The Assumptive Worlds of Psychopathy VII: Clinical Diagnosis and DSM

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In this, our sixth essay, we are arriving at the heart of the matter regarding contemporary perspectives on psychopathy. Here is where "the rubber hits the road"—for it impacts in a significant manner on the financing of mental health services in the United States and many other countries in the world. It is in the basic act of diagnosing and categorizing the psychopathy of a client seeking treatment that not only the nature of treatment is being determined (in many instances), but also the length of treatment and role played by other professionals (such as psychiatrists, clinical social workers and counsellors) are determined (or at least strongly influenced). We are referring specifically to the critical role played by the *Diagnostic and Statistical Manual of Mental Disorders,* which is now in its fifth edition—hence is usually referred to as DSM-5 (American Psychiatric Association, 2013).

There is often a "love/hate" relationship between DSM (in its many versions) and the mental health community. While DSM is a useful guide in determining treatment options and is certainly important for many clinicians who look to third-party and/or government reimbursements to keep their practices financially viable, they frequently find DSM to be an infringement on their rights and privileges as a licensed professional.

As I will note later, DSM (like many of the current "evidence-based" tools used in present day medicine), tends to fly directly in the face of the norms of autonomy and authority that is to be found in the professional culture operating in the world of both physical and mental health (Bergquist, Guest and Rooney, 2002). As I noted in our fifth essay (Bergquist, 2020), the emergence of a strong set of assumptions regarding psychopathy as a "mental illness" led to a framing of emotional (and spiritual)

disturbances in medical terms. With this reframing, it was only to be expected that the emphasis in medicine on diagnosis and classification would accompany and, in many ways, dominate the contemporary practices of many workers in the field of "mental" health.

Having set the stage for our examination of DSM, we are ready to embark on a journey of both appreciation and criticism into this challenging domain. We are offering a landscape rendering of the world in which DSM operates We begin by stepping back briefly to offer an important distinction between diagnosis and assessment, then describe both the current state and past history of DSM.

From this point, we turn to a second essay that offers the perspectives offered by the "working" professionals in diverse fields of professional psychology. This will be more of an intimate, portrait rendering of DSM. What do these professionals consider the benefits and drawbacks of DSM (and now specifically DSM-V) as those who actually use DSM on a daily basis? We are fortunate to be able to draw on the perspectives of professional psychologists from not only the United States, but also Asia—for DSM indeed is now a powerful internationally-based tool of professional mental health.

Diagnosis versus Assessment

An important distinction must be drawn between processes that are labeled "diagnosis" and those that are labeled "assessment." While both terms refer to the collection and analysis of information about specific people (or groups of people), diagnoses and assessments are being done for quite different reasons and the results of these two processes look quite different.

Diagnosis

Let's first look at the term "diagnosis". In its original meaning, diagnosis has to do with pulling something apart and then putting it back together by providing a determinative classification. We all learned about this process of pulling apart and putting together in our junior high school biology class (and lab) when we cut up a frog (or mouse) and noted the name to be assigned to each of the frog's parts. This is often a powerful memory that is frequently interwoven with emotions of both fascination and revulsion. If nothing else, we often feel some empathy for the frog that gave up its life for our education. At an even deeper level, the death of the frog and our

analysis reminds us that what is taken apart in biology can never be put back together. The "smashed frog" can never again be a live frog. Integrative functions are one-way—this is fundamental to a holistic and emergent perspective on complex, living systems.

The analytic tradition resides at the heart of the diagnostic process—this is the justification for cutting up the frog. An important assumption is made that by breaking up any entity into its parts and analyzing the ways in which these parts interact will yield important knowledge about this entity. Furthermore (and here is where diagnosis plays a central role), each of the parts as well as the whole is provided with a label and placed in a hierarchical category that should increase prediction (and hopefully control) of the entity in the future.

When the entity is a human being, who is suffering from some emotional or mental dysfunction, the diagnosis is directed toward labeling (categorizing) the dysfunction, which allows for better selection of treatment modalities and probably outcomes of this treatment (if it has been successful). The breaking into parts comes with an analysis of the specific predispositions (inherited/genetic or pre-birth) or events (usually early childhood) that precipitated the current dysfunction.

Typically, the predispositions and events are "analyzed" by consideration being given to their relative importance in influencing the current dysfunction and to the ways in which these predispositions and events interact to create the current dysfunction. A holistic description of the dysfunction is typically discounted: it is simply not enough to say that the person being diagnosed is "unhappy", "confused", "pessimistic" or (worse yet) "spiritually adrift."

The diagnostic process is also deeply saturated with American pragmatism. We diagnose not some much to understand as to predict and control. It is always nice to gain a full understanding of the conditions leading up to a current pathology—as is the want of traditional psychoanalysts (who often are not very fond of DSM or other diagnostic tools). It is critical, however, that a decision is made based on valid and useful information gathering through a diagnostic process—as is the want of more contemporary psychotherapist engaging in various forms of cognitive-behavioral therapy (who are usually more accepting of DSM and other diagnostic processes, especially if this process yields objective, quantifiable outcome measures).

In brief, most diagnostic processes (at least in the field of mental health) are output and outcome oriented. Diagnosis is all about "honing-in" (a process of convergence). There is a clear decisional-orientation: we need to make a judgment regarding how to proceed—that is what's most important. As an aside, we might conjecture that those who are supportive of diagnostic processes (based on DSM) score high on Carl Jung's "judging" function—or at least the system in which they operate is saturated with Jung' judging function (it is important, when engaging Jung's typology, to look not only at individual personalities, but also the environments in which one is operating.

Our colleagues in the growing field of behavioral economics (e.g. Kahneman, Ariely, Thayer) offer some insights regarding decision-making processes that are relevant to our reflections on diagnostic processes. There is a tendency to rely on "fast thinking" and simple heuristics (widely-shared assumptions about the world and ways in which to live and work in this world) when confronted with conditions of stress and when there are not clear indicators of what the world now looks like or how it might react to our interventions in this world.

This fast thinking certainly operates in a warzone hospital unit or when a pandemic produces an overwhelming population of men, women and children needing treatment. This is the classic triaging that occurs when decisions must quickly be made about which patients to treat and which must be left to die. Which patients do we treat first (because they are in critical condition) and which do we try to comfort (and perhaps medicate) while they await later treatment? This fast thinking makes sense and can be quite successful, if there is a strong background among those making the decisions—so that they can rely on their "old-brain" intuitions (Lehrer, 2009).

