must use the therapeutic dialogue to explore new understandings of herself, her values, and her sense of the resources she will need to cope with her life circumstances. The experience Katie describes as being "at peace" seems to qualify as a "peak experience" for her. Katie's reported distress is remarkable. She is experiencing self-defeating and other irrational thoughts that may be targeted with cognitive therapy. She is also experiencing doubts about her faith that are having a strong emotional impact on her (in addition to her other worries). These may in fact be adding to her anxiety response.

Interior Group Quadrant—The Cultural Perspective Katie has grown up with an Evangelical Christian worldview and has derived support from her faith and faith community. Her faith tradition has supported her sense of the primacy of family; however, the current problems with her family have religious as well as interpersonal significance for her. Further, developmentally Katie may have grown (or be growing) beyond aspects of her understanding of her faith tradition (e.g., the righteous are rewarded, the wicked are punished), and that may require some attention from her pastor, or possibly the counselor working with her.

Exterior Social Quadrant—The Social Perspective The church and the fiscal institutions of society are impinging on Katie the most right now. She is beset with phone calls from collection agencies and feels shame in response to these interactions. Although she understands there are bankruptcy laws in place that may offer one solution to her family's debt, her shared worldview from the lower-left quadrant does not affirm the use of them. She feels dissonance about her place in her church community and is not sure how she fits in that community right now. Katie must develop strategies that help her cope with the pressure of her creditors as well as make a decision about where she fits in her faith community.

Review Questions

1. Compare and contrast the DSM, the DC:0-3R, and the PDM. What seems to be strengths and weaknesses of each manual?
2. How do you define what is psychologically normal and abnormal? How does your cultural background seem to affect your definition of these terms?
3. Given the overview of mind and brain, do you feel closer to the materialist/physicalist perspective or the dual-substance perspective? Why and what influences from your background seem to play into your answers?
4. If a DSM diagnosis can be made only if a client suffers distress or impairment from his or her symptoms, how would you handle a client dependent on alcohol who claims to be a "functional alcoholic" but who has been charged with drunk driving and given a written warning at work for coming in late?
5. How would you summarize the elements of the Integral model? Which elements are harder for you to understand?

References

Achenbach, T. M. (1974). *Developmental psychopathology.* Oxford, UK: Oxford University Press.

Achenbach, T. M. (2009). Some needed changes in DSM-5: But what about children? *Clinical Psychology: Science and Practice, 16,* 50–53.

Allport, G. W. (1950). *The individual and his religion: A psychological interpretation.* Cambridge, MA: Harvard University Press.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th edition, text revision). Washington, DC: Author.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychiatric Association. (2013b). *Desk reference to the diagnostic criteria from DSM-5.* Washington, DC: Author.

Astin, J. A. (1998). Why patients use alternative medicine: Results of a national study. *Journal of the American Medical Association, 279,* 1548–1553.

Aten, J. D., & Leach, M. M. (Eds.). (2009). *Spirituality and the therapeutic process: A comprehensive resource from intake to termination.* Washington, DC: American Psychiatric Association.

Barlow, D. H., & Durand, V. M. (2002). *Abnormal psychology: An integrative approach* (3rd ed.). New York: Thomson.

Barry, J. M. (2005). *The great influenza: The story of the greatest pandemic in history.* New York: Penguin.

Bollinger, T. E. (1969). *The spiritual needs of the aging: In need for a specific ministry.* New York: Knopf.

Chalmers, D. J. (1995). Facing up to the problem of consciousness. *Journal of Consciousness Studies, 2*(3), 200–219.

Charney, D. S., et al. (2002). Neuroscience research agenda to guide development of a pathophysiologically based classification system. In D. J. Kupfer, M. B. First, & D. A. Regier (Eds.), *A research agenda for DSM-5* (pp. 31–84). Washington, DC: American Psychiatric Association.

Churchland, P. S. (2002). *Brain-wise: Studies in neurophilosophy.* Cambridge, MA: MIT.

Clinebell, H. (1992). *Well-being: A personal plan for exploring and enriching the seven dimensions of life.* San Francisco: Harper.

Combs, A. (2009). *Consciousness explained better: Towards an integral understanding of the multifaceted nature of consciousness.* St. Paul, MN: Paragon.

Cook-Greuter, S. (2000). Mature ego development: A gateway to ego transcendence? *Journal of Adult Development, 7,* 227–240.

Cook-Greuter, S. (2003). *Ego development: Nine levels of increasing embrace.* Wayland, MA: Cook-Greuter & Associates.

Douthit, K. Z., & Marquis, A. (2006). Empiricism in psychiatry's post-psychoanalytic era: Contemplating DSM's "atheoretical" nosology. *Constructivism in the Human Sciences, 11*(1), 32–59.

Ellison, C. W. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology and Theology, 11,* 330–340.

Forsythe, P., & Kunze, W. A. (2013). Voices from within: Gut microbes and the CNS. *Molecular Life Science, 70,* 55–69.

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life.* New York: Morrow.

Frank, G. (1984). The Boulder model: History, rationale, and critique. *Psychology: Research and Practice, 15*, 417–435.

Hacker, A., & Dreifus, C. (2010). *Higher education? How colleges are wasting our money and failing our kids—and what we can do about it.* New York: Times Press.

Harris, S. (2010). *The moral landscape: How science can determine human values.* New York: Free Press.

House, A. E. (1999). *DSM-IV diagnosis in schools.* New York: Guilford.

House, A. E. (2002). *The first session with children and adolescents: Conducting a comprehensive mental health evaluation.* New York: Guilford.

Howowitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder.* Oxford, UK: Oxford University Press.

Ingersoll, R. E. (1994). Spirituality, religion, and counseling: Dimensions and relationships. *Counseling & Values, 38,* 98–112.

Ingersoll, R. E. (2002). An integral approach for teaching and practicing diagnosis. *The Journal of Transpersonal Psychology, 34*, 115–127.

Ingersoll, R. E., & Rak, C. F. (2006). *Psychopharmacology for helping professionals: An Integral approach.* New York. Cengage.

Ingersoll, R. E., & Zeitler, D. A. (2010). *Integral psychotherapy: Inside out/Outside in.* Albany, NY: SUNY.

Jackson, F. (1986). What Mary didn't know. *Journal of Philosophy, 83*, 291–295.

James, W. (1902). *The varieties of religious experience: A study in human nature.* New York: Holt.

Kagan, J. (1981). *The second year: The emergence of self-awareness.* Cambridge, MA: Harvard University Press.

Kagan, J. (2006). *An argument for mind.* New Haven, CT: Yale University Press.

Kaufman, J., Yang, B. Z, Douglas-Palumberi, H., Hooshyer, S., Lipschitz, D., Krystal, J. H., & Gelertner, J. (2004). Social supports and serotonin transporter gene modulate depression in maltreated children. *Proceedings of the National Academy of Sciences, 101,* 17316–17321.

Koch, C. (2012). *Consciousness: Confessions of a romantic reductionist.* Cambridge, MA: MIT Press.

Langdon, R., Coltheart, M., & Ward, P. B. (2006). Empathetic perspective-taking is impaired in schizophrenia: Evidence from a study of emotion attribution and theory of mind. *Cognitive Neuropsychiatry, 11,* 133–155.

Langdon, R., Coltheart, M., Ward, P. B., & Stanley, V. (2001). Visual and cognitive perspective-taking impairments in schizophrenia: A failure of allocentric simulation? *Cognitive Neuropsychiatry, 6,* 241–269.

Lindfors, K., Elovainio, M., Wickman, S., Vuorinen, R., Sinkkonen, J., Dunkel, L., & Raappana, A. (2007). Brief report: The role of ego development in psychosocial adjustment among boys with delayed puberty. *Journal of Research on Adolescence, 17,* 601–612.

Loevinger, J. (1998). Completing a life sentence. In P. M. Westenberg, A. Blasi, & L. Cohn (Eds.), *Personality development: Theoretical, empirical and clinical investigations of Loevinger's conception of ego development* (pp. 347–355). Mahwah, NJ: Erlbaum.

Lukoff, D., Lu, F., & Turner, R. (1992). Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems. *Journal of Nervous and Mental Disease, 180,* 673–682.

Magill, F. N., & McGral, I. P. (Eds.). (1988). *Christian spirituality: The essential guide to the most influential spiritual writings on the Christian tradition.* San Francisco: Harper.

Mahoney, M. J. (1980). *Abnormal psychology: Perspectives on human variance.* San Francisco: Harper & Row.

Marquis, A. (2008). *The integral intake: A guide to comprehensive idiographic assessment in integral psychotherapy.* New York: Routledge.

Marquis, A., & Douthit, K. Z. (2006). The hegemony of "empirically supported treatment": Validating or violating? *Constructivism in the Human Sciences, 11*(2), 108–141.

May, G. (1988). *Addiction and grace: Love and spirituality in the healing of addictions.* San Francisco: Harper.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* New York, NY: The Guilford Press.

Miller, W. R. (Ed.). (1999). *Integrating spirituality into treatment: Resources for practitioners.* Washington, DC: American Psychological Association.

Mischel, W. (1968). *Personality and assessment.* Mahwah, NJ: Erlbaum.

Moberg, D. O. (1979). *Spiritual well-being: Sociological perspectives.* Washington, DC: University Press of American.

Norcross, J. C., Gallagher, K. M., & Prochaska, J. O. (1989). The Boulder and/or Vail model: Training preferences of clinical psychologists. *Journal of Clinical Psychology, 45*, 822–828.

Paris, J. (2013). *The intelligent clinician's guide to the DSM-5.* New York: Oxford University Press.

PDM Task Force. (2006). *Psychodynamic diagnostic manual.* Silver Spring, MD: Alliance of Psychoanalytic Organizations.

Pinker, S. (2009/1997). *How the mind works.* New York: W. W. Norton & Company, Inc.

Practice Management Information Corporation. (2006). *International classification of diseases* (9th ed., clinical modification). Downers Grove, IL: Author.

Richards, P. S., & Bergin, A. E. (2000). Religious diversity and psychotherapy: Conclusions, recommendations, and future directions. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 469–489). Washington, DC: American Psychological Association.

Robinson, D. (2008). *Consciousness and mental life.* New York: Columbia.

Sandys, J. E. (1909). *The characters of Theophrastus: An English translation from a revised text with introduction and notes by R.C. Jebb.* London: Macmillan.

Schiffman, J., Lam, C. W., Jiwatram, T., Ekstrom, M., Sorensen, H., & Mednick, S. (2004). Perspective-taking deficits in people with schizophrenia spectrum disorders: A prospective investigation. *Psychological Medicine, 34,* 1581–1586.

Scotton, H. W. (1996). Introduction and definition of transpersonal psychiatry. In B. W. Scotton, A. B. Chinen, & J. R. Battista (Eds.), *Textbook of transpersonal psychiatry and psychology* (pp. 4–8). New York: Basic Books.

Skovagaard, A. M., Houmann, T., Landorph, S. L., & Christiansen, E. (2003). Assessment and classification of psychopathology in epidemiological research of children 0–3 years of age: A review of the literature. *European Child and Adolescent Psychiatry, 13,* 337–346.

Snyder, C. R., & Elliott, T. R. (2005). Twenty-first century graduate education in clinical psychology: A four level matrix model. *Journal of Clinical Psychology, 61,* 1033–1054.

Soloman, R. C. (2002). *Spirituality for the skeptic: The thoughtful love of life.* Oxford, UK: Oxford University Press.

Sperry, L., & Shafranske, E. P. (Eds.). (2005). *Spiritually oriented psychotherapy.* Washington, DC: American Psychological Association.

Suite, D. H., La Bril, R., Primm, A., & Harrison-Ross, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: relevance of the historical perspective in the medical and mental health treatment of people of color. *Journal of the National Medical Association, 99,* 879–885.

Task Force on Research Diagnostic Criteria: Infancy and Preschool. (2002). Research diagnostic criteria—preschool age (RDC-PA). Retrieved from http://www.infantinstitute.org/RDC-PA.htm

Thoresen, C. E. (2007). Spirituality, religion, and health: What's the deal? In T. G. Plante & C. E. Thoresen (Eds.), *Spirit, science, and health: How the spiritual mind fuels physical wellness* (pp. 3–10). Westport, CN: Praeger.

Vonnegut, K., & Stringer, L. (1999). *Like shaking hands with God: A conversation about writing.* New York: Washington Square Press.

Webster's New World. (2008). *Webster's new world medical dictionary* (3rd ed.). New York: Author.

Wiggins-Frame, M. (2003). *Integrating religion and spirituality into counseling: A comprehensive approach.* Pacific Grove, CA: Brooks/Cole.

Wilber, K. (1995). *Sex, ecology, spirituality: The spirit of evolution.* Boston: Shambhala.

Williams, M., Teasdale, J., Zindel, S., & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness.* New York: Guilford.

Witmer, J. M. (1989). Reaching toward wholeness: An integrated approach to well-being over the life span. In T. J. Sweeney (Ed.), *Adlerian counseling: A practical approach for a new decade.* Muncie, IN: Accelerated Press.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders.* Geneva: Author.

Wulff, D. M. (1996). The psychology of religion: An overview. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 43–70). Washington, DC: American Psychological Association.

Zero to Three. (2005). *Diagnostic and classification of mental health and developmental disorders of infancy and early childhood: Revised edition (DC:0-3R).* Washington, DC: Zero to Three Press.

