Chapter 5

Disorders Versus Problems of Living in DSM: *Rethinking Social Work's Relationship to Psychiatry*

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The relationship between social work and psychiatry is already an intimate one, to the point of provoking controversy about whether psychotherapeutic treatment of mental problems is swallowing up the broader social work field (Specht 1990; Specht and Courtney 1994; Wakefield 1992c, 1992d). Nonetheless, I believe that in the future we can expect to see social work and psychiatry enter into an even more integrated relationship than now exists. This further intertwining will occur, I maintain, not primarily for reasons of professional self-interest, turf wars, status, reimbursement incentives, or even cost containment. The reasons go much deeper and concern the very conceptual foundations of the two professions and fundamental flaws in the current approach to psychiatric diagnosis.

The *DSM* and the Mission of Psychiatry

To understand social work's relationship to psychiatry, it is essential first to have a clear view of the nature of psychiatric diagnosis and where it has recently gone wrong. Psychiatry is by definition a medical profession that

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deals with mental disorders. If psychiatry is to be a viable medical discipline, it must distinguish mental disorders—that is, conditions in which something has gone wrong with how the mind is supposed to work—from the many other problems of living with which human beings must contend. "Disorder," in the medical sense, refers only to those negative conditions caused by an internal dysfunction. A dysfunction occurs when something goes wrong with the functioning of some internal mechanism, so that it is no longer capable of performing its natural function—the function for which it was designed by natural selection (Wakefield 1992a). For example, when the heart cannot adequately pump the blood to oxygenate the cells of the body, that is a dysfunction, because the heart was naturally selected to perform that task; and when the eyes cannot see, that is a dysfunction, because the function of the eyes is to make one capable of seeing. A mental disorder occurs when the dysfunctional mechanism is one of those psychological mechanisms that form the "mind," such as mechanisms concerned with motivation, perception, thinking, emotion, language, learning, socialization, and other basic psychological functions (these mechanisms are still largely unknown, but through observation of human capacities we can infer that they exist). When such a mechanism breaks down and becomes incapable of performing its functions, a mental dysfunction has occurred; if the dysfunction causes harm to the individual, there is a mental disorder. Thus, mental disorders are harmful mental dysfunctions (Wakefield 1992a, 1992b, 1999; Wakefield and First 2003).

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (APA 1994), is used throughout the mental health professions as the standard for psychiatric diagnosis. In addition to its function of listing and briefly identifying and describing the various categories of mental disorders that clinicians and researchers might confront, the *DSM* has the additional function of operationally defining each disorder in terms of a set of diagnostic criteria that are supposed to constitute the necessary and sufficient criteria for correct diagnosis of the disorder. These criteria are tremendously influential in all areas of the mental health field and in many other settings as well, such as research, epidemiology, eligibility for disability benefits, and law.

The *DSM* specifies that psychiatric disorders must be caused by a dysfunction in some internal mental mechanism; that is, something must have gone wrong with the workings of the individual's mind (Spitzer and Endicott 1978). The *DSM* defines psychiatric disorders in terms of criteria that generally refer to observable symptoms. Symptom-based criteria have been embraced because they are considered the best way to achieve the *DSM*'s twin goals of reliability (i.e., the criteria should lead to the same diagnosis every time, no matter who is using them) and theory neutrality (i.e., the criteria

should not be based on concepts that are special to any one unproved theory of etiology).

The *DSM* itself provides a definition of mental disorder that underscores these points. The *DSM* asserts that mental disorders, like all medical disorders, are distresses or disabilities resulting from internal dysfunctions (1994:xxi).

Obviously, there are many ways that internal mental mechanisms can go wrong. For example, the mechanisms that mediate sadness responses can produce deep sadness reactions despite the lack of an appropriate environmental situation that would warrant the sadness, causing depression. The mechanisms that generate appropriate fear and anxiety responses to environmental dangers may fire inappropriately, leading to panic attacks and generalized anxiety (Barlow 1991, 2001). The brain mechanisms responsible for producing rational thought may break down, leading to psychotic conditions. The mechanisms that allow children to be socialized and to internalize moral rules may not function properly, and thus some children may suffer from disorders of conduct. And attentional mechanisms or learning mechanisms may not function properly, yielding attentional disorders and learning disorders, respectively. Just as physical mechanisms sometimes do not function as they were designed to function and thus cause physical disorders, so mental mechanisms may also break down and cause mental disorders.