What about under "normal conditions" when the stress is not great (though any patient/client presenting dysfunctional behavior creates stress for all involved)? What about conditions when the issue(s) being considered and decision to be made do not have to be rushed. Is there still a reliance on heuristics, instinct, and fast thinking? When a clinical psychologist has a daily quota to reach, will this professional be inclined to slap a hastily reached diagnosis on the eighth or tenth patient being seen in the late afternoon?

Does the diagnostic process become simple or does it get complex? Are there multiple measures being taken and multiple perspectives being engaged when arriving at a decision regarding DSM categorization? How important is it to get the diagnosis "right"? What about the managers of the clinic in which the diagnoses are being made? Is accuracy of high priority for them or are levels of production (number of clients being seen) of highest priority?

The level of complexity might reside at the heart of the matter regarding the effective or ineffective use of diagnostic processes. Complexity might also reside at the heart of the matter regarding the accuracy (validity) of the diagnosis. Perhaps a few simple measures will be just as good (or even better) than the biased and often harried diagnoses being delivered by the clinician—and perhaps average people might be able to do as good a job of diagnosing emotional and mental problems and predicting psychotherapy outcomes as high-payed clinicians (Dawes, 2009; Lewis, 2016). The managers of clinics might wish to review these disturbing findings regarding the accuracy of clinical predictions. They might find the solution to the polarizing dilemma they face in choosing between accuracy and productivity.

A few simple criteria for determining treatment strategies and probably outcomes might work just as well as asking clinicians to make their judgment (often using fast thinking, inappropriate heuristics). Unfortunately, the managers might have to look outside their organization for direction in this matter. Government and insurance officials might not have reviewed the outcomes of these same clinical prediction studies. They could still be asking for more elaborate clinical diagnoses (framed in DSM terms) and would feel uncomfortable accepting simpler, but perhaps even more accurate, diagnostic processes.

Assessment

What about assessment? At its core, assessment is about making sense of something. How does this person, group or organization operate? To answer this question, it is critical that the "frog" (person, group. organization) is "alive"—for assessment takes place through observation, examination and gathering of relevant data. A dead frog yields little of importance in any assessment process. While both diagnosis and assessment serve to guide future action, the aim of diagnosis is usually much more limited in terms of scope and duration: it is about guiding the

treatment of an individual person or perhaps a small group of people (if the diagnosis is directed toward the functioning of a work team—what is often called "process consultation").

By contrast, an assessment usually is engaged to guide an action that is much bigger in scope and duration. It concerns the future of an entire program or even an entire institution. In essence, we are creating a guiding narrative when engaging in an assessment – or at least an assessment that is meant to be used rather than simply produced and put on a shelf (usually to comply with some external directive).

To return again to our conjectures about who might be supportive of assessment (rather than diagnostic) processes, we predict that the assessment-oriented folks score high on Carl Jung's "perceiving" function—or at least the system in which they operate is saturated with Jung' perceiving function (it is important, when engaging Jung's typology, to look not only at individual personalities, but also the environments in which one is operating.

While diagnosis is about coming quickly to a decision, assessment is about obtaining a full picture. While diagnosis is convergent—moving toward a specific description and diagnosis, assessment is divergent—moving outward and expanding. Assessment is about enriching one's perspective of a program or institution through expansion in the sources and methods of obtaining information ((as we shall note shortly when describing a process called Triangulation

While this essay is not intended to focus on assessment, we offer a few simple principles that will later help to direct our attention to specific aspects of clinical diagnostic processes (that are or are not present). First, assessments can be directed toward setting realistic goals for a new program—the assessment being done on similar existing programs or on the perceived needs of potential users of the services being offered by the new program and/or the expectations of key stakeholders associated with the program. The assessment can also be conducted after the program is in place (or when the leaders of an institution wish to review and improve functioning in their organization.

The assessment can help leaders determine how to proceed with the program or organization. They can modify existing tactics and strategies. At times, this second type of assessment can be

conducted on an ongoing basis—as action learning (Argyris and Schon, 1992; Senge, 2006). The leaders or members of a team can gain ongoing insights about their program based on the impact and dynamics associated with the intervention they have engaged. In many ways this action learning model might be considered a "just-in-time" strategy—with "just-in-time" learning being the norm for the assessment-embedded processes of this team.

The third type of assessment is the one most often engaged. Or it is what we usually think of when considering the purpose of an assessment. The assessment is being done as an evaluation of a program's or organization's effectiveness. This assessment is often being conducted to determine the future funding for a program (the source of this funding being a government or philanthropic organization). This type of assessment, in turn, can be either formative or summative in nature and purpose. A formative assessment is conducted while a program is ongoing. It is intended as a source of information to improve the program's functioning.

We might apply the term "meta-reflection" to this formative process, referencing the process of reflective practice that was described and advocated by Don Schon (Schon,1984; Schon, 1996). How do we keep monitoring and modifying our ongoing process? In this way, it is a bit like the ongoing meta-reflective process engaged by the traditional psychotherapist. Is transference operating right now? What about counter transference? In essence, we are stepping up and out of the program to get a better picture what is really going on and what is being accomplished. In many ways, a formative assessment is simply the second kind of assessment already mentioned. It is likely to be particularly successful if engaged in an action-learning setting.

By contrast, a summative assessment is conducted at the end of a specific period of time in the life of a program. This type of assessment is directed toward the complex and often elusive question of outcomes: has this program been successful? Have the stated outcomes been achieved? What type of impact has this program had in terms of the welfare of those for whom it was intended. The summative assessment can, in turn, be used to determine what we do in the near future or (if it is engaged when a program is at its end), the question might be framed as: "What do we do next time?"

We noted that assessments (when effective and influential) are guiding narratives for a program – whether they are formative or summative in nature. It is not enough for an assessment report to contain numbers and charts. This report must tell a coherent and compelling story—often by engaging a metaphor that yields insights or at least important questions regarding the program or organization being reviewed. In the case of assessments regarding programs intended to treat emotional and mental disturbances, the metaphors being used are often quite powerful and highly influential.

We have attempted to identify and reflect on several of these metaphors in the previous essays in this series. Are the disturbances a result of spiritual deviations (the devil's evil work), blockage in the flow of energy (one of the five elements), social deviations ("madness") or mental illness. The story told about a patient's "Illness" helps to guide strategy for treatment. Images of a patient 's "psyche" produces theories and whole textbooks on personality that impact the formation and maintenance of various schools of psychotherapy. And, most importantly (for this essay), metaphors are inherent in the classification being employed in DSM.