Zinnbauer, B. J., Pargament, K. I., & Scott, A. B. (1999). The emerging meanings of religiousness and spirituality: Problems and prospects. *Journal of Personality, 67,* 879–919.

2

The DSM and Other Manuals: History and Overview

As we noted in Chapter 1, it is important that you have a general understanding of the *Diagnostic and Statistical Manual of the American Psychiatric Association*, 5th edition, and its history, as well as some awareness of other mental health diagnostic manuals, such as the *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006) and the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3R; Zero to Three, 2005). As we also emphasized, the DSM is *unlike* medical systems of diagnosis in that we have yet to find specific, reliable physiological markers for any of the disorders listed in it (Charney et al., 2002; Frances, 2013; Paris, 2013).

The DSM-5 was supposed to be different from previous editions of the DSM, and include biological markers for disorders, but not one has been found (Charney et al., 2002). Although biological variables likely play a role in many disorders, we do not yet know what the role is or exactly what the variables are. We are closer to isolating brain circuits that may play dominant roles in disorders like Obsessive-Compulsive Disorder (OCD), but there is still a "chicken–egg" paradox between mind and brain in such cases (Schwartz & Begley, 2002).[1] Many DSM disorders (like our example of depression in Chapter 1) appear to be *overdetermined*, meaning that they appear to have multiple causes (Frances, 2013). This does not stop some parties, such as pharmaceutical companies, from alluding to clear-cut physiological origins of mental disorders, but if you listen to such claims critically, the claimant always fails to produce evidence. One example is historian Jonathan Engel (2008), who in his description of mental disorders makes

[1] Schwartz and Begley performed a study demonstrating the power of the mind to change brain structures. Their subjects were people with OCD and compulsions to wash their hands. These subjects were supposed to stand in front of a sink with running water. Those who were able to do so without washing their hands had brains that had changed similarly to matched-subjects who had been given medication for their OCD. In short, "mental force" changed their brains. Of course the brain is known for its plasticity but questions still remain about how much change can be guided mentally versus with medication.

statements like "psychiatric disorders clearly had biological causes" or ". . . schizophrenia, that most physiological of psychiatric disorders . . ." (p. 226) but then fails to name or cite even one study illustrating what the biological or physiological basis is. Although many disorders like Schizophrenia and Bipolar I Disorder *seem* to have biological substrates, we do not know what they are—until we do, those premises should be stated as hypotheses. Again, critical thinking is an ethical imperative for your clients and an important tool for your ongoing development as a clinician.

In this chapter we provide a brief history of the DSM, an overview of other manuals we will draw from in subsequent chapters, and a look at important issues related to the DSM-5. Perhaps the most important thing for you to remember is that the DSM is not a "gospel" or sacred canon. As psychiatrist, renowned researcher on Schizophrenia, and DSM-IV task force leader Nancy Andreasen and her colleagues have written, the DSM ". . . is not the Ark of the Covenant, the Ten Commandments, the Talmud, or the Holy Bible" (Andreasen, Flaum, & Arndt, 1992, p. 616). Although it serves a useful purpose, it should not be accorded excessive reverence, and excessive faith should not be placed in it. At best, the DSM is a work in progress that helps in diagnosing some but not all clients.

This said, you should also be aware that the DSM is a political document. As Alfred Korzybski (1958) has stated ". . . those who rule symbols, rule us" (p. 76). One of the reasons that the release of the DSM-5 publication was delayed three times is the current battle regarding how broadly psychiatric diagnoses should be defined/construed/written. Some of the harshest criticism of the DSM-5 revision process has come from psychiatrists Robert Spitzer and Allen Frances. Spitzer headed the DSM-III task force and Frances headed the DSM-IV task force. Both have been deeply involved in DSM development, from the DSM-III in 1980 to the present (Aldhouse, 2009). Frances (2009b) contends that the initial aim of the DSM-5 was to focus on biological markers for mental and emotional disorders. He wrote that because biological markers are thus far unattainable, the shift has gone to diagnosing sub-threshold and prodromal disorders, which he claims will result in many people (especially children) being prescribed psychiatric medication when they may not even have a disorder. In an interview with journalist Jon Ronson (2012), Frances stated that the diagnosis of Bipolar I Disorder in children is one of three false epidemics in psychiatry (the other two being Attention Deficit–Hyperactivity Disorder [ADHD] and Autism). Bipolar I Disorder is a fairly rare psychiatric disorder thought to afflict at most 1.6% of the population with early onset being age 13. In one survey (Danner et al., 2009), it was estimated that in a 6-year period the number of children being medicated for Bipolar I Disorder had increased 245%. Many of these children had subthreshold symptoms, meaning they did not meet all the criteria. Can you imagine if you went to your physician and she said "well you have subthreshold symptoms of strep throat, so we're going to load you up on antibiotics just in case"? If that wouldn't raise your eyebrows, it should. One addition to the DSM-5 is Disruptive Mood Dysregulation Disorder, located under the Depressive Disorders. Because many children diagnosed (likely misdiagnosed) with Bipolar I Disorder are diagnosed this way (based on disruptive moods), the hope is that by separating out a disorder for disruptive moods, fewer children will be diagnosed with Bipolar I Disorder (Margulies, Weintraub, Basile, Grover, & Carlson, 2012). Others fear it will simply inflate the number of diagnosed children by adding the new disorder (Jairam, Prabhuswamy, & Dullur, 2012; Raven & Parry, 2012). Time will tell.

Groups such as pharmaceutical companies (which fund a great deal of research on both diagnosis and treatment) have much to gain if disorders are broadened in such a way that more people meet the criteria for any given disorder and are prescribed psychotropic medication. This is one reason Spitzer and Frances believe DSM revisions should be as public as possible. Whereas many laypeople are not trained to understand the diagnoses in the DSM, nonmedical mental health therapists are, and their critiques could prove important to the further development of the DSM.

Robert Spitzer (2009) has been outspoken in his criticism of the secrecy with which DSM-5 revisions have been undertaken. He claims that the confidentiality agreement that all DSM-5 task force members signed violates the spirit of public science in which findings and deliberations are supposed to be open to peer review. The confidentiality agreement prohibited their sharing of any information about the revision process, including:

> . . . all work product, unpublished manuscripts and drafts and other prepublication materials, group discussions, internal correspondence, information about the development process and any other written or unwritten information in any form that emanates from or relates to my work with the APA Task Force or Workgroup. (Spitzer, 2009, p. 2)

Since Spitzer's protest, some of the DSM-5 deliberations have been made public, but mental health clinicians should be mindful that this is another illustration of the political dimension of the manual. Particularly because of these political dynamics, we believe critical thinking about the manual is imperative. The lack of scientific certainty in the DSM leaves a gap that can be bridged only by a leap of faith or a critical understanding of what the manual can and cannot do. Clearly, we prefer the path of critical thinking and hope that this book gives you the tools to engage in that process. To be clear, the DSM is a work in progress. While some disorders are overdetermined (e.g., there are many ways to get depressed, and some of them are psychological), others appear to be rooted primarily in genetics and/or the nervous system (e.g., Schizophrenia and Bipolar I Disorder, which are usually lifelong). The Research Domain Criteria (RDoC) of the National Institute of Mental Health (NIMH), described in Chapter 1, is designed to root out much of the physical and behavioral underpinnings of disorders.

NOSOLOGICAL SYSTEMS

Taxonomy is the science or technique of classification. A nosology is a type of taxonomy, and the term *nosology* is frequently used in medical literature to refer to the systematic classification and knowledge of diseases (the Greek root *noso* means "disease" and the suffix *ology* refers to "a science or branch of knowledge"). In the strict meaning of the word, nosology is probably not an accurate label for the classification of mental disorders. This again promotes the misunderstanding that mental disorders can be equated with, and understood as, physical or medical diseases. As we have said multiple times, that is not the case. In terms of classifying mental disorders, there is a paradox to referring to that classification as a nosology.

The paradox is this: In physical disorders the symptom depends on the disease—meaning that when a symptom appears, a medical doctor tries to trace it to an underlying disease process (although there are diseases that may be asymptomatic for

long periods of time). Take, for example, the medical disease colloquially referred to as strep throat (streptococcal pharyngitis). In most cases, patients report soreness in the throat, difficulty swallowing, and perhaps a fever. Doctors can do several tests for the presence of the bacteria that causes the symptoms (Group A Streptococcal infection). Tests include Rapid Antigen Detection Test (RADT) or growing a culture from the patient's throat in blood on an agar plate. If the test shows that Group A Streptococcus is growing in the person's throat, the doctor prescribes antibiotics that in most cases kill the bacteria. In this case the doctor examines the symptoms of the patient and then runs tests based on the symptoms that lead to confirmation of a disease.

This is not the case with mental disorders. In mental disorders, rather than symptoms leading to tests that reveal a disease process, *the symptoms—in combinations determined by the DSM—are themselves considered the disease.* Of the hundreds of diagnoses in the DSM-5, *not one* qualifies as a specifically identifiable disease process (which has a physiological/neurological marker) underlying the set of symptoms from which the client suffers. Thus, identification of the symptom configuration is the end of the line, so to speak. So, in general medicine, the symptom derives from the disease; in mental disorders, the "disease" *is* the set of symptoms (Goncalves, Machado, Korman, & Angus, 2002).

Despite all these problems, the fact remains that the DSM categorical system is designed to parallel the coding and descriptions for mental disorders in the *International Classification of Diseases* (ICD) of the World Health Organization. In addition to the categories, the DSM-5 does have some dimensional elements, which we discuss in the next section.

DSM HISTORY: CATEGORIES AND DIMENSIONS

One way to understand the DSM as a work in progress and to practice critical thinking is to learn about its history. In particular, the differences between a *dimensional* description of symptoms and a *categorical* description of symptoms will help you understand how the DSM has evolved, including some of the changes in the DSM-5. In addition, it should help you understand the approach we took while writing the rest of this book.

Categorical Diagnosis

The categorical approach to diagnosis is sometimes called the "descriptive" approach because the categories are supposed to describe the diagnoses. Categories in the DSM constitute the diagnoses most readers are familiar with, such as Major Depressive Disorder (MDD) or Bipolar I Disorder (BPI). Each category or diagnosis in the DSM has a list of symptoms and *threshold instructions* like those in MDD, in which clients must meet five of the nine symptoms listed under criterion "A." Ideally, the threshold derives from well-designed and carefully analyzed research, but sometimes—more often than not—the threshold is set based upon "expert consensus." Thus, categories present each clinician with a bimodal choice: The client either meets the criteria in the category or does not. With this type of a classification/diagnostic system, a person with four of the symptoms for depression does not have MDD, whereas someone with five of the symptoms does (although one can always opt for the diagnosis of Other

Specified Depressive Disorder or Unspecified Depressive Disorder[2]). Do you see the weaknesses of such a system? Do you see the potential problems of making a diagnosis categorically (yes or no) in contrast to dimensionally (how severe is this person's depression?)? Although the categorical approach simplifies the diagnostic decision in some ways, many clinicians believe that a clinically useful diagnosis is rarely that simple.

One problem with this is that categorical approaches treat each diagnosis as a distinct entity. Thinking of DSM diagnoses as distinct is difficult, especially given the high levels of comorbidity (when a client meets criteria for two or more disorders) seen in clinical practice. This is one reason the RDoC are set up to research *across* different disorders (for example, one could experience depression in Major Depressive Disorder, Bipolar I Disorder, and Schizoaffective Disorder, among others). Moreover, the younger clients are, the more prevalent comorbidity is (House, 1999). Here again this illustrates how DSM diagnoses differ from medical diagnoses. Comorbidity in DSM diagnoses (especially in children) has been much more the rule than the exception (Kessler, 1995; Kessler et al., 1994). In some studies, clients meeting the criteria for one disorder had a 50% chance of meeting criteria for at least one additional disorder. Can you imagine going to the doctor and having her tell you that because you have strep throat, there is a 50% chance you have some other disease? With regard to diagnostic practices based upon the DSM, in many cases that is the situation, and we believe this points to the limitations of the categorical approach (Angold, Costello, & Erkanle, 1999; Aragona, 2009; Clark, Watson, & Reynolds, 1995).

Dimensional Diagnosis

One proposed remedy to the weaknesses of the categorical approach is the dimensional approach to diagnosis. There are several ways that one can diagnose dimensionally. In the DSM-5, dimensionality is addressed in initial groupings of dimensions that envelop many diagnoses. For example, internalizing disorders would include depression, anxiety, and related cognitive symptoms, and externalizing disorders include things like substance use and impulse control problems (American Psychiatric Association [APA], 2013; Andrews et al., 2009; Krueger & South, 2009; Wittchen, Beesdo, & Gloster, 2009). Although this is currently primarily a research endeavor, it could have profound impact on future DSMs.

Dimensions may also be used to represent the degree of severity for a defined set of symptoms. In this case, dimensional diagnosis allows for diagnoses to be presented on a continuum. For example, you could look at depression on a continuum that runs from mild to moderate to severe in terms of the intensity of the symptoms the client is experiencing. In this sense, Major Depressive Disorder would be diagnosed when a client's symptoms exceed a cutoff on the continuum, similar to how hypertension (high blood pressure) is diagnosed when systolic and diastolic blood pressure levels exceed a particular threshold.

