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Systemic Perspectives and Psychiatric Diagnosis: Mutually Exclusive or Mutually Inclusive?

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Summary

In the discussion below, we argue for the position that a system of diagnostic categories is necessary for all psychotherapists, in a parallel but different manner to the way in which it is important for medical practitioners. We systemic therapists also have a fundamental need of organizing the domain of human suffering so that we can bring order to

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our clinical practice, our research and our professional communication. The most important question is “how?”

Throughout this chapter, the reader should bear in mind that we discuss this issue primarily as systemic psychotherapist in considering how we may think of the ICD/DSM categories—we offer no critical analysis of how other professions think of or use them, but focus only on their relevance for the practice of systemic psychotherapy. It is also central to our systemic perspective that any attempt to understand human emotional suffering, based on only one perspective such as biology, psychology or sociology, will necessarily be incomplete. One practical example of what acceptance of such a presupposition would suggest is that no single domain of knowledge that studies human beings can claim the sole right to interpret and control the meaning of any diagnostic system of categories for everyone. It is rather up to members in each domain to decide the nature of its relationship to the categories and to arrive at their own considerations concerning meaning and value. This also applies of course to specialist sub-domains—such as those found under the class of psychotherapies: no single model or approach can claim universal precedence and retain credibility. It perhaps is as Onnis (2016) suggests, that what we have learned so far from the study of complex and dynamic systems teaches us that a plurality of perspectives is necessary to understand them. The eventual value of any single perspective will perhaps have to be valued in other terms—for example utilitarian ones (Jablensky, 2016; Kendler, 2022).

Introduction

In common with most others who work in the field of mental health, we (the authors of this chapter) have been obliged to develop a professional relationship with the two dominant diagnostic guides in use today—the International Classification of Disease 10 (ICD-10: World Health Organization, 1992, 1993) and the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5: American Psychiatric Association, 2013). Several of the chapters in the present volumes describes working as

systemic therapists in relation to mental health as well as other diagnosis, see for instance the chapters by Grasaasen and Benestad Pirelli, Grasaasen, Myra, Wie Torsteinsson and Hægland, de Flon and Sheehan. We are both psychotherapists, with a professional perspective that is anchored in family and couples (systemic) therapy. While we concur with the widely held view that there are many problematic issues connected to both diagnostic systems, many of the conflicts generated within the mental health field that we are aware of seem to emerge from the different meanings that are attributed to them and/or the ways in which they are applied. One obvious example is that many people seem to think that the diagnostic categories to be found in the manuals identify and describe illnesses—something that the authors themselves explicitly say that is not what they do. Interestingly, the word “diagnosis” stems from two Greek words *dia-* (through, thoroughly) and *gignoskein* (to know, perceive). Thus, its central meaning could be conceptualized as “to learn about the nature of a phenomenon thoroughly”. As stated above, our major focus in this chapter is on the diagnostic systems themselves and how we might think about them, not on how they are used in different contexts.

It is of interest to note that the diagnostic categories described in ICD and DSM in one sense reflect our everyday need for specific words or names for identifying different kinds and classes of experience (or different kinds and classes of anything). The giving of names provides a kind of verbal shorthand when anchored in shared culture that we use in our personal narratives when describing the experience of self and others: “I feel depressed”, “She is autistic”. In folk psychology—the non-expert, public narratives used to describe and explain experience—their general acceptance is probable evidence that they possess an important functional value. This means that a systemic therapist, even when working in settings other than a strictly psychiatric one, will often encounter language-usage that identifies different forms of diagnostic categorization. In clinical practice, we cannot escape this—so we need a strategy to accommodate it into our daily work.

DSM and ICD are the dominant diagnostic guides created and published by the American Psychiatric Association (APA) and the

World Health Organisation (WHO) respectively. While DSM exclusively presents categories concerning mental disorders, ICD-10 (and its successor, 11, which is not yet universally applied) also includes most known diseases. Chapter 5 in ICD is devoted to “Mental, behavioral and neurodevelopmental disorders”, which approximates the same area of study as DSM (when we use the name ICD in the present text, we are referring only to Chapter 5 unless otherwise stated). For the purposes of this chapter, we shall consider the two sufficiently similar in content that they can be discussed as if they are—or as the authors of DSM-5 put it, “... the salient differences between the DSM and the ICD classifications do not reflect real scientific differences, but rather represent historical by-products of independent committee processes” (American Psychiatric Association, 2013, p. 11). Together the two manuals are central to the field of mental health, a position often strengthened by law as well as by their application to establish and justify political planning, resource sharing, organizational routines, research, diagnosis and treatment, epidemiological studies and professional communication. It is, in fact, difficult to imagine a world without their ubiquitous presence. Despite this, there are possibly few established manuals that attract so much debate and criticism.