Here is the fundamental challenge to be faced in the use of any compelling assessment. The metaphor can, appropriately and effectively, be used to guide the tactics and strategies being used in a program (including a clinical treatment program); however, the metaphor can be changed as the program (treatment) progresses. This is where an ongoing formative assessment process becomes so important. The metaphor is essential—but should not be taken as the "truth." Action-learning and meta-reflective processes help to ensure that the metaphor being used is helpful but not restrictive regarding the capacity to challenge underlying assumptions and modify what is being done to serve the intended client population.

One final point regarding assessment. It is critical that data do not come from just one source or be produced through the deployment of just one method. Even two sources and two methods are not enough—for what do you do when each of these sources or methods produces quite different results? If there are three sources and three methods, then it is likely that two of the sources and methods will yield similar results—and the "outlier" source or method provides an important alternative perspective. This fundamental multi-source/multi-method tenant of effective assessment is called Triangulation. In anticipation of the application of our analysis of assessment

processes to our critical analysis of diagnostic processes (and DSM in particular), we can apply Triangulation to a clinical setting.

What might be the three sources of information used in clinical work? One source can be the therapist and a second source can be the patient/client. How often do we actually take seriously the perspective offered by our patients/clients? Two noted psychotherapists, Irvin Yalom (2012) and Louis Breger (2012), suggest that we should. The perspective offered by our patient/client might differ in important (and insightful) ways from our own perspective and narrative about what has occurred in a therapy session.

What would be the third source? It might be the test report—this is often a self-rating done by the patient/client (so is not always a unique third source). The third source might instead be the perspectives on our patient/client offered by a referring clinician or our own clinical supervisor. Triangulation leads us inevitably to the value inherent in the rule played by a supervisor—regardless of our level of expertise and experience.

What about methods? These might be our direct observations of our client. A related method can be participant/observer. We note our own reactions to the person we are treating, rather than (or in additional to) observing our patient/client's behavior. A second method can be the test that we administer (it can serve as both a source and a method). What is the third method? As in the case of a third source, Triangulation yields something of a challenge for many clinicians. A third method might be an audio or video recording of the session we just conducted (and are now reviewing). This review of a recording becomes a way for us to "distance ourselves" a bit from the therapy session. We can more truly become an observer of our own behavior as well as the behavior of our patient/client.

There is another method that might be used—this is the review of existing documents we have about the patient/client that are not specifically related to the therapy session itself. For instance, when does the patient/client show up for the therapy appointment and how quickly do they pay their therapy bills (if there is not a third-party payer involved)? What type of outfit do they wear when coming to the session? This review of documents is often called an "unobtrusive" method,

though as therapists we know that all of this is highly “obtrusive” and closely related to the therapeutic process.

Nevertheless, document review is a bit different from direct observation, participant-observation or testing. This focus on Triangulation leads us to a final critical question: are all three sources and methods being deployed when a DSM diagnosis is being made? We will be returning to this question repeatedly in this essay and the next essay as we address the opportunities and challenges associated with use of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

I would suggest, in summary, that the distinction to be drawn between diagnosis and assessment can be captured in the artistic analogy that (as we have already mentioned) defines the purpose of this essay and the next essay in this series. Diagnoses are essentially intimate portraits that are rendered to help us capture the unique features of one person’s pathologies. An intimate rendering is also being offered in our next essay on the assumptive worlds of psychopathy that focuses on the actual experiences of senior clinicians in using DSM.

By contrast, assessments are broader landscape renderings that help us capture the way(s) in which a specific pathology fits into (and is often at least in part induced by) the environment in which the person being diagnosed must operate. This essay is itself a landscape rending, with DSM being placed in a broader societal context. Now, with this brief foray into the fundamentals of both diagnosis and assessment, we are ready to focus specifically on DSM.

Diagnostic and Statistical Manual of Mental Disorders: Current Status

At the present time – and for the foreseeable future, DSM is the official diagnostic classification system in the United States. It is likely to go through future revisions— but will continue to be the “bible” of mental health. We purposefully use the term “bible”, for in many ways this document is treated with a great deal of reverence and is considered to be the definitive word from “on high” (in this case, its publisher, the American Psychiatric Association.

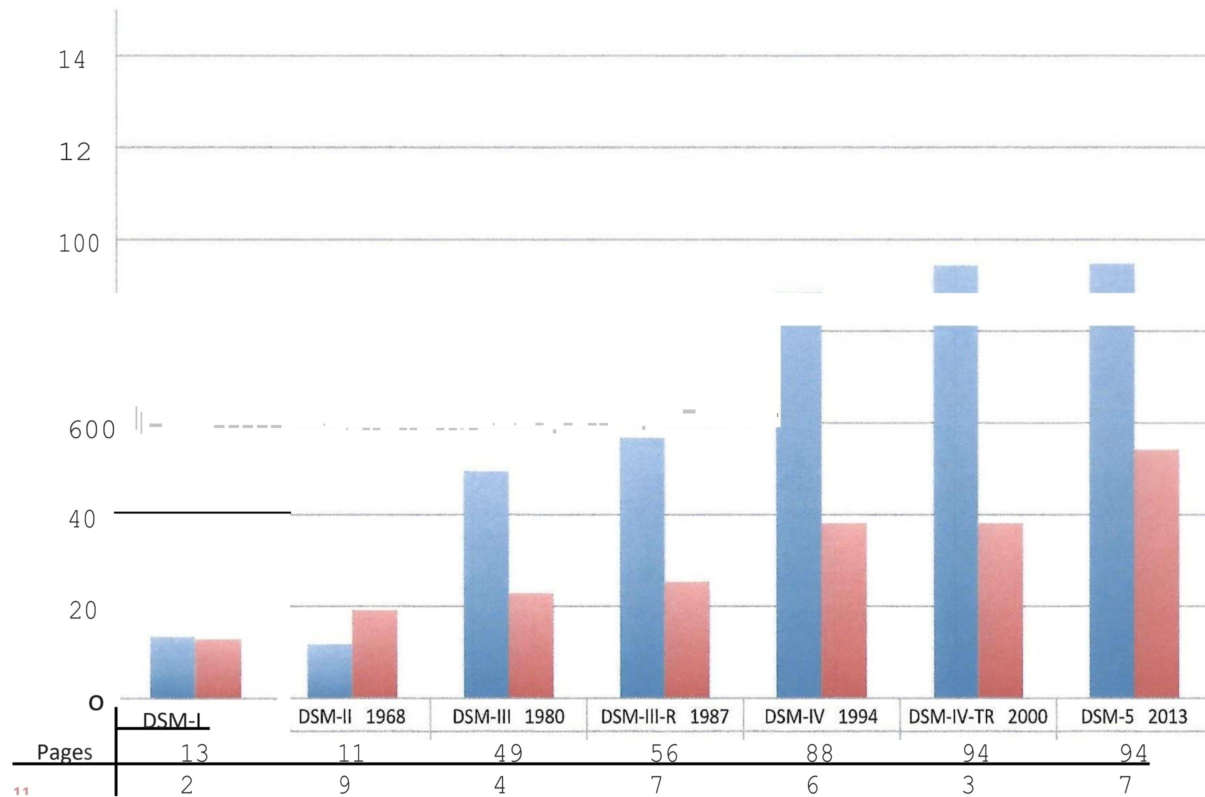
Like more traditional religious documents, DSM resides on a strong foundation and is encased and protected in a fortress that seems impenetrable. The DSM foundation consists of criteria and evidence assembled and validated by a notable group of mental health "authorities". Furthermore, the nature of the evidence that has been assembled is fully aligned with the methods and values of the paradigm (Kuhn, 2012) that currently prevails in the domain of mental health services.