The dimensional model also allows for subthreshold levels of symptoms to be identified as the target of interventions. For example, the literature on Personality

[2] These are the options presented in the DSM-5. In previous DSMs, the option was Major Depressive Disorder, not otherwise specified (NOS).

Disorders shows that in 50% of the cases in which a Personality Disorder is comorbid with an axis I disorder (such as depression or anxiety), there are personality variables that contribute to the axis I disorder but are not diagnosable in the current DSM (Westen, Kegley-Heim, Morrison, Patterson, & Campbell, 2002). Of course, this type of model complicates certain aspects of clinical practice, some of which involve third-party payment. Also significant is who sets the threshold (and *how*—the process by which that threshold is established) beyond which the client is said to have a "disorder" and below which the client is said to simply be struggling with problems of living. This is similar to how it was decided that it's five symptoms out of nine that will lead to a diagnosis of depression, not four or six.

The DSM-5 presents the Personality Disorders in the same format as those in DSM-IV. The initial DSM-5 revision of Personality Disorders was so radical it was decided to present the revised dimensional approaches to these disorders in an appendix. Also included in that appendix is an alternative model for assessing impairment in personality traits or functions in a dimensional manner. For example, a general level of personality functioning can be measured by the Level of Personality Functioning Scale (also included in the same appendix). Other domains, such as grandiosity or deceitfulness, are proposed for similar dimensional measures. Again, time and more research will tell if this revised approach will become standard practice in future manuals.

Dimensional diagnosis can also refer to symptoms or personality dimensions that—in combination—produce a variety of psychopathologies. Much of the research on the relationship of the Five-Factor Model of personality and Personality Disorders uses this understanding of dimensional diagnosis (Nestadt et al., 2008). Dimensions can also be used to reflect genetic vulnerabilities as well as specific biological parameters. For example, we know that the heritability of mental disorders is more accurately described as *genetic vulnerability*. This means that we may have a higher risk for a mental disorder because one of our parents has suffered from one. The increased risk is because the disorder is related to the genome (genotype) we inherited from the person suffering from the disorder.

The challenge here is that the expression of genetic vulnerabilities (gene expression is referred to as phenotype) is dependent on environmental triggers, but we don't know exactly which environmental triggers trigger which genetic vulnerabilities. The relation of gene expression to environmental triggers is referred to as *epigenetics*. As we learn more specifically what sorts of environments trigger which sorts of genetic variables, then dimensional approaches for the environmental triggers can be used to complement the existing categorical structure of the DSM.

By way of example, imagine a child who has one parent suffering from Schizophrenia. In this scenario, assume we have a correlation between increased risk for the development of any mental disorder if the child suffers from poor attachment to caregivers and/or the stresses associated with lower socioeconomic status. In this case, we would add these dimensions to the child's chart and try to quantify his socioeconomic status and degree of attachment. In our view, this type of multidimensional diagnosis gets closer to ideal assessment, and also makes it more likely that we will engage in prevention by trying to increase the probability of healthy attachment and decrease the stressors related to lower socioeconomic status.

DSM HISTORY: THE EVOLUTION OF THE DSM

The DSM began as War Department Technical Bulletin Medical 203 (hereafter referred to as Medical 203), first drafted in 1943 (War Department, 1946). Medical 203 began in a committee chaired by Brigadier General William Menninger, a psychiatrist and brother of Karl Menninger (who, with their father, founded the Menninger Clinic in Topeka, Kansas). William Menninger was serving in the Office of the Surgeon General when Medical 203 was created. Menninger was instrumental in the utilization of nonmedical mental health professionals (psychologists and social workers) to conduct mental health assessments in the U.S. Army. It is important to understand that prior to World War II, organized psychiatry did not conduct outpatient practices with "normal" individuals, and the fields of clinical psychology, social work, and counseling either didn't exist or were just getting started (Houts, 2000).

The military had known that life circumstances (particularly combat experiences) could produce or trigger mental illness, but with the droves of veterans returning from WWII, the public began to realize it too. Psychiatrist Adolf Meyer (1866–1950) introduced the concept of mental disturbances as psycho-biologic reactions. In his work in New York and later at Johns Hopkins, Meyer (like Freud before him) had hoped to trace mental disorders to something physiological (even then this was the ultimate hope). He eventually realized, however, that because no physiological causes had been discovered that had consistently underlain mental disorders, it was more accurate to understand mental disturbances as *reactions* of the person to emotional states brought on by circumstances (this came to be known as the "reaction concept"). Again, Freud (1950 [1895]) ran into the same obstacle with his Project for a Scientific Psychology: being unable to identify and correlate physiological markers with mental disorders (Meyer, 1908). Meyer was exceptional in his desire to build theories based upon data, rather than mere speculation. He approached psychiatry in a pragmatic sense and advocated nonadherence to theory in understanding mental illness. Meyer also distanced himself from what he viewed as cultish dynamics in psychoanalytic circles, in which he believed that a type of faith seemed to play a stronger role than science (Engel, 2008). Although we agree with many of the strong arguments that have been made pointing out the impossibility of a truly "atheoretical" diagnostic system (Douthit & Marquis, 2006), we also admire Meyer's goal of trying to be as unbiased by theory as possible. With psychoanalytic theory, this turned out to be very important because it has been falsified on some counts and written in a way that makes it impossible to falsify on other counts.

Psychoanalytic theory did play a role in both Medical 203 and the DSM-I. The spread of psychodynamic thinking within psychiatry ". . . coincided with the expansion of medical-school training programs funded by the newly founded National Institute of Mental Health" (Houts, 2000, p. 942). This expansion shifted the priorities of psychiatry in that prior to WWII, it is estimated that about 60% of the members in the American Psychiatric Association were employed in inpatient hospitals. In 1956 (4 years after the appearance of the DSM-I), that number had fallen to 17% (Grob, 1991). The infusion of psychodynamic thinking in medical school psychiatric rotations was given a large boost when William Menninger served as president of the American Psychoanalytic Association and then the American Psychiatric Association (hereafter referred to as APA). Medical 203 was described as the document that paved the way

for psychodynamic concepts to dominate the study of psychopathology for 30 years (Barton, 1987). Thus, Medical 203 had a substantial influence on the first DSM (DSM-I; American Psychiatric Association, 1952).

Prior to the DSM-I, psychiatric taxonomies were produced by multiple organizations (such as the New York Academy of Medicine and the American Medico-Psychological Association [the precursor to the APA]), mostly for use in state mental institutions. The treatment of soldiers during and after WWII changed that focus because the increase in soldiers suffering mental problems required diagnoses to help bring order to the increasingly chaotic field (Raines, 1952). The APA Committee on Nomenclature was heavily influenced by psychiatrists who had used Medical 203 during the war to the extent that the first draft of the DSM-I was ". . . some amalgamation of Medical 203 . . ." (Houts, 2000, p. 945). The final draft of the DSM-I was approved by the APA in 1951 and released in 1952. The categories in the DSM-I were directly based on many Medical 203 categories, including organic psychoses, disorders of intelligence, psychotic disorders, psychoneurotic disorders, character and behavior disorders, and simple personality disorders. Psychoanalytic terms were particularly reflected in neurotic, psychotic, and character disorders.

In both Medical 203 and the DSM-I, the basic idea was that mental disorders were caused by ". . . some aberration in the development of the personality, most likely, but not necessarily, combined with stressful environmental circumstances" (Houts, 2000, p. 946). This was an early version of what is today called the *diathesis-stress model*. "Diathesis-stress" is an unfortunate label in that it is grammatically awkward and colloquially vague. The "diathesis" can be thought of as a "weak link" or inherent vulnerability that is then exacerbated or broken by stress, which then results in the disorder. The World Health Organization (also influenced by Medical 203) included a section on mental disorders for the first time in its sixth edition of the International Classification of Diseases (ICD) in 1948.

The bottom line is that Medical 203 and the DSM-I combined psychoanalytic concepts with Adolph Meyer's idea of psychobiologic reactions. This is ironic given Meyer's skepticism about psychoanalysis in general and the orthodoxy of its practitioners in particular. The DSM-II, which was published in 1968, retained the psychoanalytic concepts but did away with Meyer's reaction concept (American Psychiatric Association, 1968). In the foreword to the DSM-II, committee chairperson Ernest Gruenberg noted that the committee could not agree on the etiology of disorders such as Schizophrenia, so the concept of reaction was deleted. The DSM-II was designed to mirror the mental disorders listed in the 8th edition of the International Classification of Diseases (ICD-8), which was released in 1966. The ICD-8 also retained much of the psychoanalytic thinking about mental disorders. Disorders were viewed as problems rooted in personality and intrapsychic conflict. Karl Menninger captured the thinking of this era when he wrote that mental disorders were the failure of the person to adapt to his or her environment; the problem was "what was behind the symptom" (Menninger, 1963, p. 325). It has been argued that this psychodynamic system did an unsatisfactory job of separating unhealthy from healthy individuals (Grob, 1987), although similar criticisms can be made of all other DSMs. The DSM-I and the DSM-II were artifacts that reflected the esteem that psychoanalytic thinking had in the psychiatric profession at that time; however, that esteem was not to last. The DSM-III would be a radical departure from the previous two versions.

Why did the DSM-III so radically depart from its two predecessors? The simple answer is for the survival of psychiatry. Even well before 1980—when the DSM-III was released—the psychiatry, psychology, and social work professions were all becoming painfully aware of the weaknesses of psychoanalytic theory. How was it that a theory that claimed to have explanations for most human behavior failed to ameliorate the very symptoms it supposedly understood with such omniscience? One problem began at the root of psychoanalysis with Sigmund Freud's famed intolerance of colleagues who disagreed with his theory. His shunning of any dissenters quickly established a cult-like orthodoxy wherein the master's theory was to be believed, not tested. The reliance on psychodynamic terms in the DSM produced what has been called a crisis of legitimacy for psychiatry in the 1970s (Mayes & Horwitz, 2005).

As the fields of psychology and psychiatry aimed to practice more scientifically, their practitioners aimed to practice the scientific method that required theoretical assertions to be tested against empirical data. If a theory cannot be tested or cannot predict the course of treatment, is it any different from any other leap of faith, whether religious or philosophical? The need for descriptive criteria that could be tested empirically paved the way for the categorical method pioneered in the DSM-III and that is still used in the DSM-5. If we think of the DSM as a work in progress, we can appreciate that the current DSM has its weaknesses but also that it is a vast improvement over the earlier psychoanalytically-based manuals (Frances & Egger, 1999).

The Role of the World Health Organization in Changing the DSM

Due to the lack of empirical support for the mental disorder taxonomies in the DSM I, DSM II, ICD-6, and ICD-7, the World Health Organization initiated a comprehensive review of diagnostic issues. The review was conducted by British psychiatrist Erwin Stengel. His work is credited with advancing the practice of diagnosis and operationalizing labels to increase reliability (APA, 2000). The development of the DSM-III (begun in 1974 and published in 1980) coincided with the ICD-9 (published in 1977) and introduced the categorical approach (with each category listing specific symptoms). The DSM-IV (published in 1994) introduced the five-axis approach that was supposed to give a more well-rounded picture of the client by taking an atheoretical stance with regard to the cause of the disorders. It is interesting to note that the DSM-5 (APA, 2013) did away with the five-axis diagnostic system because it was claimed that the five-axis system had never been scientifically validated (APA, 2013). However, many of the categories in the DSM-III and DSM-IV were inconsistent and in some cases the criteria were still unclear. This led to revisions, the DSM-III-R in 1987 and the DSM-IV-TR in 2000.

The DSM-III was also heavily influenced by the work of psychiatrist John Feighner and what some have called the "Feighner Criteria." In his third year of residency, Feighner began to develop criteria for specific disorders (Editorial, 1989). This led to his development of the Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1972). Using the SADS, patients were to be assigned a diagnosis only if they met a certain number of the total criteria listed. Most of the criteria were based on symptoms, but in some cases history and prior mental health problems were included. This approach was used in the DSM-III and remains with us today in the DSM-5. To increase the reliability of the diagnostic system, the SADS was revised and simplified. The revised assessment is the Structured

TABLE 2.1 Number of Diagnoses in, and Length of, All the DSMs

Version	Year	Total Number of Diagnoses	Total Number of Pages
I	1952	106	130
II	1968	182	134
III	1980	265	494
III-R	1987	292	567
IV	1994	365	886
IV-TR	2000	365	943
5	2013	approx. 350	946

Clinical Interview for DSM-III (SCID; Spitzer, 1983; Spitzer, Williams, Gibbon, & First, 1992). Since its inception, there have been numerous versions of the SCID, including a clinical version, a research version, and a version specifically for Personality Disorders.[3]

The DSM-III contained 265 disorders; the DSM-III-R, published in 1987, contained 292; and the DSM-IV, published in 1994, increased the total number of diagnoses to 365. Table 2.1 summarizes the increases in diagnoses and page length with each subsequent DSM version.

Reviewing the increase in diagnoses and general length raises some interesting questions about the DSM in general. Although mental disorders are not like physical, allopathic illnesses, it would seem that we "discover" new mental disorders each time the manual is revised; in fact, some authors have even suggested that the DSMs are "making us crazy" (Greenberg, 2013; Kutchins & Kirk, 1997). To be fair, we would expect that as we study criteria sets we may come up with "subdivisions" of a particular set, thus creating a new disorder, but it is hard to tell if that is what is happening in the DSMs. For the first time since its inception, the DSM (in the current version, the DSM-5) actually has fewer disorders than its predecessors (unless you include all the modifications of disorders, such as mild, moderate, or severe).