This chapter will describe some of the ways in which we (the authors) have learned to relate to and live with DSM/ICD. To do so, the principal perspective we employ is that of the philosophy of science, which encourages us to think about how we think—a meta-perspective familiar not only to philosophers, but also to systemic psychotherapists. As both DSM and ICD represent formal attempts to categorize a specific part of the natural world, we begin with a general discussion about the nature and function of categories.

The Nature and Function of Categories

Day in and day out, our senses are consciously and unconsciously stimulated by a vast number of experiences, while a steady stream of thoughts pass through our minds. We must learn to navigate in a complex world in which danger is an ever-present possibility. One of the most powerful

intellectual tools that we possess to help us organize our experience of the world is that of making categories—of sorting phenomena into different groups, where all the selected members of any given group are placed there because they are judged to share specific characteristics or elements which separate them in some distinctive way from other phenomena. We continually employ categories, often without being aware that we are doing so. For example, a mushroom picker has hopefully learned that there is something called mushrooms and that some kinds may be eaten and even that some taste better than others—while knowing that being able to distinguish between edible and poisonous species is as important today as it was for our ancestors.

The creation of a primary category called mushrooms, along with its sub-categories, is one example of knowledge that has been accumulated and organized over time. While the function of the category is obvious, its ultimate value is to be found in how well it serves the needs of both the ones who created it, as well as any others who choose to use it. Categories themselves are usually considered intellectual and social constructs that are used in the process of cognition as it acts on experience, helping to bring some form of order to the latter (Cohen & Lefebvre, 2005; Harnad, 2005; Lakoff, 1987). They influence how we feel, think, behave and relate—and are even used to order the physical world, for example, in the form of standardization (Bowker & Star, 2000). In the case of ICD/DSM, they represent an attempt to organize information obtained from individuals who have sought professional help with their emotional suffering and loss of function. ICD/DSM are therefore basically an attempt to answer the question, “Are there recognizable, recurring patterns to be found in human suffering?”

If we wish to understand why any given system of categories is as it is, and accepting that they are intellectual and social constructs created in a particular social context by someone (or in the case of diagnostic categories, a “group of someones”), for a specific purpose, then we can begin by asking four questions: (1) Who created the system, and in what context? (2) What kinds of things are included/excluded? (3) What is the defined purpose of the system? (4) What are the consequences of its implementation—how well do they match the intended purpose?

1. Who created the system and in what context?

A brief examination reveals that both systems are clearly medically oriented. A look at those who were responsible for and contributed to the latest edition of DSM reveals the following: overall 72% were members of the medical profession and when we examine the composition of The Task Force (those who selected and suggested the contributors) 82% were medical doctors. This composition can only be interpreted and understood as signifying that the dominant paradigm that controlled the creation of DSM-5 was a medical one.

From a gender perspective, it is noteworthy that the DSM Task Force was composed of almost 90% men. Furthermore, of all those who were responsible for and contributed to DSM, 72% were men.

The first of our questions is therefore simply answered: DSM was created by (mostly) male medical doctors. It is free for everyone to imagine what might have been the case if the categorization had been carried out, for example, by female philosophers! (The list of principle investigators at the end of ICD is comprised of 100% doctors, with gender unknown as they are identified only by initials before their surnames.)

Some Reflections

Couple and Family therapy (CFT) was widely criticized in the 1980s and 1990s for, amongst other things, failing to consider the ways in which gender influences roles and relationships (Goodrich et al., 1998; Walters et al., 1988 for a contemporary perspective, see: Almeida & Tubbs, 2020; McGeorge et al., 2020). Today, the theory of intersectionality is generally accepted to be an important contribution that helps in understanding the dynamics of both individual and family life in particular, and of society in general. One defining aspect of CFT is to be found in an awareness of the politics of power, both at a macro- and micro-level, embedded in the general framework of human relationships.

Knowing that the diagnostic systems are the brainchildren of a powerful profession that appointed its own members to create them

should make us properly sensitive to the possibility that it may contain bias that inclines it towards the best interests of that profession, and possibly towards men as well. Such a bias is found frequently when research examines in the practice of medicine from a gender perspective (Medical News Today, June 2021, October 2021). It is also obvious that we psychotherapists will use the system—when we do—in a somewhat different manner, and for a different purpose, when compared to medical practitioners. There are overlaps, of course: medical doctors may suggest psychotherapy, while psychotherapists may suggest medication. The diagnostic systems are simply created lists: they only possess value—positive or negative—when applied in the real world.