The DSM fortress has been designed, built and maintained by not only the American Psychiatric Association—with all of its economic and political power—but also state and federal agencies who not only provide regulations but also funding that are guided by DSM. A similar fortress has been built in many other countries to protect the integrity and consistent application of the DSM.

Finally, there are the insurance companies which play a key role in determining economic funding of many mental health services in the United States. This third architect, builder and maintainer of the DSM fortress is unique to the United States (and a few other countries) that rely in part on third party reimbursements of mental health services.

One way to portray the successful introduction, expansion and protection of the DSM is to look at its history over the past seventy years. DSM-I was published in 1952. DSM-5 published in 2013. During this seven-decade interval, five other editions of DSM have been published (DSM-II, DSM-III, DSM-III-R, DSM-IV, and DSM-IV-TR). Here is a graph portraying the growth of DSM in terms of both number of pages in the manual and number of diagnostic categories being identified and described.

DSM Editions



As can be seen from this chart, DSM has truly been a "growth industry" regarding size and scope. There is an increasing number of pages and categories with each addition. Perhaps of even greater interest is the ratio of pages to number of categories. While both have grown, it is readily apparent that an increasing number of pages are being devoted to each category. It is also important to note that DSM, unlike many other "religious" documents, is constantly evolving. It has not remained static, as in the case of the King James version of the Christian *Bible* (or other versions of this Bible) and the *Quran* of the Islamic faith. In many ways, DSM more closely resembles the Jewish Bible, which is founded on the *Torah*, but contains many companion interpretative texts (the *Talmud* and *Midrash*).

The Expert Viewpoints of DMS

In a word, the viewpoints and opinions offered by experts in the field of mental health are *Varied.* Clearly, DSM is the gold standard in the field of mental health. It truly holds biblical power and is well fortified—but it is also controversial. Most traditional mental health practitioners would

admit that DSM is not perfect, resulting in the periodic updating of the document (this updating itself being quite controversial). While not perfect and controversial, DSM is reflective of the treatment challenges of mental health professionals. In many ways, DSM is treated in mental health practices and agencies like diagnostic categorization is treated in the traditional medical establishment.

At best, DSM is considered necessary for educational and insurance purposes, but it holds limited clinical utility. At worst, DSM is the product of a non-transparent and conflicted process. The Revision schedule is unpredictable. Furthermore, DSM establishes mental health diagnostic categorization and treatment options, that are United States centered, and not fully aligned with ICD (the International Statistical Classification of Diseases and Related Health Problems).

A Brief History and Critique of DSM

We offer a bit of historical background, as we have done throughout this series of essays on psychopathy. History tends to reveal something about the assumptive world that arises from specific events and social/political forces operating when and where emotional and mental disturbances are being identified, described, and treated.

Early 20th Century: The Pre-DSM Years

We can start by looking at the state of affairs operating in North America during the first years of the 20th Century. First, there were very few psychiatrists and virtually no psychologists or social workers focused on the treatment of those people with emotional or mental dysfunctions. The services that were provided tended to be offered in psychiatric hospitals. Only the most severely disabled men and women were sent to and confined in these facilities. The marginally "crazy" folks were tolerated in the community as "social deviants" (see our essay on the third assumptive world: Bergquist, 2019) and many were quite poor and homeless. Given the strong stigma associated with being "crazy", those "afflicted" men and women who did have home (coming from lower, middle or upper social-economic classes) were often were isolated and protected by their families—as has been the case in most other countries (often up to the end of the 20th Century).

The hospitals were primarily in the business of confinement rather than treatment. As "insane

asylums" there institutions were rarely expected to send rehabilitated people home. The "unfortunate" residents of the asylums were expected to remain there for life. Thus, there was little reason for diagnosis. Why determine cause or assign a category to someone who is not going to receive any specific treatment.

Why provide a prognosis when a resident of the asylum is expected to remain in the institution until they die (which is likely to be much sooner than would be the case if they were not confined in these often unhealthy environments). At most, there was the first gathering of statistics about how many people were admitted to the hospital—and there was the first tentative use of the term "mental illness" (after all these people were being admitted to a "hospital" and there were usually one or more physicians affiliated with the hospital).

This condition tended to exist throughout most of the first half of the 20th Century, though the returning soldiers from World War I with "battle fatigue" were often sent to a hospital or "soldier's home" (begun after the Civil War) and World War II produced many victims of "shell shock" that lead to a significant increase in the number of men (and some women) admitted to hospitals that specialized in the confinement (and limited treatment) of emotional and mental disturbance.

Early DSM

The significant increase in "mental health" patience in the late 1940s, created a crisis in the field of psychiatry and, more broadly, the newly emerging field of "mental health." Movies and books were produced that portrayed the horrible conditions in many hospitals—the movie, *Snake Pit,* being the most popular of these portrays. It now became clear that something more had to be done in the use of numbers and classifications.

With large funding now going to the treatment of mental health patience—especially returning soldiers—there was greater public awareness of and concerns about mental illness. The Veterans Administration was established, and a new, more consistent classification system was called for. Within the United States, there were actually three competing classification systems. The military was using the Armed Forces Nomenclature, while a 1942 system (the Standard

Classified Nomenclature of Disease) was used with the Civilian population. Finally, the Veterans Administration had its own classification system. None of these were fully aligned with the systems being used in traditional medical settings (as is still the case).