Some researchers have claimed that the proliferation of diseases in the ICD is radically different than the proliferation of disorders in the DSM. Part of this is a function of how disorders are conceptualized in the DSM. From the DSM-III onward, the concept of dysfunction is equated with disorder, and this has led to the proliferation of diagnostic categories (mental disorders) in the DSMs (Houts, 2001). Psychologist Arthur Houts has published numerous papers on this topic. His main point revolves around the remarkable increase in the number of diagnoses in the four decades separating DSM-I and DSM-IV. He also notes that, not coincidentally, at the same time, we have seen a drastic increase in the number of mental health professionals in practice (driven strongly by the licensing of master's-level therapists in counseling and social work) (Houts, 2002).

[3] Materials on the SCID can be found at http://www.scid4.org/index.html.

First and foremost, the intent of DSMs III through 5 is "to facilitate clinical practice and communication" (Clark et al., 1995). The idea of the DSM being atheoretical and a-etiological was a direct reflection of the failure of psychoanalytic theory (or any other theory of personality, for that matter) to further our knowledge of mental and emotional disorders. In plain English: we don't know the exact causes of these disorders, just as we don't have much agreement on what personality and mind are and how they may contribute to mental disorders.[4] Again, this is in sharp contrast to most of the disorders found in the ICD, and one of the many differences between the DSM and the ICD. The new approach in the DSM-III was based upon field trials of criteria that *described (not explained)* the symptoms that seemed to cluster together (for example, fatigue, appetite disturbance, and anhedonia[5] cluster together under the category "Major Depressive Disorder"). In this manner, symptoms and their categories could then be tested in different settings to see how clearly they were being described ("clear" in this sense means helping clinicians correctly diagnose clients). From this point of view, even if we don't know the specific etiology of mental disorders, if we describe them accurately, we enable subsequent research to investigate the etiology. The editors of the DSM (from III onward) have used this categorical approach (derived from the Feighner Criteria), which aims to create categories of symptoms based on an observable pattern of behaviors or experiences that is reproducible across individuals and causes significant distress or impairment of functioning. In this system, literature reviews and clinical trials are used to determine how many of the criteria in a given category must be met for the person to be diagnosed with the disorder.

THE DISEASE MODEL IN DSM

Although the editors of the DSM claim that the manual is "atheoretical," critics have pointed out that such claims seem intended to mask that the model is in fact a medical or disease model of psychopathology that is biased toward psychiatrists and away from nonmedical mental health therapists (Douthit & Marquis, 2006; Malik & Beutler, 2002). According to the American Psychiatric Association, the five-axis diagnoses of the previous versions of DSM were supposed to facilitate "comprehensive and systematic evaluation," capture "the complexity of clinical situations," and provide a more holistic model that allows for comments on clients' current levels of functioning and psychosocial stressors (APA, 2000). The five-axis system that was eliminated in the DSM-5 was supposed to reflect physician George Engel's (1977, 1997) biopsychosocial paradigm as a holistic alternative to the medical model that focused disproportionately on the physical aspects of illness.

Engel noted that to practice from the allopathic medical model (described in Chapter 1) is to operate from what is called the "disease model." Recall that the allopathic model treats disease with agents that produce effects different from the disease process, with the hope of ameliorating it. For example, if the inattention in Attention Deficit–Hyperactivity Disorder (ADHD) is believed to be correlated with a deficiency

---

[4] This is an old problem dating back to Mischel (1968). See also the chapter on types in Ingersoll and Zeitler (2010).

[5] As we'll describe in Chapter 3, anhedonia is one of the vegetative signs of depression that manifests as a loss of pleasure or joy in things that used to give the client pleasure or joy.

in dopamine activity in the brain, one allopathic approach is to administer medications that increase dopamine activity (e.g., amphetamines) in the brain, with the hope of reducing symptoms and increasing the client's ability to attend. Engel contended that all branches of medicine (including psychiatry) should be taught such that clinicians consider biological, psychological, and social variables when dealing with patients' symptoms. Many psychiatrists lament that Engel's call was not heeded in any branch of medicine and that in psychiatry, the allopathic approach, or disease model, has won the political day; this appears particularly true given the loss of the five-axis diagnosis system (Cohen, 1993; Victor, 1996).

The disease model got a real boost when psychiatric nosology adopted the descriptive format of the DSM-III. Up to that point, psychiatric practice and the labeling of disorders had a more dimensional quality to it. The dimensions were varied and related to the severity of symptoms or the client's manifestation of diverse symptom sets that seemed to go together (such as symptoms of both anxiety and depression). However, as previously mentioned, much of the dimensional quality of the first two DSMs relied on psychoanalytic concepts, and many critics thought that reliance too heavy, especially given that psychoanalytic approaches tend to rely heavily on the client's reported subjective experience, in contrast to the more "objective" statistical procedures that characterize the DSM-III onward.

These critics turned to researchers of mental disorders who used more objective statistical techniques to conclude that certain symptoms tend to occur together and can be organized as syndromes. As psychiatrist Stephen Dilts (2001) noted, the syndromes are described by the symptoms that compose them; thus, the approach is called "descriptive," in contrast to dimensional. Dilts added that the descriptive model does not capture everything about a particular disease state or client; he also proposed a more rigorous use of the biopsychosocial approach. Once again, his recommendations have not been followed. Currently, many psychiatrists are challenging the descriptive model and urging an integration of the dimensional model in the DSM-5 (Helzer & Hudziak, 2002; Maser et al., 2009; Tackett, Balsis, Oltmanns, & Krueger, 2009). Although dimensions are included in some categories, they are really "add-ons" rather than changes to the categorical structure of the DSM-5.

Challenges to a Psychiatric Disease Model

The disease model that underlies the DSM has been called into question on many counts. Critics like Thomas Colbert (2000) and Seymour Fisher and Roger Greenberg (1997) have written whole volumes illustrating that psychological disorders are overdetermined and, in that sense alone, very different from allopathic disorders. In their view, there is a world of difference between a streptococcus infection and depression. Whereas the former can clearly be conceptualized and treated through the allopathic approach, the latter may or may not respond to allopathic approaches and may require hermeneutic therapies (approaches that depend upon intersubjective dialogue, discussion, interpretation, and shared understanding between client and therapist, rather than the procedural administration of objective knowledge). Other critics have challenged the validity of DSM categories of disorders. For example, psychiatrist David Healy (1997) has documented how the concept of depression was "sold" by the medical community and the pharmaceutical industry through the descriptive (DSM) model.

The correlation of certain symptoms occurring together was first labeled "depression." Then the construct of depression was "sold" via the DSM. After the concept of depression was "bought" by the medical establishment, antidepressants were marketed as a treatment for the disorder because, as Healy has pointed out, people must have a disorder before they will be interested in purchasing a cure for it. Healy has also documented how, in the United States, the Food and Drug Administration (FDA) regulations reinforce the descriptive model of psychiatry because potential drugs must show efficacy for the treatment of some disorder. Without the DSM categories, there are no disorders on which drugs may be shown to have an effect. In other words, the FDA will not allow pharmaceutical companies to market a drug unless there is a clearly defined disease (mental disorder) that the drug ameliorates (Healy, 2004). It probably isn't hard for you to see why the pharmaceutical industry would be invested in maintaining and proliferating an artifact such as the DSM, without which it could not garner its huge profits. We are not trying to deny how invaluable some pharmaceuticals are to many people; we are merely trying to highlight the complex economic and political (social, lower-right quadrant) dimensions regarding what actually constitutes a mental disorder and how they have come to be defined the way they are.

Whatever the validity and reliability of particular DSM diagnoses, what used to be axis I diagnoses tend to be the primary focus of third-party payers, and this bias is reflected in psychology and other mental health training. Such dynamics have likely fueled the negative reaction many therapists have to the topic of diagnosis. As Thomas Hohenshil (1994) has noted, many clinicians question the necessity of diagnosis and feel it is an unproductive labeling process based on oversimplified categories to describe complex human dynamics. Ideal training in the use of the DSM requires an approach that acknowledges the spirit of the biopsychosocial model advocated by Engel but that goes beyond it to include the full spectrum of the human condition; unfortunately, this type of training is quite rare.

HOW ARE DSM CATEGORIES DEVELOPED?

DSM categories and symptoms are created and explored by workgroups in a process using literature reviews, data analysis and re-analysis, and field trials. The literature reviews begin with each workgroup (organized by diagnosis) identifying issues relevant to the group's topic and then conducting a literature review. The domains to be considered should include clinical utility, descriptive validity, reliability, and psychometric properties of individual criteria. The literature reviews can potentially be biased by several factors. First and most obvious, papers with statistically significant findings are more likely to be published than papers without statistically significant findings, so many studies that found no significant difference are never publicly available. Also, pharmaceutical companies that have a vested interest in the diagnoses related to their products fund a great deal of the research reviewed. In many instances, the pharmaceutical company has a contract with the researchers that allows the company to withhold nonsignificant findings.[6] What this means is that a drug company may run

[6] For a summary of this problem, see Ingersoll and Rak (2006).

five clinical trials and not obtain any significant findings until the fourth and fifth trial. With such a contract, the company can legally (although not ethically) report that the drug has been found repeatedly effective in clinical trials, without any mention of the first three trials in which the drug was not effective.

Data analysis and re-analysis can include unpublished data sets. There were 40 data re-analyses for the DSM-IV and in several cases they produced new criteria sets tested in the field trials. The number of re-analyses for reliability in the DSM-5 is a point of contention, with critics claiming that important steps were skipped (Frances, 2013) while the American Psychiatric Association defends the rigor of the task-force approach (American Psychiatric Association, 2012a). Again, though, all of the literature review and data analysis questions are derived from the expert opinions of the workgroup members. Significantly, the manner in which these work group members are chosen often has more to do with each member's theoretical approach, ideological stance, and other political factors than with "objective," value-free science. The field trials allow the workgroups to see how new criteria sets perform in the field and begin anticipating the impact that changes to the existing DSM will have on the field. The editors of the DSM had some guidelines for developing criteria that included trying to make the criteria as clear and simple as possible, striking a balance of making the DSM as compatible as possible with the ICD, and collecting as much evidence as possible to support the changes. Before moving on, it is important to explicitly examine reliability and validity with regard to the DSM.

Reliability

Readers may recall the two constructs of reliability and validity from their research or testing courses. Reliability is the first criterion needed to document the quality of a diagnostic category. Simply phrased, reliability is the degree to which a diagnosis holds up across raters and across time. As with validity, there are multiple ways to explore reliability—including internal consistency, inter-rater, and test-retest. An example of internal consistency in diagnostic categories is when the different symptoms in the same diagnostic category are in fact quite consistently present in people diagnosed with that category, as opposed to only a few of the different symptoms manifesting together in a more occasional or random manner. Inter-rater reliability is when multiple raters using DSM criteria independently assign the same diagnosis for the same client. Some diagnoses have high inter-rater reliability (like Major Depressive Disorder) while others have practically none (most of the Personality Disorders). Finally, test-retest reliability is when the same criteria are applied across time and the same outcome results; in other words, a person who is diagnosed with specific mental disorder is diagnosed with the same disorder 6 and 12 months later. As you can imagine, this is complicated and difficult with mental health diagnoses because a client may improve (or worsen) during the time interval.

Perhaps the chief challenge to reliability is that few clinicians follow a standardized interview format when making diagnoses (Aboraya, 2008). Although the DSM mentions interviews, associated laboratory findings, and associated physical examination findings, clinicians rarely collect this type of data unless they are ruling out substance-induced disorders or perhaps something like medication-induced delirium. The DSM-5 also allows that if a patient is incoherent (e.g., unable to make psychological

contact), clinicians may obtain information from family members or other informants. Despite these exceptions, making a diagnosis is usually done solely with information obtained directly from the client. To deal with this problem, semistructured and fully structured interviews have been developed (Meyer, 2002). In one review, inter-rater reliability approached .92 using the Composite International Diagnostic Interview (CIDI), which can be administered by a computer or a clinician (Wittchen, 1994). Even in these cases, the increased reliability comes at the cost of depending more on client self-report than on clinician expertise (Meyer, 2002). While diagnoses made from unstructured interviews rely heavily on client self-report too, they also involve the clinician's ability to synthesize the information.

So, although there are drawbacks and benefits to both structured and unstructured interviews, they may yield different results for different reasons. Structured interviews are vulnerable to clients' memory problems, denial, or deliberate efforts to present oneself in an inaccurate (usually more positive) manner (John & Robins, 1994). Many readers may recall the famous study by David Rosenhan wherein he secretly planted eight pseudopatients in several psychiatric units and instructed them to say during their diagnostic interviews that they heard different sounds (empty, hollow, and thud-type sounds). Aside from these few fabrications (made only at intake), the pseudopatients were told to simply give honest details from their lives (with the exception of their true identities). Immediately after their admission, all of the patients stopped displaying symptoms and interacted with staff in a normal manner. Despite their normal behaviors, seven of the eight were diagnosed with Schizophrenia (Rosenhan, 1973). Perhaps even more interesting, many of the actual inpatients surmised that they were more "normal" than the other inpatients, an important fact that the psychiatrists/mental health staff did not recognize.