Note that nothing in the *DSM*'s definition of disorder in terms of internal dysfunction implies that all mental disorders must be physiological disorders. Just as computer software can malfunction even when the underlying hardware is functioning flawlessly, so, in principle, the mind's "programming" might become dysfunctional for reasons other than that there is a malfunction of underlying brain mechanisms. For example, a sequence of experiences ("inputs") that the programming was not designed to handle might occur, leading to dysfunctions in some mental processes, as in post-traumatic stress disorder.

The *DSM*'s definition of mental disorder emphasizes that the distress, disability, or other harm warranting a condition's classification as a disorder must occur as a direct result of a dysfunction and not just because society disapproves of the person's condition or for other reasons originating in interpersonal or social conflict. This last requirement is meant to preclude the misuse of psychodiagnosis for sheer social control purposes. For example, the Soviet Union classified many political dissidents as mentally disordered, incarcerated them in mental institutions, and "treated" them with sedating drugs. Many of these "patients" were clearly not really mentally disordered, even though they were socially deviant and they were in distress and socially impaired in their functioning as a result of their refusal to accept the tyrannical nature of their state. The *DSM*'s definition of mental disorder explains

why such cases are not genuine cases of mental disorder. These individuals' problems could not be attributed to a breakdown in the designed functioning of some internal mental mechanism but developed as their normal-range reaction to an unjust and adverse environment. They suffered not from internal dysfunctions but from the consequences of their courage in a repressive situation. The definition of mental disorder is supposed to distinguish true disorders in the medical sense from such problems caused by a normal response to a difficult environment.

An Inconsistency in the *DSM*

There is, however, a basic inconsistency in the *DSM*'s system that limits the effectiveness of its symptomatic diagnostic criteria. The problem is that for many categories of disorder, the diagnostic criteria for identifying specific disorders do not in fact satisfy the general definition of mental disorder presented in the *DSM*'s own introduction. Although the categories themselves are generally perfectly good categories of mental disorder, the criteria used to identify people as having those disorders do not in fact distinguish the genuinely disordered, who, according to *DSM*'s own definition of disorder, must have an internal dysfunction, from the nondisordered, who do not have internal dysfunctions of some psychological mechanism. The source of the inconsistency between the definition and the criteria is what systems theorists call "equifinality"; many different causes can lead to the same effect. In this case, the same symptoms can result from normal reactions to adverse environments and from mental dysfunctions. Thus, the very "symptoms" that would indicate a psychiatric disorder may instead indicate a normal response to an adverse social environment.

For example (see below for more elaborated examples), the same intense sadness that satisfies *DSM* criteria for the diagnosis of major depressive disorder could be indicative of a genuine depressive disorder in which something is wrong with one's sadness-response mechanisms, or it could result from a normal response to a serious loss; the same antisocial conduct that satisfies *DSM* criteria for the diagnosis of conduct disorder or antisocial personality disorder could be indicative of a genuine mental disorder resulting from a dysfunction in, for example, the sense of empathy, or it could be the result of a normal response to adverse, deprived, or otherwise criminogenic environments; and the same intense anxiety that satisfies *DSM* criteria for a diagnosis of generalized anxiety disorder could be indicative of a genuine anxiety disorder that involves inappropriate triggering of anxiety response mechanisms or it could indicate a normal response to overwhelming environmental demands.

In these cases and many more, the "symptoms" of a normal response to an adverse environment, where nothing is wrong with the workings of the internal mechanisms, can satisfy *DSM* diagnostic criteria for the corresponding mental disorder. Yet such normal responses are not true mental disorders in the medical sense that the *DSM* embraces. Thus, *DSM* symptomatic criteria often do not successfully distinguish between true mental disorders (i.e., internal dysfunctions), which are within the domain of psychiatry, and problems in the interaction of persons and environments, which are traditionally within the province of social work.

To achieve the goal of reliable diagnosis that is theory-neutral, *DSM* criteria must be composed of easy-to-assess symptoms and behaviors that do not make reference to unobservable internal etiological processes. Thus *DSM* criteria do not generally say much about how the symptoms were caused. Yet, as noted earlier, the *DSM*'s definition of mental disorder requires not only that there be symptoms but that the symptoms be caused by an internal dysfunction, if the problem is to be viewed as a genuine mental disorder. This is why *DSM* criteria often fail to distinguish symptoms that indicate genuine mental disorders from symptoms that indicate normal reactions to adverse environments or other problems in living (Wakefield 1992a, 1992b, 1993, 1996).