What was to be done? As often seems to be the case when there is a major crisis in a specific society—and when the existing assumptive world is being challenged, a commission was convened made up of "experts" in the field. These commissions were often at least implicitly given the charge not so much of challenging and changing the existing set of assumptions, but rather of repairing the dysfunction of the existing world and patching up the cracks that have appears so that everything can proceed without further controversy or internecine warfare. Such was the case when the American Psychiatric Association convened a commission to establish a common and consistent classification system for mental illness.

The APA Committee on Nomenclature and Statistics prepared a report in 1952 that led to the first version of DSM. A first draft of DSM was sent out to about ten percent of the members of APA (but not other mental health professionals) for their approval. Virtually, all of the respondents approved of the draft and DSM was firmly founded and now fortified by those with the greatest authority (accepted expertise) and clout (access to governmental legislation and funding) A second draft was produced and approved by the APA membership in 1951. DSM-I ended up being 145 pages long and included a total of 106 disorders—substantial but nothing compared with the length of and number of classifications offered in later editions.

Perhaps it is most important to note that the first DSM version tended to be aligned in structure with the classification system being used by the traditional medical community. In fact, many of the descriptions of mental illnesses were borrowed directly from Medical 203 (a widely used and accepted document in the medical field). If we are going to treat emotional and mental disturbances as "mental illness" then we need to look a lot like the physicians. The first versions of DSM were also closely aligned with psychodynamic (psychoanalytic) perspectives on mental illness. The more behavioral and cognitive perspectives on mental illness had not yet been firmly established in psychiatric and clinical psychological practices.

Fundamental to this psychodynamic perspective is the assumption that some (though probably not all) forms of mental illness can be attributed not to physiological dysfunctions, but rather to early life experienced. Inspired, in particular, by the work of Adolf Meyer, the psychiatric and psychological community in the United States was turning toward what today is often identified as a biopsychosocial model of mental illness (Satterfield, 2013). While there was an emphasis in DSM-I on organic and psychotic disorders, the world of mental illness that was not physically based had entered the picture.

This more comprehensive model, in turn, meant that some mental illnesses could be treated with something other than medications and physical interventions. A broad categorization of mental illnesses was required. Thus, of great importance, was the division in DSM of mental illness into three categories that were associated closely with the psychoanalytic perspective. These three categories were (1) neurosis, (2) psychosis and (3) character disorder. The foundation for this tripartite categorization was firmly established for it was used not only in DSM-I but also Medical 203. Underlying this fundamental categorization are a set of assumptions about the appropriate treatment (or nontreatment) modalities associated with category—and these assumptions are directly related to the state of psychoanalytic practices at the time.

It was during the 1950s and 1960s that an assumption was often made that anything categorized as psychosis would require formal medical intervention and often institutionalization. It is inside a mental hospital that a heavy medical regiment can be implemented, often complemented with other physical interventions, such as electro-shock and even surgery (lobotomies). By contrast, a mental illness that was categorized as neurosis could be treated through use of "talking cures" (psychotherapy) and institutionalization was rarely required (usually only with the threat of self-harm).

Only a few psychoanalytically oriented therapists, such as Harry Stack Sullivan, would dare suggest that a talking cure could be used to successfully cure a psychosis (such as schizophrenia) (Sullivan, 1974). Thus, the diagnosis of someone seeking assistance with their emotional or mental disturbance make a big difference regarding not only the treatment method being engaged, but also the residency of the person being treated. Diagnosis suddenly became very important – and a

valid and consistent diagnostic tool such as DSM had to be invented and fortified given the critical nature of this point of decision.

This is where the distinction between diagnosis and assessment becomes salient. DSM is not intended as a tool for assessment of the environment in which psychopathy takes place. There is no room for looking at a neurotogenic or psychotogenic setting in which the client/patient is living. These odd terms were not even used during the 1950s and 1960s (and still aren't being used). The closest thing to these terms was schizophrenogenic—which as used to describe families and institutions that produce schizophrenia (a concept that is currently in disrepute).

Psychopathy was (and still is) assumed to be a personal condition, not a condition of the environment in which one lives. We only begin to get a taste for this environmental (assessment-based) categorization when addressing the issue of "institutionalization" in a mental hospital: the pathology that is manifest in many patients after the first few months of institutionalization often overshadows their entering pathology. This dynamic is dramatically portrayed in the novel, play and movie, *One Flew Over the Cuckoo's Nest,* and in the accounts of many patients in mental institutions (to which we turn in a later essay in this series).

What then about the third category: character disorder? This category was not only an assemblage of diverse, dysfunctional behavior patterns and a source of considerable controversy and modification over the past 70 years—but was also carrying considerable freight in terms of the assumptive world in which it typically resided. The third assumptive world, social deviation, that I identified and described in a previous essay in this series (Bergquist, 2019) is prevalent. It seems that character disorders are often considered dysfunctional not because they are considered harmful to the person with this "disease", but because of the potential harm the behaviors resulting from this disease have on other people and society in general.

It is typically assumed (even today) that character disorders cannot easily be treated with psychotherapy (as is the case, supposedly, with neuroses); not does institutionalization do much good—except to keep the person out of the general public. *One Flew Over the Cuckoo's Nest* describes the way in which one person with a "character disorder" (Randle McMurphy) can create

mayhem in a carefully run and dictatorial mental institution (the novel and movie being based on actual practices in two mental health institutions in California and Oregon).

A similar portrayal was more recently offered in the Television series called *House*. The protagonist in this series, Gregory House, is a physician who was himself hospitalized for a short period of time. During his residency in the mental institution, House terrorizes everyone—staff and patients. You certainly want to keep someone like McMurphy or House out of your mental hospital. If they were admitted during the 1950 and 1960s, then constraint of their behavior was critical. During the time of *Cuckoo's Nest*, heavy medication (often Thorazine), electroshock and eventually lobotomization were often (tragically) used for this constraint and control.

Later DSM

Up to this point, we have been focusing on the foundation of DSM and its initial three-fold categorization system. We turn now briefly to the fortress that was being built around DSM as it became a central player in the American mental health community—and eventually in other mental health communities around the world. First, it is important to note that the fortress was indeed built by the medical community. The psychologists, social workers and other mental health workers had little clout and controlled none of the purse strings. The medical schools were teaching DSM (now in its third iteration). A substantial number of other publications were being prepared to supplement and provide interpretations of DSM. By the time that DSM-III was published, it had become the "Bible" of American mental health.