In a follow-up study, Rosenhan found another psychiatric institution that agreed to having pseudopatients sent over a 3-month period. This particular institution had staff who did not believe a study like Rosenhan's could be replicated under their system. During the 3-month period that Rosenhan told them to expect the pseudopatients, 41 out of 118 screened were identified as pseudopatients—despite the fact that Rosenhan had sent no such patients during the agreed-upon time frame (Rosenhan, 1984). Both Rosenhan studies highlight the problems regarding the reliability and validity of diagnostic labels that are the result of clinical interviews with clients.

One of the controversies over the DSM-5 concerns the reliability of many diagnoses. According to Allen Frances (chair of the DSM-IV task force), there should have been two stages of reliability testing but the design of the field trials was so complicated that only one stage was completed. Frances feels the problems also lie with the fact that the criteria sets in the DSM-5 are unclear (Frances, 2009a, 2009b, 2012). Another part of the problem is that whereas the DSM-IV field trials were funded by the NIMH, the American Psychiatric Association failed to find such external funding for the DSM-5. Because of the NIMH funding the methodology for the DSM-IV had to go through the peer-review process, but the methodology for the DSM-5 was not subjected to peer review that could have improved the methodology. As a result, Frances (2013) contends that the DSM-5 researchers focused exclusively on reliability, avoiding questions of validity and practical utility. The methodology problems led to incomplete reliability testing, and the reliability of many diagnoses was far lower than in previous

DSMs. As noted, technically, there were supposed to be two stages in reliability testing for the DSM-5. Diagnoses that had reliability problems in the first round could then be changed and tested again in a second round; however, only the first round was completed (Frances, 2009b, 2009c; Jones, 2012). The APA has defended the work on its website, but only time will tell if the DSM-5 is an improvement or not.

Validity

Validity can be thought of as the extent to which your construct (in this case a DSM category) describes what you believe it describes. There are six ways to judge validity: face validity, content validity, convergent validity, discriminant validity, predictive validity, and construct validity. We'll describe each type using a DSM category as an example. Face validity is simply the extent to which your diagnostic category "looks like" what you believe it to be. Therefore fatigue, lethargy, and sadness all support the face validity of Major Depressive Disorder (MDD). Interestingly, face validity relies on the mental, psychological, subjective aspects of a disorder. Those materialists who think psychological suffering is a direct result of the electro-chemical symphony in the brain will never achieve face validity. Content validity is the extent to which the content of a category relates to what you believe you are measuring. Again, significant numbers of clients who suffer from depression report fatigue, lethargy, and sadness. Convergent validity is the degree to which a category is similar to other categories or tests. For example, people who are diagnosed with MDD often score in the depressed range on inventories like the Beck Depression Inventory (Beck, Steer, Ball, & Ranieri, 1996) or the Hamilton Rating Scale for Depression (Williams, 1989). Discriminant validity is the degree to which a category or diagnosis is different from things presumed to be antithetical to it. For example, people with diagnoses of MDD do not meet the criteria for scores in the 90–100 range (high to very high functioning) on the DSM-IV's Global Assessment of Functioning (GAF). Predictive validity is the extent to which a diagnosis is predictive of a certain course. For example, diagnoses of Schizophrenia predict a poor prognosis for later functioning, whereas diagnoses of Brief Psychotic Episode do not. Finally, construct validity is the extent to which a diagnosis is similar to related psychological constructs; that is, a diagnosis of MDD should present similar symptoms to what is psychologically referred to as depression.

Interestingly, for all we know about what should happen in validating a diagnosis, it is very hard to actually carry out. In 1970, Eli Robins and Samuel Guze (Robins & Guze, 1970) published a paper that proposed the most rigorous validity process for psychiatric diagnoses. They recommended five dimensions that should be assessed: careful clinical description, laboratory studies, delimitation from other disorders, follow-up research, and family studies. The most important steps for Robins and Guze were the last two, which would demonstrate continuity over time and give researchers a sense of how much of the diagnosis emerged longitudinally in families. When Robins and Guze used these five dimensions, they felt only 16 diagnoses were validated. Spitzer (1991) contrasted this with the DSM-III's over 200 diagnoses that were based on clinical judgment. Spitzer concluded that, in fact, expert consensus will continue to play a large role in diagnostic validation. One consistent problem in the DSM-III, III-R, and IV is that the knowledge bases from which different criteria have been developed

and validated differ drastically across diagnoses. The take-home message: not all diagnoses are equally valid (Rounsaville et al., 2002).

As you'll see throughout the book, this can be a problem in a society where pharmaceutical companies have inordinate influence in crafting the public's understanding of what a "disease" is. As of this writing, pharmaceutical companies have two lobbyists for every senate and congressional representative in the federal government (Petersen, 2008). In addition, a 1992 federal law now allows drug companies to pay "user fees" to the FDA to have their products approved more quickly. Prior to this law, the only function of the FDA was to protect consumers and police companies (Petersen, 2008). In addition, with the exception of New Zealand, the United States is the only country in the world where direct-to-consumer (DTC) advertising of medications is legal. The DTC advertising of psychotropic medication has exponentially correlated with increased sales of those drugs advertised (whether they effectively treat a disorder or not). Some of the disorders that appear in these advertisements have been shown to be concocted by drug companies (e.g., "overactive bladder"), whereas at other times the advertisements use a more saleable title, such as calling Social Phobia "Social Anxiety Disorder," which prior to the DSM-5 only appeared parenthetically. Many times, companies lose a patent on a medication (as with Prozac/fluoxetine[7]) and then go on to create a new formulation of the same drug to recapture patent status (as with converting Prozac to Sarafem) (Petersen, 2008). Sarafem is nothing more than a time-release formulation of fluoxetine that has been marketed by Eli Lilly to treat symptoms of Premenstrual Dysphoric Disorder (PDD). The problem is that PDD was first introduced in the DSM-IV as a condition warranting further study. Even before it was validated and included as a Depressive Disorder in the DSM-5, medications were being developed to treat it. To return to the main point of this section, if expert consensus is a primary mode of validating a diagnostic category, then having experts paid as consultants by pharmaceutical companies should be a conflict of interest. A recent study investigated relationships between pharmaceutical companies and workgroups writing clinical practice guidelines for the American Psychiatric Association for the treatment of Schizophrenia, Bipolar Disorder, and Major Depressive Disorder. In this study, 18 workgroup members (90%) had at least one financial tie to the pharmaceutical industry (Cosgrove, Bursztain, Krimsky, Anaya, & Walker, 2009). All of the clinical practice guideline authors who had industry relationships had financial relationships with companies whose products were considered or included in the guidelines they authored (Cosgrove et al., 2009). This should be very disturbing to you; we cannot understand how or why this is legal. The American Psychiatric Association (2012b) has challenged the Cosgrove study as not fairly assessing the steps task-force members took to divest themselves of financial affiliations. In creating DSM-5, work-group members were asked to complete financial conflict of interest (FCOI) forms, as this was not done with DSM-IV. The result was that approximately three-fourths of DSM-5 panel members had financial ties to the pharmaceutical industry and the panel groups with the most ties were studying disorders where medication is considered a first-line treatment intervention (Cosgrove & Krimsky, 2012).

---

[7] Throughout this book, when we refer to a psychotropic medication we will name the brand name (e.g., Prozac) followed by the generic name (e.g., fluoxetine).

Surprising as this is, it is important to understand these political dynamics and their potential relationship to the approval of new diagnostic categories and how the process may be influenced by those with money, power, and more to gain by the approval of new diagnoses. Equally, we must be willing to hear both sides of the story, as the appearance of undue influence can be as damaging as actual undue influence. From an Integral perspective, the lower quadrants remind us to consider how political, social, and cultural dynamics influence the way psychopathology is understood and defined. Again, this is where critical thinking on the part of clinicians is needed.

WHAT IS "STATISTICAL" ABOUT THE DIAGNOSTIC AND STATISTICAL MANUAL?

In early versions of the DSM, the word "statistical" reflected the intended use of the manual, which was to statistically gauge the prevalence and incidence of disorders (Kraemer, Shrout, & Rubio-Stipec, 2007). Beginning with the DSM-III, there was more emphasis on statistical assessment of the reliability (see earlier discussion) of the diagnoses. In other words, in a study in which several clinicians were diagnosing the same individual by observing a diagnostic interview, what was the inter-rater reliability between them? More simply put, what was the probability that the clinicians would all reach the same diagnosis for the same client? It has been argued that since the DSM-III, many of the problems in the DSM were created by the statisticians. One particular argument (particularly pronounced in the DSM-5) was that in the process of focusing on reliability, the statisticians sacrificed validity—which is more important to clinicians (Kirk & Kutchins, 1992).

The DSM-IV, DSM-IV-TR, and DSM-5 attempted to place greater emphasis on the role of empirical evidence as a requirement to change diagnostic rules. As noted, the DSM-5 had two stages of reliability studies planned, but stage two was never completed. This resulted in far less statistical rigor than was hoped for by the DSM-5 task force (Kraemer et al., 2007). One of the most important decisions that statisticians play a role in is to clarify what we mean by "disorder." The word *disorder* is used when the etiology is unknown; when the etiology is known, the word *disease* is used (World Health Organization, 1992). Furthermore, a "diagnosis" should help clinicians decide whether a client is suffering from a particular syndrome. The quality of any diagnosis depends on how well the clinician's assessment corresponds to the client's condition and what has been documented about other clients with the same diagnosis (Kraemer et al., 2007).

Statisticians can also assess whether changes to diagnostic categories bring researchers closer to things such as risk factors, causal factors, or even progress toward effective prevention and treatment. Again, when a category is changed, the DSM task force must test the reliability and validity of the changes. Ideally, this is done across multiple sites in the field trials phase of developing the categories or changes to existing categories. Without going into too much detail, it is important to note that the proper use of statistics requires that an appropriate statistical test be performed for the proper reasons under the best possible conditions. As Anne Spence and her colleagues (Spence, Greenberg, Hodge, & Vieland, 2003) have noted, statisticians frequently will be drawn to a field because of employment opportunities or because the field is new and exciting. In these cases, rather than deeply understanding the basis of a diagnosis,

they look for applications of statistical skills they already know. This can lead to the development of new statistical designs that are poorly adapted to the needs of the field in which the statistical practices are being applied (Spence et al., 2003).

A PRACTICAL GUIDELINE FOR DSM USE

What we hope you take away from this part of the chapter is, again, an active practice of critical thinking with regard to the DSM. Now that we have provided a critical view of the DSM, we'd like to suggest an outline form of how to use it with this text. Throughout the text we'll include cases that you can practice both DSM and Integral diagnoses with. Similar to the case of Katie in Chapter 1, we'll note a client's presenting concern and then encourage you to practice narrowing down the narrative to what seem to be presenting symptoms. With cases presented in written format it is harder to do an accurate diagnosis because many aspects of the clinical interaction are missing. Toward that end, we want to start with a summary of one approach to using the DSM to diagnose, and then we'll offer a briefer version for practicing with written cases. The following summary is taken from Ekkehard and Sieglinde Othmers's (1994a, 1994b) two volumes on clinical interviewing. These are to be understood as general guidelines. Some agencies and practices may have you use a formal interview format like the Structured Clinical Interview for DSM (SCID), mentioned earlier.

Four Components to the Clinical Interview

The four components of the clinical interview are establishing rapport, gathering information, assessing mental status, and making a diagnosis. We now describe each component in detail.

RAPPORT How the client and the clinician relate is one of the most important aspects of clinical assessment, and the client–clinician relationship has been shown to be a primary factor in psychotherapy outcome (Duncan, Miller, Wampold, & Hubble, 2009). Think of rapport as including your ability to put the client at ease, recognize the client's state of mind, warm the client up with a brief explanation of what you'll be doing in the session, and meet the client where she or he is psychologically. Your ability to establish rapport with the client is directly related to the client's level of comfort in talking about what are often difficult things to share. Typically, rapport has been discussed in psychodynamic and descriptive frameworks. You can use aspects of both in establishing rapport.

The psychodynamic framework typically conceptualizes rapport in terms of *transference* and *countertransference.* Transference is when the client responds toward the interviewer in a manner that resembles the way the client responds to significant others in his or her life. For example, when I (Ingersoll) was interviewing an African American inmate preparing for release from prison, he said "you just tell me what you want 'cause that's what this about anyway." As we interacted, it was pretty clear that he viewed me as one more privileged Caucasian "cog" in the machinery of a society that had no place for him. Whether or not that was an accurate description of my role in his release was not important—that he *believed* it was what was important and as Yalom and Leszcz (2005) have noted, to ignore something of such emotional import would pretty much guarantee that we wouldn't get much else done in the session.

Whether or not you accept psychodynamic theories as a whole, most of us have moments when we react to people in ways that mirror our history more than our present interaction with a given person.