It is worthwhile to note that even within the medical establishment there are both questions and critical opinions concerning current nosologies (lists that categorize diseases). For example, "...diseases (and disorders) are not self-subsisting entities like electrons, gold and species. They are processes existing in hosts. Within the larger category of pathological states, such as broken bones and dehydration, many different things are grouped into the subclass called disease. So many different kinds of things are called diseases that few scholars consider the category of disease to be a natural kind...The only viable candidates for natural kinds of disease are individual disease types, such as tuberculosis (an infectious disease) and Huntington's chorea (a genetic disease)" (Zachar & Kendler, 2017, p. 57). History reveals to us that creating and then applying categories to living things and therefore attempting to sort them into types (think of contemporary discussions concerning gender or race, for example), is a very difficult, perhaps even an impossible, task. But at the same time, cognizing requires that we do. Knowing that even within systemic therapy we must use some categorization to help bring order to our knowledge, the challenge is to decide if ICD/DSM can be of value for our work, and if not, what system of categories we propose to use instead (see, for example: Raskin, 2018).

2. What kinds of things are included/excluded?

When we look for definitions of what a mental disorder is in the two manuals, in ICD we are informed that, "These descriptions and

guidelines carry no theoretical implications, and they do not pretend to be comprehensive statements about the current state of knowledge of the disorders. They are simply verbal descriptions of symptoms and comments that have been agreed, by a large number of advisors and consultants in many different countries, to be a reasonable basis for defining the limits of categories in the classification of mental disorders” (World Health Organization, 1992, p. 2). It goes on to state: “The term “disorder” is used throughout the classification, so as to avoid even greater problems inherent in the use of terms such as “disease” and “illness”. “Disorder” is not an exact term, but it is used here to imply the existence of a clinically recognizable set of symptoms or behaviour (sic) associated in most cases with distress and with interference with personal functions” (ibid., p. 5).

DSM reflects in a similar manner over its own list of disorders, which we can summarize in four points:

- I. they seldom have any identified, underlying pathological processes “Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the DSM-5 disorder criteria will be their clinical utility for the assessment of clinical course or treatment response of individuals grouped by a given set of diagnostic criteria” (American Psychiatric Association, 2013, p. 20).
- II. they are descriptive categories that seek to capture how the disorder is expressed
- III. they represent the best currently available system of categorization and will almost certainly need to be corrected in the future
- IV. many specific symptoms are to be found in different kinds of disorder, and “...the boundaries between disorders are more porous than originally perceived.” (American Psychiatric Association, 2013, p. 6) (See also: Caspi et al., 2020; Plana-Ripoli et al., 2019)

The original data from which the categories in both manuals are formed has two main sources: reports by patients/clients of their own experience, and/or information about them from significant others—psychosocial data, rather than medical. Simply put, the goal of both

systems of categorization is to organize the psychosocial data that medical and other health practitioners have gathered in the course of their work, in a manner similar to the collection and organization of data to be found in all other branches of knowledge. In other words, it is an attempt to bring order to a specific area of human experience using experts predominantly selected from a single discipline.

The authors of both manuals point out the atheoretical nature of their data. The primary category (mental disorders) is the name of the class or set within which different types of psychosocial phenomena are grouped and named (schizophrenia etc.). This means that—once created—neither the primary category nor any of the sub-categories are to be thought of as being necessarily attached to any single domain of knowledge, or to any specific theory. In practice, the diagnosis, once established, can be approached from many perspectives. However, somewhat confusingly, while the authors refer to their categories as being atheoretical, they are referred to as being “nosologies”. By definition, nosologies are lists of diseases—so what are neutral, non-theoretical categories doing in a nosology? DSM goes as far as to say, “DSM is a medical classification of disorders” (American Psychiatric Association, 2013, p. 10). This mixing of conceptualization occurs several times, creating confusion in the text’s basic contextual marking (“what are we talking about, exactly?”) and one possible explanation is that they are the consequences of the medical perspective or bias that the creators of the systems share. At first sight, the methodology used to create ICD/DSM is clear: in the real world, psychosocial suffering and related loss of function have been identified using psychosocial judgements and then grouped into disorders. However, even the use of the term “disorder” is in itself easily made problematic in this context. Wakefield’s (1992) words highlight one such issue: “...a disorder is a harmful dysfunction, wherein harmful is a value term based on social norms, and dysfunction is a scientific term referring to the failure of a mental mechanism to perform a natural function for which it was designed by evolution”.