Let's take, for example, a short manual published by the American Psychiatric Association (APA), called *Diagnosis and Treatment of Anxiety Disorders: A Physician's Handbook* (McGlynn and Metcalf, 1989). First, it is noteworthy that this manual is intended from use by physicians and was edited by two medical doctors with all articles written by physicians. An expansive APA editorial board populated by physicians and an association with the US Food and Drug Administration ensures that everything is credible and aligned with APA's assumptive world of "mental health". The world of mental health and DSM is well fortified in this handbook. Published as a spiral-bound guide with thick, lacquered pages, the Anxiety Disorders handbook is meant to be used—rather than put on the shelf. This handbook exemplifies the important role played by interpretative texts as companions to and fortifiers of the "biblical" DSM.

The first section of the book is devoted to diagnosis and DSM-III-R provides the guidance. While this book is touted as a "new approach to anxious patients", it doesn't veer far from DSM and, to the credit of DSM, encourages a "comprehensive" diagnosis: "The DSM-II-R system of diagnosing anxiety and other mental disorders encourages the clinician to make a comprehensive diagnosis, using five axes to identify essential elements of the patient's clinical profile." (McGlynn and Metcalf, 1989, p. 21)

While the initial three categories in DSM-I has now expanded to five, there is still a focus on the symptoms manifest by the individual person and little is done regarding the pathology of the patient's environment. What might induce and sustain the anxiety? This is a critical question that is not really addressed by these individual patient-oriented physicians.

By the 1970s, the National Institution of Mental Health in the USA was using DSM in its epistemological studies, while the Federal Drug Administration was using DSM as the major guideline for the use of specific drugs. Other federal dollars in the United States, being distributed to non-Washington based research firms, were closely tied in with DSM categorizations. With this increasing use of DSM as a research tool, there were now (in DSM-III) research criteria added to the growing volume of the DSM manual. Greater specificity was also to be found in DSM-III, resulting in a greater sense that this manual was credible and appropriate for use by these major government agencies in making important decisions regarding mental health in the United States.

While there were some folks outside the mental health establishment who were throwing stones at the mighty fortress protecting DSM, most of these stones just bounced harmlessly off the walls. The one set of stones that did seem to impact the fortress were thrown by those who were working with the soldiers returning from yet another war (Korea). The revisions of DSM-II were reflecting some of the concerns about the diagnosis of post-war trauma. The less influential dissenters included feminists who protested gender biases in DSM and those who declared that homosexuality was not a mental disease.

Other dissenters were pointing to important cultural biases in DSM—and this concern was becoming increasingly important as DSM was being used increasingly in other countries. It was only later that the fortress walls were breached, and intense controversy occurred inside the mental health community leading to some important changes in DSM. We turn now to these controversies and changes.

Current Challenges in the Use of DSM

By the turn of the 21st Century, strong opposing viewpoints were being articulated regarding both the process and content of DSM. Concerns were expressed from many elements of the mental health community regarding who was sitting at the table when decisions were being made regarding DSM categorizations and descriptions. The psychologists, clinical social workers and other nonmedical members of this community now had some clout and were benefiting from governmental and third party funding: DSM was making a real difference in the financial life and choice of treatment strategies for these professionals and they wanted to be at the table.

There were also major concerns voiced about the content of DSM. While there are many sources of these concerns and many areas in which controversy has arisen, we will focus on just two: (1) homosexuality and gender identity, and (2) post-traumatic stress disorder. We also turn to the challenges posed at the present time by two major sources of societal disruption and potential mental illness: (1) COVID-19 and (2) racism and political polarization.

Sexual Orientation and Gender Identity

The contemporary societies in which most of us live are now experiencing a growing recognition, acceptance, and even open support for those members of society who are homosexual, bisexual or transsexual. The LGBTQ community is alive and well—public recognition is here to stay. There is also recent and growing recognition and acceptance of diffuse gender identity—the desire of some members of our society to break out of traditional gender categorizations and constraints. With this shifting societal perspective regarding sexual-orientation and gender identity comes many challenges in all domains of society—including mental health. When it comes to the diagnoses of nontraditional sexual-orientation and diffuse gender identity as mental illnesses, we witness a "perfect storm" in the collision of all the assumptive worlds identified in our previous

essays.

For some people, nontraditional sexuality and gender diffusion are spiritual aberrations. It is a "sin" to be queer in any way—all categories of LGBT are God-less or even God-defying. God has assigned us a gender and sexual orientation and any attempt to change this assignment is a declaration of war against God. The history of this spiritual/religious warfare is legendary and profoundly disturbing. Yet, the religious institutions and religious zealots have not controlled the dialogue about LGBTQ and gender diffusion, for there are just as many people and secular institutions that are aligned with a second assumptive world: being "queer" is a social deviation. These people aren't "sinners"; rather, they are violators of the law and clearly wish to bring about the collapse of our current social order. We must all declare ourselves as "male" or "female". If we refuse this categorization—if we insist on being gender neutral-- then many social structures and regulations will be trampled.

Is it a matter of gender confusion? If this is the case, then we can readily diagnosis this problem as a "developmental Issue' that can be treated with some counselling or therapy. However, what if it is a matter of gender diffusion or even indifference? What do we do about those people who want to live with a shifting sense of gender identity ("sometimes I feel like a man and sometimes like a woman and sometimes I feel like neither male or female").

I am reminded of the powerful tale that Ursula LeGuin (2016) offers in *The Left Hand of Darkness*. She portrays a world in which gender can change from moment to moment and in which people spend most of their time in a state of neutrality (they are not always "in heat" as are we Earthlings who insist on always being male or female). This shifting stance is troubling to many members of our society, as is the third stance—which is an indifference to gender. It simply makes no difference. How is this possible in a world that requires us to be male or female and that has this distinction embedded in all aspects of life and culture (including language, clothing, and manners).

It is even more frightening (though perhaps less deeply disturbing) with regard to sexual orientation. If members of the LGBTQ community have their way, then the traditional family structure which is critical to the stability of our society will be challenged and will potentially collapse. There must always be one father and one mother to raise a child. Any variant on this

fundamental premise is unacceptable. The deviation is even more threatening, for these men and women seek to abuse our vulnerable children both physically and mentally. Members of the LGBTQ community are intent upon "preying" on those in our society who are looking up to adults as trusted role models. Isolation in prisons might be required for these even more extreme deviations.