The other approach to rapport is descriptive, which derives more from humanistic and, particularly, client-centered theory. In this approach to rapport, the ideal is that the client–clinician interview progresses from understanding to trust. The ideal is that you can empathize with the client's experience and accurately reflect back to the client issues that are of most concern, based upon his or her narrative. When clients experience you as someone who is listening to both content and emotion (because you are reflecting feelings as well as content), you can at times increase the trust they have in you.[9] One example of this was a client who had a laundry list of issues but, at root, she was in counseling because she found life to be overwhelming. In this instance, the clinician reflected "I hear all your concerns about your marriage and children, getting back to working at least part-time, and fear of being criticized by your friends. It seems, though, that a connecting thread is fear or perhaps anxiety that you'll never be able to address it all. Does that feel accurate?" This response not only drew the client into the interview more; it seemed to also focus the session on what the client wanted relief from.

STRATEGIES FOR GATHERING INFORMATION ABOUT THE CLIENT The second component of the clinical interview is sometimes called technique. This involves the methods used to establish rapport and the theories the clinician relies on to guide the methods. Othmer and Othmer (1994a) summarize three strategies focusing on client complaints, resistance, and defenses. Client complaints are perhaps the most obvious thing to listen for, but they may point you in numerous directions. For example, a client who is suffering from aural hallucinations (hearing voices) may want you to stop the voices. In this example, the symptom is ego-dystonic, meaning *it is incongruent* with how the client sees himself—he wants to get rid of the symptom. You need to meet him where he is, while at the same time, gather enough information to create a treatment plan that will help him. Another client's problem may be the way she interacts with others and her lack of emotional boundaries; clients who meet the criteria for Personality Disorders may show these sorts of signs. She may seem overly complimentary—saying she knows you'll cure her in no time, for example. In this case, we say the problem is ego-syntonic, meaning it is *congruent* with how the client sees herself, and more often than not, people with ego-syntonic problems do not recognize their problems as problems (they are unable to make their problems the object of their awareness); they see others or the world as the problem.

Sometimes, the way clients resist questions or psychological contact with the clinician can give you insight into what problems they may need to tackle in clinical work. Expressing acceptance when a client is reluctant to talk may help the client overcome what might be a fear of ridicule or judgment. In these cases, to help him overcome his resistance you can encourage him and reflect what you think the fear is (e.g., "I'm guessing that you're hesitant to talk because you don't know me and wonder if I might judge you"). Another approach is gently confronting the resistance or, in other words, making what the client is doing an object of awareness. In one session

[9] This is, of course, a paraphrase of one of Carl Rogers's (1957) six core conditions for therapeutic change.

we supervised, a client would change the subject every time the clinician brought up the topic of emotions. Finally, the counselor said "It seems to me that when I mention emotions, you shift the discussion onto another topic. I'm wondering if emotions are hard for you to talk about."

For clients who are more actively resistant (and aware that they are resisting), you can still talk about the process. One client who was in treatment for heroin dependence kept shifting the discussion away from her use and onto unrelated topics, stating that she didn't want to talk about her use anymore. In this case the therapist stated "It seems that you really have trouble facing the way you've lived your life these past 2 years." To this, the client responded that she really didn't have trouble facing it but just didn't want to stop. That opened up a more important topic: her lack of commitment to sobriety.

Another route to understanding the client's difficulties can be through addressing defenses. The DSM-5 (like its predecessors) offers a list of defenses in the glossary. They are psychodynamic in nature but may be useful in identifying what a client needs to work on. In the case of the heroin-dependent client just described, denial continued to be a problematic defense for her. Bear in mind that defenses are necessary and serve healthy psychological needs (if you doubt it, consider how many days you've gotten through without a rationalization). One client tended to use humor in ways that, over time, appeared to be hurting him more than it was helping him. In the initial interview, he offered to shake hands, then pulled his hand back before the clinician could shake it. The client said "isn't that what crazy people do doc?" His humor was usually aggressive and focused on others, and this led to identifying his anger as one of the things he sought relief from.

MENTAL STATUS Mental status refers to the client's state of mind during the interview. In particular, we start by assessing whether a client is oriented to person (who she is), place (where she is), time (when she is—"what time/year is it?"), and situation ("what is this interview about?"). A client who is able to respond within the boundaries of consensual reality is said to be "oriented × 4" or to possess "clear sensorium." If the client is able to make psychological contact, you can usually discern this in the interview without going through special questions to determine the client's orientation. If the client seems confused as to person, place, time, and/or situation, you can proceed in a direction that more directly assesses mental status (Faber, 2009; Davis & Zimmerman, 1994; Strub & Black, 1993).

Mental status exams can be helpful if you suspect that a client may have suffered an organic injury (e.g., stroke, head trauma), is under the influence of intoxicating substances, is suffering from a side effect of a medication, or perhaps is suffering from a psychotic disorder. It is often not easy to tell the difference between these things, and that is when the client needs to be referred for a medical evaluation. In private practice, it is helpful if the client has had a medical checkup in the past year, but frequently clients will not have had this and may not have the insurance to pay for such an exam. In these instances, you have to make your best clinical guess regarding when to refer for medical evaluation.

Although this is not a text about diagnostic interviewing, it is important to at least list other sources of information about a client (Hamstra, 1994). The client's appearance—including body type, hygiene/grooming, clothing, posture, eye contact, and poise (the way a client holds him- or herself)—can give you clues as to things that may be part of the

presenting problem. One client came in to a July session wearing an overcoat, winter hat, and earmuffs. While his statement that the clothes kept the voices away gave a primary clue that he was likely suffering from a severe disorder, his attire helped the clinician more quickly confirm that. Another client who suffered from Bipolar I Disorder (formerly known as Manic-Depressive Illness) would start wearing very bright colors prior to suffering a manic episode. In this case, family members came to be able to preclude several episodes by getting him to his doctor when his attire changed to the flashier clothing.

Another important component of assessment is the client's attitude. Does the client want to be in the interview or not? Is the client suspicious, angry, apathetic, or showing great apprehension? For example, apprehension is common in people suffering from Anxiety Disorders; thus apprehension can be a sign in the initial session that points the clinician in the correct direction. Another thing to observe is the client's speech. Sometimes obvious problems with speech can point to organic disorders or head trauma. Clients who are depressed frequently speak with softer volume and in a less animated way. This leads to other things to observe: mood and affect. Mood is considered to be the client's emotional state as reported by the client, whereas affect refers to the outward expression of emotion as observed by the clinician. Affect is revealed by facial expressions, body movements, and sometimes vocal tone, and it can change quickly.

Thought process and thought content are also important to assess in the clinical interview. Thought content is basically what the client shares as the content of his or her thoughts. Content such as delusions, hallucinations, or obsessions may point to various disorders, including Psychotic Disorders and Obsessive-Compulsive Disorder.

With regard to levels of development (discussed in Chapter 1), thought process gives clues about the cognitive tools a client has access to. A client who uses metaphors appropriately, can follow a train of abstract thought, and is able to discuss the same thing in different contexts likely has the capacity for formal operational thinking. Clients who speak more concretely and seem puzzled by metaphors may be limited to concrete operational thinking.

There are particular thought problems that show up in several DSM disorders that can be clues to the presenting disorder or problem. Loose associations are when ideas that the client expresses do not seem to be related. Flight of ideas is when a client seems to jump rapidly from one idea to the next. Perseveration is when a client seems to get stuck on a particular word or phrase. In one case, the client shared "I know you doc; you're not the kind of person who is phony to be with. I know you doc; you don't think they are treating me right at work. I know you doc; you should see the way they treat me at work. I know you doc . . .," and so forth.

DIAGNOSING Finally, the fourth component to the interview is actually providing a diagnosis of the client—if that is within the scope of your practice. Most states allow (licensed) psychiatrists, psychologists, social workers, counselors, and psychiatric nurses to diagnose mental and emotional disorders, but you must make sure you understand the law and scope of practice for the state you are working in. The more you learn about clients—their strengths and weaknesses, their deficits and resources, and the complaints they present with—the better able you are to get into the appropriate diagnostic ballpark. As noted earlier, you may use a structured diagnostic interview (like the SCID) or a structured intake form that covers concerns related to both body and mind (and spirit, if that is part of the client's worldview) (Marquis, 2008).

One diagnostic tool that came with DSM-IV was the decision trees in Appendix A of that manual. These offer flow charts for differential diagnosis of Mental Disorders Due to General Medical Condition, Substance-Induced Disorders, Psychotic Disorders, Mood Disorders, Anxiety Disorders, and Somatoform Disorders. These can be helpful guidelines, but they are no substitute for clinical judgment. Clinical judgment develops with experience, but the intake assessment, your experience of the client, and the other areas we previously noted should provide you enough information to outline both a DSM and an Integral diagnosis (discussed in Chapter 1). Before moving on, here is another sample case that we'll flesh out first with an Integral diagnosis and then discuss how that can be used to arrive at a DSM-5 diagnosis.

CASE OF JORGE

Jorge is a 43-year-old owner of two small sandwich shops. His family is from Peru and moved here when he was 3. He has no mental health history, no history of substance abuse, and is oriented × 4. Because of his cultural background, he was also given the Cultural Formulation Interview (CFI) that is newly included in the DSM-5. Several responses to CFI items suggested that he feels some of his shyness and awkwardness with others is due to his temperament and some the result of growing up with his Peruvian family in a primarily Caucasian, Midwest suburb. He has trouble sustaining eye contact when speaking, and speaks without much inflection. He lives alone with his dog and has few friends. He says he tried attending churches but is not religious. He hoped to meet some people there but felt he didn't really fit in. He says he spends most of his time working and says that at his job is really the only place he feels like he fits in. He can converse easily with customers because he says he knows they don't expect anything from him other than service. One of the things that makes his problems harder to cope with is his lack of a family support system. Jorge has one brother who lives on the West Coast and some contact with his mother (his father died 4 years ago).

His presenting complaint is difficulty sleeping, due to anxiety. Jorge presents as well dressed and well groomed but also unsure of himself. In the interview, he keeps correcting himself. First he says "I am not sleeping," then "No, that's not right; I'm anxious and that is why I don't sleep well." His attitude seems cautious, although sincere, and when the clinician states "You seem like you may be a little wary of counseling," Jorge responds "Wary, yeah, I've . . . you know . . . never done anything like this." After discussing what happens in counseling, Jorge shares more about his current concerns. He states that his business has "taken a hit" in the economy, although he thinks things are beginning to improve. When asked if that is a main source of stress, he says "not really." Jorge shares that he sometimes feels like he is having a heart attack. He says ". . . my heart races, I sweat, and then I start thinking like I've got to run out of the shop." He has had a full assessment by his doctor, who says he is in excellent cardiac health.

Jorge tends to rationalize when the clinician speaks about anxiety. He says ". . . oh yeah, I know it's all in my head, I guess everyone has this problem." After half an hour of discussion, it seems that the panic Jorge experiences as well as his anxiety are the primary problems. He says ". . . well they may be, but I wonder if there is some kind of pill you can take for this that doesn't make you tired." His doctor had prescribed a low dose of Xanax/alprazolam, but Jorge said it made him sleepy. The doctor tried a low

dose of Lexapro/escitalopram, but Jorge didn't like the sexual dysfunction side effect. When the clinician summarizes that he didn't seem to like the medications his doctor prescribed, Jorge says ". . . well, yeah . . . I thought maybe there was something else without side effects." Jorge's thought processes seem normal enough, but he says his thoughts race when he has panic episodes. He also says he tends to dwell on negative thoughts sometimes. He read a book about positive thinking but it didn't seem to help him. He wonders if he fits in anywhere besides at work.

When asked what the negative thoughts are about, he responds "Well this will seem weird, but I worry about my heart and my business. I know they are both OK but I start wondering, what if they are not?" It appears that there are no compulsions accompanying his obsessions. He finally says "I guess it is the panic that is the biggest problem." His panic comes on only when he is at work, but not every time he is at work. It happens about six times a month and he worries about it happening again. He twice called in sick to avoid an attack. He hated to do that because, in his words, "work is my life."

	INTERIOR	EXTERIOR
INDIVIDUAL	Feelings of panic Unrealistic fears and obsessions Anxiety as racing thoughts Worries about fitting in	Calling in sick to avoid an attack Tried medication but didn't like it Trouble maintaining eye contact Speaks without much inflection
GROUP	Does not feel a sense of community in his life business Comes across as socially awkward	Economic stressors Tried churches but didn't feel he fit in Lives alone

Integral Diagnosis for Jorge

It seems that Jorge could use some coaching on social interactions and ways to meet other people. For him, we might view that as a *developmental* task, addressing the *line* of interpersonal development. The problematic *states* for Jorge are anxiety and panic. As far as types go, Jorge appears to be very conventional in his sense of self. The idea of fitting in (belonging) is very important for him. Again, the *four quadrants* give us a sense of the "hotspots" for Jorge. He is beset with panic and anxiety symptoms, wants to fit in, is starting to engage in avoidance behavior because of the panic symptoms, and would like a sense of community but doesn't know how to find it.

With the DSM-5, we would document Jorge's diagnosis as

F41.0 Panic Disorder; client has cultural concerns about "fitting in" and is experiencing financial stress.

Between the Integral diagnosis and Jorge's DSM diagnosis, we have several important pieces of information. As we noted in Chapter 1, we view the two assessments (Integral and DSM-5 diagnoses) as complementary. The DSM diagnosis gives us codes that, if accurate, are paired in many cases with treatment manuals that offer good summaries of peer-reviewed literature on the most effective treatments for the disorder (Gabbard, 2001). The Integral diagnosis gives us more insight into the client's

experiential perspective as well as cultural and social issues that used to be represented in the five axes of the DSM-IV-TR diagnosis.