The notion of relying on symptomatic "syndromes" to identify disorders makes some sense in physical medicine, where, on average, symptomatic conditions are very different and clearly delineated from normal functioning and the same symptoms tend to be caused by the same underlying etiology without too much influence of environmental context. But in the mental domain, neither of these generalizations holds true. As the above examples illustrate, the symptoms of many mental disorders often are very much like normal responses to extreme environments, and whether a certain symptom set is best presumed to constitute disorder or normality depends heavily on the environmental context in which the symptoms occur. Thus, within the mental domain, the symptom-syndrome approach to diagnostic criteria does not work as well as in the physical domain.

The result is that *DSM* categories in fact (contrary to their medical intent) go beyond disorders and overlap substantially with nondisordered conditions that have traditionally been seen as falling within social work's distinctive domain of person-in-environment problems, blurring the boundary between the two professions. This flaw in the *DSM* makes greater involvement of social workers in the mental health system inevitable. People with normal responses to adverse environments must be distinguished from people with breakdowns in internal mechanisms, whether or not they are incorrectly labeled as disordered for reimbursement purposes. Effective treatment depends on such a discrimination of causes; the alternative is chronic misdi-

agnosis and mistreatment of nondisordered clients. Yet psychiatrists are neither motivated nor trained to deal with environmental diagnosis or treatment. As it becomes apparent that the symptoms that determine *DSM* diagnosis do not indicate whether a mental disorder or an interactional problem exists, it will become necessary to routinely involve social workers and psychiatrists in teams that can diagnose and treat both internal dysfunctional causes and interactional, environmental causes of a patient's symptoms.

Examples of Invalid Criteria Sets That Fail to Adequately Discriminate Normal and Disordered Responses

The problems described above occur in categories throughout the *DSM*. Let me offer a few examples:

Separation Anxiety Disorder

This disorder is diagnosed on the basis of symptoms indicating inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, lasting at least four weeks. The symptoms (e.g., excessive distress when separation occurs, worry that some event will lead to separation, refusal to go to school because of fear of separation, reluctance to be alone or without major attachment figure) are just the sorts of things children experience when they have a normal, intense separation anxiety response. The criteria do not distinguish between a true disorder, in which separation responses are triggered inappropriately, and normal responses to perceived threats to the child's primary bond because of an unreliable caregiver or other serious disruptions.

Substance Abuse

Diagnosis of substance abuse requires any one of four criteria: poor role performance at work or home due to substance use; substance use in hazardous circumstances, such as driving under the influence of alcohol; recurrent substance-related legal problems; or social or interpersonal problems due to substance use, such as arguments with family members about substance use. Contrary to the *DSM*'s definition of mental disorder, these criteria allow diagnosis on the basis of conflict between the individual and social institutions such as police or family. Arguments with one's spouse about alcohol or drug use, or between a child and his or her parent, are sufficient for diagnosis, as is being arrested more than once for driving while under the influence of alcohol or for possession of marijuana. These social problems and interpersonal conflicts need not be the result of mental disorders.

Learning Disorders

The sole basis for diagnosis of learning disorders is achievement test results that are "substantially below that expected." However, this criterion does not distinguish true learning disorders, in which some internal mechanism necessary for learning is dysfunctional, from problems of learning that occur because of family problems, lack of motivation, lack of adequate language skills, or other acculturation issues.

Major Depression

Diagnosis of major depression is made on the basis of a set of symptoms indicating an extreme sadness response. The criteria correctly contain an exclusion for uncomplicated bereavement (i.e., one is not diagnosed as disordered if the symptoms are the result of a normal-range response to having recently lost a loved one), but they contain no exclusions for equally normal reactions to other losses, such as a terminal medical diagnosis in oneself or a loved one, separation from one's spouse, or losing one's job.

Antisocial Personality Disorder

The *DSM* criteria for antisocial personality disorder are the following: in addition to having experienced conduct disorder before age fifteen, the adult must meet three or more of the following criteria: either inconsistent work history or failure to honor financial obligations, breaking the law, irritability and aggressiveness, impulsivity, deceitfulness, recklessness, and lack of remorse. These criteria do not adequately distinguish between career criminals and the mentally disordered. The criminal will satisfy the illegal activity criterion and possibly or even probably satisfy the work/finance criterion (criminal activity is not "work" as intended in this criterion), the deceit criterion (by the nature of a criminal career), and one or more of the impulsivity, recklessness, or irritability/aggressiveness criteria (by the nature of criminal activity).

Note that because our society tends to be more generous in reimbursing for medical ailments than for other problems of living that might be equally impairing, there is tremendous pressure on social service agencies to diagnose their clients as having mental disorders, whatever the reason that brings them into the agency. Reimbursement pressure puts a premium on looking at cases through a psychiatric prism, whether or not the condition is in fact a dis-

order. While pragmatically useful, this strategy raises complex ethical questions. Such pragmatic reimbursement-driven decisions to classify certain patients as having mental disorders do not necessarily reflect the clinician's best judgment that those patients do in fact have mental disorders (Kirk and Kutchins 1988).