We still are not done. Advocates for a third assumptive world enter the dialogue. Those who are "queer" should not be faulted. They are simply victims of a "disease." There is something wrong with their genes, their hormonal system or their neo-natal development. It is simply not "right" that anyone is confused about their sexual orientation or, more profoundly, their gender identity. We should not shame these "queer" people nor should they be ostracized. Rather, they should be medically treated. With the proper medication or perhaps surgical intervention, we can do something to alleviate the disorder. In this way we are being profoundly humane (but wrong).

Even advocates of our other assumptive world, that views psychopathy as a blockage of energy or clarity regarding reality can enter the dialogue regarding homosexuality and gender identity diffusion. While many Asian cultures are tolerant regarding sexual and gender orientation, there is still the lingering sense that somehow there is something wrong with the way in which energy is accumulated and engaged in matters of human sexuality or there is a distortion in one's orientation toward their own identity or the more general reality of gender and sexuality. We don't necessarily have to do anything about this disorder—but should recognize that it is not part of the "normal" state of nature and humankind.

How then does DSM enter the picture, given these differing, long-standing and often passionately advocated perspectives on sexual-orientation and gender identity? First, it should be noted that DSM enters this fray with caution and considerable confusion. There is no other area of DSM that is fraught with as much controversy as the matter of sexual orientation and gender identity. Fundamentally, it is a matter of determining whether any form of being "queer" or gender neutral is to be included in a DSM manual. The pathology might reside not in the individual who is "queer" or gender neutral, but rather in the society that treats this person in a manner that is profoundly biased and often fundamentally inhumane. Perhaps we need a DSM that focuses on societal pathologies, rather than just personal pathologies.

This does not mean that our current DSM classifications are irrelevant to the broader assessment of being "queer" in contemporary societies. Clearly, the pathology of contemporary societies help to create or at least exacerbate a variety of mental health issues among those who are "queer" or gender neutral as well as those family members and friends who are living with (and hopefully provided support for) the LGBTQ or gender neutral person.

These issues might include diffuse anxiety, depression and even paranoia. There might be specific traumatizing events that are associated with societal intolerance and ostracism escalating to physical and emotional violence. Clearly, any DSM diagnosis of sexual orientation or gender identity diffusion must be embedded in a broader assessment-based understanding of the social context within which LGBTQ is operating and in which a stance regarding gender identity is being taken.

Posttraumatic Stress Disorder

It is interesting and perhaps instructive to trace the use of terms to label and describe the kinds of emotional and mental dysfunctions that accompany the stress and threat inherent in combat and directed involvement in warfare. The term "Shell shock" was coined during World War I not by an American psychiatrist, but rather by a British psychologist Charles Samuel Myers. Building on several commonly used expressions ("I am shocked" or "I am in a state of shock"), this term was used to describe a particularly intense form of "shock" that left returning soldiers with confusion of thought (dysfunctional mental processes) often accompanied by a dampening or intensification of emotions (dysfunctional emotions).

A different term was used to label a similar outcome of combat following World War II. The new term was "battle fatigue". The typical description of this form of fatigue was a bit more detailed then that used to describe "shell shock." The person diagnosed with battle fatigue was typically numb at first when returning home (or recuperating in an armed forces hospital. This numbness often yielded to a state of depression as well as excessive irritability. Horrible nightmares often were experienced, and the fatigued ex-soldier often was "trigger-happy" leaping up or running way from any loud sound. The depression was often accompanied by "survivor guilt" (why am I alive and well when my comrades were severely wounded or died.

It is quite understandable that both terms were aligned with a military perspective. "Shell shock" identifies the experience of a shell exploding in one's presence, while "battle fatigue" clearly described the physical and emotional drain of energy that accompanies not only action but also inaction (freeze). Stress is fatiguing, especially when accompanied by a sense of helplessness. The emotional casualties of war clearly called for a new assumptive world that was founded not in a sense of spiritual aberration, the blockage of energy or distortion of reality, social deviation—or even mental illness.

The assumptive world of shell shock and battle fatigue was one of warfare. This assumptive world requires a powerful and evil enemy, the myth of bravery and valor, and a yearning for a peace that never seems to arrive. It is an assumptive world that is also occupied by the "war on poverty", the "war on drugs" and the war against anyone who is an "other" (racial, ethnic, gender, socio-economic level, and on and on).

What happens when our society introduces a new term (following the Korean War and, in particular, following the Viet Nam War). The new term is "posttraumatic stress disorder" (PTSD). Note the language being used. Three of these words come from the medical community: "traumatic", "stress" and "disorder." Our fourth assumptive world of mental illness has taken command: "move over military, we are now claiming the turf!"

The new label conveys not only something about the source (etiology) of the "disorder" (a traumatic event or lingering stay in a traumatizing environment), but also the ways in which this disorder relates to broader physical processes (the role played by stress). This framework makes it ripe for DSM to step in, for this diagnostic process is founded primarily on the observation and categorization of symptoms. And what are the symptoms? Many are the same as those observed during both World War I and World War II.

There is an important distinction to be drawn, however, that is contained in the fourth word ("post"). This is a disorder that is not about the immediate manifestations of emotional and mental dysfunction that takes place on the battlefield. We know that emotional and mental functions often operate at a high level in the midst of war. Adrenaline and other hormones and neurochemicals prime the pump for effective, immediate action. Fear and threat can drive action which is the natural and adaptive response to be taken by any organism.

It is at a later point, when the threat is relived and when no further action can be taken, that the adrenaline and related neurobiological changes create havoc and illness (both physical and mental). As Robert Sapolsky (2004) has noted, human beings are quite adept at imagining lions and reacting to these imagined lion as if they actually exist. In the case of PTSD, the lion might have been real at one point in time or at many points in time (there really was a threatening enemy); however, the lions (threatening enemy) is now being remembered (rather than being imagined or encountered in reality). Whether real, imagined or remembered, the lions produce reactions that are not helpful under the second or third condition.

DSM seems to fit beautifully in the domain of PTSD. It is through the DSM diagnostic process that we can classify the symptoms being observed and point to the established procedures for treating this “disorder.” Furthermore, the domain of PTSD is growing. We now assign this label to the disorders that arise from many other traumatic events or enduring life in a traumatizing environment (family, organization, society). While PTSD and DSM diagnoses of PTSD is clearly a “growth industry” in the field of mental health, there is a major roadblock to be confronted or (as is often the case) ignored. It seems that PTSD is not a personal malady (though some people are more prone to this “disorder” than other people); rather, it is an environmental malady.