AN OVERVIEW OF THE DC:0-3R AND THE PDM

The last part of this chapter is a brief overview of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-3R) and the *Psychodynamic Diagnostic Manual* (PDM). As noted in Chapter 1, both of these manuals can complement the DSM. In particular, the DC:0-3R is important because most of the disorders in the DSM (with the exception of Neurodevelopmental Disorders) are normed on adults and the criteria for adults frequently do not generalize to children. In some cases, such as for Major Depressive Disorder, the DSM will note different symptom manifestations for children, but in general, clinicians are on their own in determining the extent to which the disorders can be applied to child and adolescent clients.

This has become particularly problematic with Bipolar I Disorder. As noted earlier, there has been an explosion in the diagnosis of Bipolar I Disorder in children as young as 2 years old, and this has been a controversial topic in child psychiatry (Paris, 2009; Youngstrom, Birmaher, & Findling, 2008). It is estimated that a *40-fold increase* in the diagnosis of Bipolar I Disorder in children took place between 1994 and 2003. Many of these children had what are called "subthreshold" symptoms, meaning the symptoms did not meet the adult criteria for severity. Here again, we see that the ontological assumptions of researchers are important in understanding the type of research they do. Those who want to believe that the increase in diagnoses is legitimate try to make the case that Bipolar I Disorder is actually part of a spectrum and that we should diagnose this entire spectrum (Merikangas et al., 2007). Bear in mind that there is no conclusive evidence to support this, other than the conjecture of the researchers (one of whom was consultant to 13 pharmaceutical companies, and there is a note at the end that the preparation of the article was supported by AstraZeneca) (Merikangas et al., 2007, p. 551). Other (more critical) researchers note that many of the symptoms in the supposed Bipolar Spectrum diagnoses are comorbid with Attention Deficit–Hyperactivity Disorder (ADHD), and suggest that these may in fact be side effects of stimulant medication (Sahling, 2009).

Bipolar I Disorder is one of the disorders in which it appears that we need diagnostic criteria specific to children and adolescents. Although the DC:0-3R does not cover Bipolar Disorders, the idea is that it sets a precedent for looking at children's disorders differently than adult disorders. This is imperative because of the radically different nature of the nervous system and mind between children and adults, not to mention different developmental levels in general. In many cases, the children are "acting out" or showing what is called mood lability or aggression; whether this actually constitutes Bipolar I Disorder remains to be determined (Duffy, 2007).

The DC:0-3R

The DC:0-3R is a slim 75-page volume that offers initial mental health and developmental diagnoses for infants and children ages 0–3. The DC:0-3R task force developed a five-axis diagnostic system that is better suited to reflect the lives of the young clients that are its focus. Axis I is considered the Primary Diagnosis and clinical disorders are coded on it; these include Posttraumatic Stress Disorder, Deprivation/Maltreatment

Disorder, Disorders of Affect, Prolonged Bereavement/Grief Reaction, Anxiety Disorders of Infancy and Early Childhood, Mixed Disorder of Emotional Expressiveness, Regulation Disorders of Sensory Processing, Sleep Behavior Disorder, Feeding Behavior Disorder, Disorders of Relating and Communicating, and Multisystem Developmental Disorders.

Axis II is different than the DSM in that it focuses on Relationship Disorders and provides a series of assessments. These include a Parent-Infant Relationship Global Assessment Scale (PIR-GAS), which ranges from "well adapted" to "documented maltreatment." Next, there is a Relationship Problems Checklist (RPCL) that covers descriptive features of a relationship's qualities—ranging from "overinvolved" to "underinvolved"—and lists a set of emotional qualities that may be observed in the relationship (e.g., angry or hostile, anxious or tense, and categories such as abusive).

Axis III is devoted to Medical and Developmental Disorders and Conditions, and particular emphasis is given to medical disorders that can cause what appear to be psychiatric symptoms. Among the common examples listed are endocrine disorders causing mood symptoms, metal toxicity causing irritability and restlessness, Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcus (PANDAS) causing obsessive or compulsive symptoms, and hearing or speech problems that manifest as irritability, frustration, and behavior problems.

Axis IV, similar to the DSM-IV, is devoted to psychosocial and environmental stressors. Psychosocial stressors can be acute (time-limited) or enduring. Normal events in the life of a family (like the arrival of a new baby) can be inordinately stressful for some children. What is also assessed is the extent to which the caregiving environment can shield the child from stressors. This is assessed with the Psychosocial and Environmental Stressor Checklist. The checklist helps clinicians identify multiple sources of stress as well as the duration and severity of stress.

Finally, Axis V is for Social and Emotional Functioning; it reflects the young child's affect and interaction with important caregivers in relation to expectable patterns of development. This is done by rating the child's capacities for emotional and social functioning using the Capacities for Emotional and Social Functioning Rating Scale. Capacities the child is rated on include attention and regulation (usually observable between birth and 3 months), forming relationships and mutual engagement (observable between 3 and 6 months), intentional two-way communication (observable beginning between 4 and 10 months), complex gestures and problem solving (observable between 10 and 18 months), use of symbols to express thoughts and feelings (observable between 18 and 30 months), and connecting symbols logically (observable between 30 and 48 months). Whether the DC-03R will be revised to eliminate the multiple axes (like the DSM-5) has yet to be decided.

The Psychodynamic Diagnostic Manual (PDM)

The PDM is the result of collaboration between the American Psychoanalytic Association, the International Psychoanalytical Association, the Division of Psychoanalysis (division 39) of the American Psychological Association, the American Academy of Psychoanalysis and Dynamic Psychiatry, and the National Membership Committee on Psychoanalysis in Clinical Social Work. The manual is supposed to be a diagnostic framework that attempts to reflect a client's emotional, cognitive, and social functioning (PDM Task Force, 2006).

The PDM aims toward a multidimensional approach to describe the intricacies of a client's overall functioning and the way the client engages the therapeutic process. To do this, the PDM utilizes three dimensions labeled "P," "M," and "S." The "P" axis stands for Personality Patterns and Disorders. This axis uses a dimensional continuum for the client's personality ranging from "healthier" to "more disordered." In addition, the way the client organizes mental functioning and engages the world is described on this axis. The "M" axis stands for Mental Functioning. This offers a more descriptive profile of emotional functioning, including the capacities that contribute to a client's personality and overall level of psychological health or pathology. The third dimension, the "S" dimension, stands for Manifest Symptoms and Concerns. This dimension begins with DSM categories and proceeds to describe what we refer to as experiential states, cognitive processes, somatic experiences, and relational patterns that are typical for the client. The PDM refers to symptom clusters as useful *descriptors* but does not regard them as demarcated biopsychosocial phenomena. The editors note that their main goal is to not go beyond the knowledge base in the field (PDM Task Force, 2006).

Although far fewer clinicians use the PDM than use the DSM, from an Integral standpoint it is an important contribution to the literature because its editors have aimed to look at mental disorders from a strictly psychodynamic point of view. In this sense, the PDM can be a useful complement to our Integral diagnosis, particularly the experiential perspective (upper-left quadrant). It is interesting that although fewer clinicians use the PDM, Gordon (2009) found that psychologists in his study gave the PDM a 90% approval rating.

Concluding Thoughts

We have covered a great deal of material in this chapter. The rest of the book will deal with particular types of psychopathology, starting in Chapter 3 with depression. We hope that these first two chapters have given you some reasons to approach the DSM with a critical mind as well as introduced you to some of the other efforts at diagnostic systems that are available. We also hope that this chapter has given you an outline for how to begin using the DSM while reading through cases in this book. With that said, we will now turn to the various manifestations of depression.

Review Questions

1. What is the difference between the categorical and dimensional approaches to diagnosis?
2. What is the status of the search for consistent biological markers that cause specific mental disorders?
3. What seems to be the relationship between *epigenetics* and *gene expression*?
4. How did the DSM-III radically differ from its predecessors, and why were the changes made?
5. What is the general relationship between the ICD and the DSM?
6. What is "statistical" about the *Diagnostic and Statistical Manual of Mental Disorders*?
7. What are four general components of the clinical interview?
8. What aspects of the initial interview provide information about the client and the client's diagnosis?
9. What are the four components of the mental status exam orientation?
10. How do the DSM axes differ from the DC:0-3R axes?

References

Aboraya, A. (2008). Do psychiatrists use structured interviews in real clinical settings? *Psychiatry, 5*, 26–27.

Aldhouse, P. (2009). Psychiatry's civil war. *New Scientist, 18.* Retrieved from http://www.newscientist.com/article/mg20427381.300-psychiatrys-civil-war.html?full=true&print=true

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders.* Washington, DC: Author.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

American Psychiatric Association. (2012a). Reliability and prevalence in the DSM field trials. Retrieved from http://www.dsm5.org/Documents/Reliability_and_Prevalence_in_DSM-5_Field_Trials_1-12-12.pdf

American Psychiatric Association. (2012b). Statement for John Oldham, M.D.: President of the American Psychiatric Association. Retrieved from http://www.dsm5.org/Documents/APA%20Refutes%20Secondary%20Analysis%20of%20DSM-5%20Disclosures.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andreasen, N. C., Flaum, M., & Arndt, S. (1992). The comprehensive assessment of symptoms and history (CASH): An instrument for assessing diagnosis and psychopathology. *Archives of General Psychiatry, 49*, 616.

Andrews, G., Goldberg, D. P., Krueger, R. F., Carpenter, W. T., Hyman, S. E., Sachdev, P., & Pine, D. S. (2009). Exploring the feasibility of a meta-structure for DSM-V and ICD-11: Could it improve utility and validity? *Psychological Medicine, 39,* 1993–2000.

Angold, A., Costello, E. J., & Erkanle, A. (1999). Comorbidity. *Journal of Child Psychiatry, 40,* 57–87.

Aragona, M. (2009). About and beyond comorbidity: Does the crisis of the DSM bring on a radical rethinking of descriptive psychopathology? *Philosophy, Psychiatry and Psychology, 16,* 29–33.

Barton, W. E. (1987). *The history and influence of the American Psychiatric Association*. Washington, DC: American Psychiatric Press.

Beck, A. T, Steer R. A., Ball R., & Ranieri, W. (1996). Comparison of Beck Depression Inventories-IA and -II in psychiatric outpatients. *Journal of Personality Assessment, 67,* 588–597.

Charney, D. S., Barlow, D. H., Botteron, K., Cohen, J. D., Goldman, D., Gur, R. E., . . . Zalcman, S. F. (2002). Neuroscience research agenda to guide development of a pathophysiologically based classification system. In D. J. Kupfer, M. B. First, & D. A. Regier (Eds.), *A research agenda for DSM-V* (pp. 31–84). Washington, DC: American Psychiatric Association.

Clark, L. A., Watson, D., & Reynolds, S. (1995). Diagnosis and classification of psychopathology: Challenges to the current system and future directions. *Annual Review of Psychology, 46,* 121–153.

Cohen, C. I. (1993). The biomedicalization of psychiatry: A critical overview. *Community Mental Health Journal, 29,* 509–521.

Colbert, T. C. (2000). *The four false pillars of biopsychiatry: One hundred years of medical nonsense.* Tustin, CA: Kevco.

Cosgrove, L, Bursztain, H. J., Krimsky, S., Anaya, M., & Walker, J. (2009). Conflicts of interest and disclosure in the American Psychiatric Association's clinical practice guidelines. *Psychotherapy and Psychosomatics, 78,* 228–232.

Cosgrove, L., & Krimsky, S. (2012). A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: A pernicious problem persists. *PLoS Medicine, 9,* 1–4.

Danner, S., Fristad, M. A., Arnold, E., Youngstrom, E. A., Birmaher, B., Horwitz, S. M., Demeter, C., Findling, R. L., Kowatch, R. A., & The LAMS Group. (2009). Early-onset bipolar spectrum disorders: Diagnostic issues. *Clinical Child and Family Psychological Review, 12,* 271–293.

Davis, F. A., & Zimmerman, M. (1994). *Interview guide for evaluating the DSM-IV psychiatric disorders and the mental status examination.* East Greenwich, RI: Psych Products Press.

Dilts, S. L. (2001). *Models of the mind: A framework for biopsychosocial psychiatry.* Philadelphia, PA: Brunner/Rutledge.

Douthit, K. Z., & Marquis, A. (2006). Empiricism in psychiatry's post-psychoanalytic era: Contemplating DSM's "atheoretical" nosology. *Constructivism in the Human Sciences, 11*(1), 32–59.

Duffy, A. (2007). Does bipolar disorder exist in children? A selected review. *The Canadian Journal of Psychiatry, 52,* 409–417.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2009). *The heart and soul of change: What works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Editorial. (1989). This week's citation classic. *Archives of General Psychiatry, 43,* 14.

Endicott, J., & Spitzer, R. L. (1972). The schedule for affective disorders and schizophrenia. *Archives of General Psychiatry, 35,* 837–844.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196,* 129–136.

Engel, G. L. (1997). From biomedical to biopsychosocial: Being scientific in the human domain. *Psychosomatics: Journal of Consultation Liaison Psychiatry, 38,* 521–528.

Engel, J. (2008). *American therapy: The rise of psychotherapy in the United States.* New York: Gotham.

Faber, R. A. (2009). The neuropsychiatric mental status exam. *Seminars in neurology, 29,* 185–193.