Further Reasons for the Blurring of the Psychiatry–Social Work Boundary

There are several more reasons for the breakdown in professional boundaries between social work and psychiatry that warrant brief mention—one of them specific to the *DSM* and the other one more general. First, the authors of the latest edition of the *DSM* did perceive that there was a problem with validity, and they did attempt to deal with it. The main thing they did was to add to almost all the criteria sets a "clinical significance" requirement that the symptoms must cause clinically significant distress or impairment of social, academic, or occupational functioning.

However, that was the wrong medicine for the *DSM*'s ailment (Spitzer and Wakefield 1999). Normal responses to adverse environmental factors can also cause intense distress or impairment (for example, as the *DSM* implicitly acknowledges, normal bereavement can be as distressing and impairing as the disorder of major depression). In all of the above examples, the disorders and the corresponding nondisordered responses cause similar "symptoms." So the central problem with the *DSM*'s validity is not that the criteria do not require enough symptomatic distress or impairment but that such distress or impairment itself often does not tell you whether the condition is a disorder or a normal response. The distress or impairment requirement does, however, have the effect of making explicit a central feature of the *DSM*, which is that the judgment of whether a condition is a disorder often depends largely on assessment of social functioning. There is a *DSM* axis for rating social functioning, but I am referring to something different here; the symptoms in the diagnostic criteria themselves and especially the role-impairment part of the clinical significance criterion reflect issues in social functioning. Thus, the distress or impairment requirement further erodes the distinction between psychiatric disorders and those problems of social functioning that constitute the domain of social work.

Second, there is a more general reason for a breakdown in the distinction between the respective professional domains of psychiatry and social work. Internal mechanisms are designed to operate in certain "expectable" environments. Indeed, that is the heart of evolution; the organism's nature adapts to features of the environment. The concept of disorder is to some degree

based on the simple idea that sometimes something goes wrong with an internal mechanism and it can no longer do what it was designed to do. However, there is a hidden presupposition here—namely that the environment stays roughly the same in relevant ways, so that the internal mechanism could perform its functions if nothing was wrong with it.

The problem with this assumption is that humankind is so radically altering the environment that it is becoming less clear when a problem results from a breakdown in a mechanism and when it results from changes in the environment that make it impossible for the mechanism to perform its function. For example, pervasive anxiety may be a disorder in which internal anxiety-generating mechanisms start firing inappropriately, or it may be the response of normal anxiety mechanisms to unprecedented demands of modern life that did not exist when humankind was evolving. These are not exclusive possibilities, of course. However, as the environment changes, it becomes more difficult to tell whether symptoms indicate true disorders or failures of the environment to provide what people need to have in order to function adequately. Again, this means that the traditional roles of psychiatry and social work are becoming conceptually harder to separate.

A final source of confusion is not substantive but semantic. These days, the label "dysfunctional" is commonly used for all manner of negative behavior or mismatches between individual and environment; thus one can have a "dysfunctional marriage" or, if bored and distracted, be "dysfunctional at work." It is easy to confuse "dysfunctional" in this broad sense with "dysfunction" in the sense that warrants attribution of disorder. But this common use of "dysfunctional" does not in fact imply the existence of a dysfunction in the medical sense, which refers to something going wrong with some internal mechanism.

Implications: Toward a New Conceptually Based Partnership

What we see in the examples presented earlier, and in many other criteria sets in the *DSM*, is a breakdown in the basic distinction between psychiatric and social work problems. Not only do the criteria that are now universally used to diagnose mental disorders in fact diagnose either mental disorders or person-in-environment problems, but one cannot tell from the criteria themselves which category applies in a given case.

What are the implications of this fundamental problem for the relationship between psychiatry and social work? Because an understanding of the nature and source of a problem is critical to effective treatment planning, there is no alternative but for patients to be routinely assessed for both internal dysfunctions and person-in-environment problems. This sort of joint assessment

requires coordination; if cases are to be properly understood and treated, psychiatrists must routinely work together with social workers.

Ironically, the need for such radical integration of psychiatric and social work efforts is a result of psychiatry's attempt to define itself as a medical discipline, different from social work. To do so, it tried to formulate reliable diagnostic criteria for genuine mental disorders in terms of symptoms. The resulting diagnostic criteria, considered from a medical standpoint, possess flaws (elaborated above) that yield false positives (i.e., they sometimes incorrectly diagnose nondisordered, normal responses as disordered). But these same flaws make *DSM* criteria important to social work because they mean that the *DSM* encompasses a large part of social work's domain.