The symptoms of PTSD probably would not have afflicted this person if there was no war, no dysfunctional family, no sexually abusive uncle, physically and emotionally abusive mother, or cruel and vindictive boss. This means that individual diagnoses of PTSD, using DSM, is inadequate—especially as a source of guidance for the treatment of this “disorder.” Immediately, there might be critical to remove the PTSD patient from the abusive setting. Over the longer term, we must seek to remove the abusive boss, provide counselling (or incarceration) to the abusive family member—or work toward the elimination (or at least reduction) of war.

All these actions require that we better understand the nature of the system in which the trauma took (and may be still taking) place. This requires assessment as well as diagnosis. This requires that we look beyond the individual and seek a fully appreciation of the whole, rather than just the dissected part (the PTSD patient). The traumatized ex-soldier, like the smashed frog’s leg, is only one part of the puzzle that must be solved. The traumatized daughter is only a part of the traumatized and traumatizing dysfunctional family.

A systemic, holistic approach must be taken that requires assessment—not just isolated DSM diagnosis. Triangulation might also make sense, with multiple sources being accessed to help describe the tale of trauma for a specific person or a category of people. Multiple methods could also be used to gain a more complete picture of what the trauma looks like, feels like and is lived with. At least the military-based assumptive world of shell shock and battle fatigue came with full recognition that it is a matter of war and not just personal illness. Furthermore, the descriptions of these war-related ailments often came from many sources (including novelists and movie makers)—not just the medical community

COVID-19

There are many dysfunctional behaviors associated with the COVID-19 outbreak. They range from the benign, but seemingly antisocial hording of medications and supplies (such as toilet paper and disinfectants), to the failure to observe social distancing and the wearing of masks that protect other people from infection. At a more extreme level, there is the anxiety associated with the threat of becoming infected to the profound fear (even paranoia) of contacting other people, resulting in an inability to leave one's home. In each of these instances, there can be a DSM-based diagnosis and at least in the case of anxiety and social phobias a treatment plan can be formulated based on this diagnosis.

It is important to note, however, that an individual diagnosis in the case of a virus-related pathology is clearly inadequate, for this pathology must be viewed within a much broader context. In these cases, pathology exists in the society, not just in the individual. Diagnoses must be accompanied by (or even superseded by) assessments. We must know more about what is happening in the world if we are to understand and do something about what is happening in the individual.

Thus, at the end of the day, we find that DSM can't really handle the complex, systemic nature of COVID-19. A sick and anxious child or grandparent is not the disease—rather this person is the symptom of a much bigger and much more challenging disease which is the pandemic virus. We need an assessment rather than a diagnosis to be in any way successful in addressing the mental as well as physical illness created by the virus. Once again, Triangulation might prove useful, with multiple sources and methods being deployed to gain a clearer and more complete perspective on

this virus (enabling better preparation for future viruses).

It should be noted, however, that multiple diagnoses (using DSM) could be assembled to help address some aspects of a systemic assessment. For instance, what is likely to be the most common psychological/psychiatric response to the current virus? Are we most likely to find phobias, depression or paranoia and are any of the DSM diagnoses likely to be more prevalent within specific regions, cultural groups, social-economic groups, or nations? This would be a wonderful way in which diagnosis and assessment might join in a collaborative dance leading to both understanding and cure.

Prejudice and Authoritarianism

This leads us to a final topic that might be the most challenging in our current deeply troubled world. At a recent meeting I attended, one of the members asked if racism could be classified as a mental illness. What about, more broadly, the appearance of prejudice and authoritarianism in the perspectives and behavior of an individual?

On the one hand, the diagnosis would not be particularly difficult. Many tests have been produced and validated over the years that are associated with these personality factors—beginning with the F scale which served as a base for one of the most important (and controversial) social psychological studies ever conducted—and reported in *The Authoritarian Personality* (Adorno, *et. al*, 1964). Furthermore, this diagnosis could be supported and fully reinforced by an assumptive world of social deviance. Many behavioral scientists and political policy formulators would love to place a scientifically validated label on people whom they consider "abnormal" and despicable.

On the other hand, this assignment of a label and associated condemnation is fraught with problems regarding bias and polarization. Most of the studies and descriptions of prejudice, authoritarianism and racism come with a left-wing bias and agenda. There is little in the way of research on the prejudice to be found at the extreme of the liberal political perspective. We do find in the work of Milton Rokeach (1973) a recognition that both the left and right extreme of the political spectrum can be closed minded. What specifically is the case with racism? Is this only a "pathology" of the right-wing? Is there a virulent form of racism to be found across all political

perspectives? And what do we do with this "pathology" once it has been diagnosed? As in the case of sexual orientation, gender identification, trauma and pandemic viruses, we might find that what we wish for is not something about which we can do much about if granted the wish.

Conclusions

There is a song in the Broadway musical (and movie) called West Side Story. The song is called "Dear Sergeant Krubske" and it is sung by a bunch of "juvenile delinquents" who are commenting on the many diagnoses that have been assigned to their behavior. One of the delinquents (Action) lets Sergeant Krubske know that they are "psycholgic'ly disturbed" because of their parent's pathology. Diesel subsequently suggests that they should be taken to a "headshriker". The psychiatrist, however, determines that it is a sociological problem. "Society's played [them] a terrible trick." So, these "punks" have a "social disease" and need to be seen by a social worker. However, the social worker determines that these delinquents are just lazy and "deep down inside" they are no good! So how do we diagnosis the "mental illness" that inflicts these young men and results in bad behavior? What should be done with them? Therapy? Disciplinary action? Jail? Is this not also the case with a DSM diagnosis that is detached from a broader environmental and societal assessment?

In this essay, we have been operating a bit like the juvenile delinquents in West Side Story. We have been questioning the labels assigned to people in our society who are declared "mentally ill." While there are many benefits to be found in the use of DSM as a diagnostic tool, there is much more to be done in the broader assessment of psychopathy. In essence. we have just provided the first draft of a broad-based assessment of DSM and its past and present use.

In providing this first draft, we have identified some of the initial broader based assessment questions to be asked. In the next essay, we move from this broad-based landscape rendering to a more intimate portrait of DSM as it is actually perceived and used by clinical practitioners around the world. We hope that the landscape rendering along with the portrait moves us to a clearer understanding of and appreciation for the strengths and weakness associated with the assumptive worlds of psychopathy.

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