Fisher, S. F., & Greenberg, R. P. (Eds.). (1997). *From placebo to panacea: Putting psychiatric drugs to the test.* New York: Wiley.

Frances, A. (2009a). A warning sign on the road to DSM-V: Beware of its unintended consequences. *Psychiatric Times, 26.* Retrieved from http://www.psychiatrictimes.com/display/article/10168/1425378

Frances, A. (2009b). Whither DSM-V? *The British Journal of Psychiatry, 195,* 391–392.

Frances, A. (2009c). Limitations of field trials. *American Journal of Psychiatry, 166*, 1322.

Frances, A. (2012). Newsflash from APA meeting: DSM-5 has flunked its reliability tests. *HuffPost Science*. Retrieved from http://www.huffingtonpost.com/allen-frances/dsm-5-reliability-tests_b_1490857.html

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life.* New York: Morrow.

Frances, A. J., & Egger, H. L. (1999). Whither psychiatric diagnosis? *Australian and New Zealand Journal of Psychiatry, 33,* 161–165.

Freud, S. (1950 [1895]). *The standard edition of the complete psychological works of Sigmund Freud, Volume I (1886–1899): Pre-psycho-analytic publications and unpublished drafts*, (pp. 281–391). London: Vintage.

Gabbard, G. (Ed.). (2001). *Treatments of psychiatric disorders* (vol. I & II, 3rd ed.). Washington, DC: American Psychiatric Association.

Goncalves, O. F., Machado, P. P. P., Korman, Y., & Angus, L. (2002). Assessing psychopathology: A narrative approach. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective* (pp. 149–176). Washington, DC: American Psychological Association.

Gordon, R. M. (2009). Reactions to the *Psychodynamic Diagnostic Manual (PDM)* by psychodynamic, CBT and other non-psychodynamic psychologists. *Issues in Psychoanalytic Psychology, 31*(1), 55–62.

Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry.* New York: Blue Rider Press.

Grob, G. (1987). The forging of mental health policy in American: World War II to the New Frontier. *Journal of the History of Medicine & Allied Sciences, 42,* 410–446.

Grob, G. N. (1991). Origins of DSM-I: A study in appearance and reality. *American Journal of Psychiatry, 148,* 421–431.

Hamstra, B. (1994). *How therapists diagnose: Professional secrets you deserve to know and how they affect you and your family.* New York: St. Martins Griffin.

Healy, D. (1997). *The antidepressant era.* Cambridge, MA: Harvard University Press.

Healy, D. (2004). *The creation of psychopharmacology.* Cambridge, MA: Harvard.

Helzer, J. E., & Hudziak, J. J. (Eds.). (2002). *Defining psychopathology in the 21st century: DSM-V and beyond.* Washington, DC: American Psychiatric Association.

Hohenshil, T. H. (1994). DSM-IV: What's new? *Journal of Counseling and Development, 73,* 105–107.

House, A. E. (1999). *DSM-IV diagnosis in the schools.* New York: Guilford.

Houts, A. (2000). Fifty years of psychiatric nomenclature: Reflections on the 1943 War Department Technical Bulletin, Medical 203. *Journal of Clinical Psychology, 56,* 935–967.

Houts, A. C. (2001). The diagnostic and statistical manual's new white coat and circularity of

plausible dysfunctions: response to Wakefield, Part 1. *Behaviour Research and Therapy, 39,* 315–345.

Houts, A. (2002). Discovery, invention, and the expansion of the modern manuals of mental disorders. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective* (pp. 17–68). Washington, DC: American Psychological Association.

Ingersoll, R. E., & Rak, C. F. (2006). *Psychopharmacology for helping professionals: An integral approach*. Pacific Grove, CA: Brooks Cole.

Ingersoll, R. E., & Zeitler, D. A. (2010). *Integral psychotherapy: Inside out/outside in.* Albany, NY: SUNY.

Jairam, R., Prabhuswamy, M., & Dullur, P. (2012). Do we really know how to treat a child with Bipolar Disorder or one with severe mood dysregulation? Is there a magic bullet? *Depression Research and Treatment, 2012,* 1–9.

John, O. P., & Robins, R. W. (1994). Accuracy and bias in self-perception: Individual difference in self-enhancement and the role of narcissism. *Journal of Personality and Social Psychology, 66*, 206–219.

Jones, D. K. (2012). A critique of DSM-5 field trials. *Journal of Nervous & Mental Disease, 200,* 517–519.

Kessler, R. C. (1995). The epidemiology of psychiatric comorbidity. In G. E. P. Zahner (Ed.), *Textbook of psychiatric epidemiology* (pp. 179–197). New York: Wiley.

Kessler, R. C., McGonagle, K. A., Zhao, S., Neson, C. B., Hughes, M., Eshleman, S., . . . Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51,* 8–19.

Kirk, S. A., & Kutchins, H. (1992). *The selling of the DSM: The rhetoric of science in psychiatry*. New York: Aldine De Gruyter.

Korzybski, A. (1958). *Science and sanity: An introduction to non-Aristotelian systems and general semantics* (5th ed.). Brooklyn, NY: Institute of General Semantics.

Kraemer, H. C., Shrout, P. E., & Rubio-Stipec, M. (2007). Developing the diagnostic and statistical manual V: What will "statistical" mean? *Social Psychiatry and Psychiatric Epidemiology, 42,* 259–267.

Krueger, R. F., & South, S. C. (2009). Externalizing disorders: Cluster 5 of the proposed meta-structure for DSM-V and ICD-11. *Psychological Medicine, 39,* 2061–2070.

Kutchins, H., & Kirk, S. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.* New York: Free Press.

Malik, M. L., & Beutler, J. E. (2002). The emergence of dissatisfaction with the DSM. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective.* Washington, DC: American Psychological Association.

Margulies, D. M., Weintraub, S., Basile, J., Grover, P. J., & Carlson, G. A. (2012). Will Disruptive Mood Dysregulation Disorder reduce false diagnosis of Bipolar Disorder in children? *Bipolar Disorders, 14,* 488–496.

Marquis, A. (2008). *The integral intake: A guide to comprehensive idiographic assessment in integral psychotherapy.* New York: Routledge.

Maser, J. D., Norman, S. B., Zisook, S., Everall, I. P., Stein, M. B., Schettler, P. J., & Judd, L. L. (2009). Psychiatric nosology is ready for a paradigm shift in DSM-V. *Clinical Psychology: Science and Practice, 16,* 24–40.

Mayes, R., & Horwitz, A. V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences, 41,* 249–267.

Menninger, K. (1963). *The vital balance*. New York: Viking.

Merikangas, K. R., Akiskal, H. S., Angst, J., Greenberg, P. E., Hirschfeld, R. M. A., Petukhova, M., & Kessler, R. C. (2007). Lifetime and 12-month prevalence of bipolar spectrum disorder in the national comorbidity survey replication. *Archives of General Psychiatry, 64,* 543–552.

Meyer, A. (1908). The problems of mental reaction-type, mental causes and diseases. *Psychological Bulletin, 5,* 385–403.

Meyer, G. J. (2002). Implications of information-gathering methods for a refined taxonomy of a psychopathology. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective* (pp. 69–106). Washington, DC: American Psychological Association.

Mischel, W. (1968). *Personality and assessment.* Mahwah, NJ: Erlbaum.

Nestadt, G., Costa, P. T., Hsu, F.-C., Samuels, J., Bienvenu, O. J., & Eaton, W. W. (2008). The relationship between the five-factor model and latent *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Personality Disorder dimensions. *Comprehensive Psychiatry, 49,* 98–105.

Othmer, E., & Othmer, S. C. (1994a). *The clinical interview using DSM-IV: Volume 1: Fundamental.* Washington, DC: American Psychiatric Association.

Othmer, E., & Othmer, S. C. (1994b). *The clinical interview using DSM-IV: Volume 2: The difficult patient.* Washington, DC: American Psychiatric Association.

Paris, J. (2009). The bipolar spectrum: A critical perspective. *Harvard Review of Psychiatry, 17,* 206–213.

Paris, J. (2013). *The intelligent clinician's guide to the DSM-5.* New York: Oxford University Press.

PDM Task Force. (2006). *Psychodynamic diagnostic manual.* Silver Springs, MD: Alliance of Psychoanalytic Organizations.

Petersen, M. (2008). *Our daily meds: How the pharmaceutical companies transformed themselves into slick marketing machines and hooked the nation on prescription drugs.* New York: Sarah Crichton. ["two for each member of congress" p. 10; the 1992 law is described on pp. 330–331]

Raines, G. N. (1952). Foreword. In American Psychiatric Association (Ed.), *Diagnostic and statistical manual of mental disorders* (pp. v–xi). Washington, DC: American Psychiatric Association.

Raven, M., & Parry, P. (2012). Psychotropic marketing practices and problems: Implications for DSM-5. *The Journal of Nervous and Mental Disease, 200*, 512–516.

Robins, E., & Guze, S. B. (1970). Establishment of diagnostic validity in psychiatric illness: Its application to schizophrenia. *The American Journal of Psychiatry, 126,* 983–986.

Rogers, C. R. (1957). The necessary and sufficient conditions for therapeutic change. *Journal of Consulting Psychology, 21,* 95–103.

Ronson, J. (2012). *The psychopath test: A journey through the madness industry.* New York: Riverhead.

Rosenhan, D. (1973). On being sane in insane places. *Science, 179*, 250–258.

Rosenhan, D. (1984). On being sane in insane places. In P. Watzlawick (Ed.), *The invented reality: How do we know what we believe we know?* (pp. 117–144). New York: Norton.

Rounsaville, B. J., Alarcon, R. D., Andrews, G., Jackson, J. S., Kendell, R. E., & Kendler, K. (2002). Basic nomenclature issues for DSM-V. In D. J. Kupfer, M. B. First, & D. A. Regier (Eds.), *A research agenda for DSM-V* (pp. 1–30). Washington, DC: American Psychiatric Association.

Sahling, D. L. (2009). Pediatric bipolar disorder: Underdiagnosed or fiction? *Ethical Human Psychology and Psychiatry, 11,* 215–227.

Schwartz, J. M., & Begley, S. (2002). *The mind and the brain: Neuroplasticity and the power of mental force.* New York: RegenBooks.

Spence, M. A., Greenberg, D. A., Hodge, S. E., & Vieland, V. J. (2003). The emperor's new methods. *American Journal of Human Genetics, 72,* 1084–1087.

Spitzer, R. (1983). Psychiatric diagnosis: Are clinicians still necessary? *Comprehensive Psychiatry, 24*, 399–411.

Spitzer, R. L. (1991). An outsider-insider's views about revising the DSMs. *Journal of Abnormal Psychology, 100,* 294–296.

Spitzer, R. L. (2009). DSM-V transparency: Fact or rhetoric? *Psychiatric Times, 26.* Retrieved from http://www.psychiatrictimes.com/display/article/10168/1385346?verify=0

Spitzer, R. L., Williams, J. B., Gibbon, M., & First, M. B. (1992). The Structured Clinical Interview for DSM-III-R (SCID). I: History, rationale, and description. *Archives of General Psychiatry, 49,* 624–629.

Strub, R. L., & Black, F. W. (1993). *The mental status exam in neurology* (3rd ed.). Philadelphia: F.A. Davis.

Tackett, J. L., Balsis, S., Oltmanns, T. F., & Krueger, R. F. (2009). A unifying perspective on personality pathology across the life span: Developmental considerations for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders. Development and Psychopathology, 21,* 687–713.

Victor, B. S. (1996). Psychopharmacology and transpersonal psychology. In B. W. Scotton, A. B. Chinen, & J. R. Battista (Eds.), *Textbook of transpersonal psychiatry and psychology* (pp. 327–334). New York: Basic Books.

War Department. (1946). Nomenclature of psychiatric disorders and reactions: War department technical bulletin, Medical 203. *Journal of Clinical Psychology, 2*, 289–296.

Westen, D., Kegley-Heim, A., Morrison, K., Patterson, M., & Campbell, L. (2002). Simplifying diagnosis using a prototype-matching for the next edition of the DSM. In L. E. Beutler & M. L. Malik (Eds.), *Rethinking the DSM: A psychological perspective.* (pp. 221–250). Washington, DC: American Psychological Association.

Williams, J. B. W. (1989). A structured interview guide for the Hamilton Depression Rating Scale. *Archives of General Psychiatry, 45,* 742–747.

Wittchen, H.-U. (1994). Reliability and validity scales of the WHO-Composite International Diagnostic Interview (CIDI): A critical review. *Journal of Psychiatric Research, 28*, 57–84.

Wittchen, H.-U., Beesdo, K., & Gloster, A. T. (2009). A new meta-structure of mental disorders: A helpful step into the future or a harmful step back to the past? *Psychological Medicine, 39*, 2083–2089.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.* Geneva: Author.

Yalom, I. D., & Leszcz, M. (2005). *Theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Youngstrom, E. A., Birmaher, B., & Findling, R. L. (2008). Pediatric bipolar disorder: Validity, phenomenology, and the recommendations for diagnosis. *Bipolar Disorders, 10,* 194–214.

Zero to Three. (2005). *Diagnostic and classification of mental health and developmental disorders of infancy and early childhood: Revised edition (DC:0-3R).* Washington, DC: Zero to Three Press.