There are powerful intellectual, historical, and institutional reasons for framing psychiatric diagnostic criteria in the *DSM*'s operationalized, symptom-based way. This practice is unlikely to change. Moreover, the equifinality problem in this area is so great that it is hard to envision any operational criteria that could distinguish true disorders from person-in-environment problems without detailed assessment of both kinds of possible causal factors. Thus, for the foreseeable future, psychiatric diagnostic criteria will continue to encompass social work problems, and psychiatry and social work will be even more deeply connected at a conceptual level than the traditional roles would indicate.

Psychiatrists have neither the training nor the motivation to explore the patient's environmental circumstances adequately enough to distinguish internal from external problem sources or to treat the environment when necessary. Indeed, many psychiatric visits are extremely brief and targeted at prescribing and monitoring medication (Olfson, Marcus, and Pincus 1999). Short of a radical shift in psychiatric training and practice, psychiatrists are not about to routinely do direct assessments of the family and community context of the patient's symptoms or intervene directly in those systems when the person-environment relationship is the source of a client's problem; these are the tasks of social work. Yet, if the above arguments are correct, such assessments are necessary to decide whether a patient meeting *DSM* diagnostic criteria actually has a mental disorder or not, and such environmental interventions may be necessary to deal effectively and appropriately with the client's problem. Thus the future of psychiatric diagnosis and treatment will have to involve teams of psychiatrists and social workers sorting out the social and internal factors that determine the individual's problem and implementing the appropriate psychiatric and social treatment strategies.

Granting that those who meet *DSM* criteria are often not genuinely disordered and are suffering instead from normal reactions to problematic person-in-environment interactions, and granting that psychiatrists are not about to engage in social diagnosis and person-in-environment intervention

on the scale required by the flaws in the *DSM,* why can't psychiatrists still just ignore these conceptual points and continue to treat as psychiatric disorders the entire range of disorders and social problems encompassed by *DSM* criteria? The answer is that to do so would be unethical, for informed-consent reasons if for no others. People care greatly about whether a problem is a normal problem of living or a genuine mental disorder; controversies often erupt when medical treatment is provided to those who are not genuinely disordered, in areas ranging from the use of hormone treatments to increase normal children's height to using Prozac to elevate normal patients' moods. It is even more problematic to label and treat normal people as disordered when they are not so. Given that *DSM* diagnostic criteria do not correctly distinguish the normal from the disordered, it will eventually become apparent that a great wrong is being done in summarily dispensing psychotropic medication or psychotherapy without adequate differential diagnosis (including social diagnosis) to ensure that a genuine disorder exists.

To take just one example, drug trials for separation anxiety disorder using *DSM* criteria risk giving drugs to children to suppress a normal separation anxiety response. The use of drugs to treat normal, nondisordered reactions is generally controversial and raises complex value questions, but it is particularly problematic to use drugs to treat normal reactions in children without proper social diagnostic assessment and thus without consideration of alternative environmental interventions. Such inadvertent errors can be prevented only if genuine disorders and normal reactions to environmental problems can be distinguished through the combined efforts of social workers and psychiatrists during the diagnostic phase of treatment. Indeed, it is the professional responsibility of social workers to insist that such errors not be allowed to continue.

Conclusion

A genuine psychiatric disorder exists when symptoms are caused by a breakdown in the functioning of some internal mental mechanism. This is why it is thought that anyone diagnosed with a psychiatric disorder needs intervention into the internal workings of their mental mechanisms, whether through psychotherapy or drug treatment. However, this assumed connection between psychiatric diagnosis and internal dysfunction no longer holds. Psychiatry has embraced symptom-based criteria for mental disorders, for a variety of intellectual and institutional reasons. It turns out that the same "symptoms" (e.g., sadness, anxiety, antisocial behavior) that can be caused by internal dysfunctions can also be caused by normal responses to social problems. Therefore, psychiatry's symptom-based criteria inadvertently and

incorrectly classify a large part of social work's domain as medical disorders. Moreover, it is impossible to tell from symptoms alone which apparent disorders are actually genuine disorders that require change of internal functioning and which are normal responses to environmental problems that require social intervention. Thus parallel social and psychiatric assessment is necessary if correct diagnosis and effective and appropriate treatment are to be achieved. It follows that social workers and psychiatrists must work together to respond to presenting symptomatic complaints. Such teamwork is necessary so long as psychiatry remains committed to symptom-based criteria and so long as psychiatrists are not trained or interested in doing what social workers now do, including direct family and community assessment and intervention.

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