This is not hair-splitting. Definitions are important in this discussion, as logically, if we are looking for specific kinds of phenomena to add to our primary category, then we must know what we are looking for, and be provided with a clear description for how to recognize them.

Any proposed category is by definition not a natural phenomenon to be found in the world but is a cognitive construction created by using some form of a priori concept or knowledge (logical or reasoned) or some form of a posteriori knowledge (experiential, empirical). For example, if I wish to categorize clocks, then I must know beforehand what a clock is, what it might look like and perhaps even how it works. In DSM/ICD, the primary category “mental disorder” is identified through two elements: loss of function and distress. The sub-categories are simply refinements of the primary category, trying to group the different ways in which patterns of dysfunction and suffering typically occur. Each category or sub-category is a collection of descriptions of thoughts, feelings and behaviour and nothing more. Discussions concerning causality, nature or aetiology may add to our understanding, and even influence treatment, but are not part of the category itself.

Some Reflections

Knowing from the start how those who created the diagnostic systems describe their reasons for doing so and knowing how they built them, allows us to approach the system on its own merits, in the sense that was intended (For example: Is it logically coherent? Does it fit with existing knowledge? Does it fit with our own experience?). It also helps us to understand if the system as it was originally envisaged is influenced in some way when used in different contexts in the real world. That an idea or an artefact is influenced by who use it is hardly surprising. But in the case of ICD/DSM, what is surprising are some of the claims made by different groups about the nature and purpose of the system itself. Thus, some suggest it is an attempt to “biologize” human experience in general, and human suffering in particular. Others claim it seeks to redefine human pain and loss of function as forms of sickness. No such claims are to be found anywhere in the contextualizing preamble to the texts (Interestingly, no one appears to claim it is an attempt to “psychosocialize” human suffering!).

The two systems of categories are revealed as being both more profound and more trivial if one takes the time to read about the

methodology and the amount of work that was put into accumulating the data they contain and then organizing them. The system is, in one real sense, the final product of an enormous amount of qualitative research (as opposed to quantitative research), in which individual stories of suffering and lack of function are first collected and then sorted into recurring patterns, and finally the patterns are named. The end product provides us with a vocabulary that can then be used in our work. We can say to the patient, “You are not alone in your suffering; it belongs to a known pattern that we call X”.

We can in this manner, gain strength and clarity in our professional role from the texts themselves. If, for example, the patient asks if depression is a sickness, we can respond by saying that there is no evidence for or against the idea that their suffering is the product of biological pathology. However, identifying the symptoms provided by the patient as a “fit” with the category “depressed” opens up the possibility of a variety of treatments, some medical, others psychosocial. In contemporary Western society, these are the two main perspectives for understanding and treating debilitating suffering; however, the diagnostic systems themselves offer no clue for deciding which perspective is the “right” one—rather there appears to be an appreciation that both should be kept in mind in choice of treatment.

At the beginning of the diagnostic process are personal descriptions of experience provided by the client. On the other hand, we have a long list of categories that the clients experience can be matched against. If a match is made, then we have access to a great deal of knowledge readily available that can (hopefully) help us in understanding the patient’s narrative and making decisions about possible treatment choices. In medicine, sometimes a diagnosis suggests a known pathological condition. This is *never* the case for the diagnostic categories contained in DSM/ICD (This position is clearly and simply described in Fiske, 2019; Hickey, 2021). People do not “have” their diagnoses: their experienced symptoms have simply been matched with a specific category. In other words, establishing a diagnosis does not identify the existence of a new phenomenon or specific pathology—ADHD, for example, is only the name of a category, not the identification of some “thing” inside the patient (Hyman, 2010; Kendler, 2022; Werkhoven,

2021). Being matched with a category does not identify specific causes for the experiences shared by the client, it simply offers a shorthand way of naming and identifying their general nature. It is only in the information provided by the patient that we can actually gain some understanding of what it is like to be that person.

3. What is the defined purpose of the system?

Both DSM and ICD are clear about their purpose—they see themselves as providing the foundation for consensual diagnoses: “Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates” (American Psychiatric Association, 2013, p. 5). This is the important statistical aspect of both systems: descriptions of experience provided by individual patients will suggest to the physician one of the major sub-categories (such as “Anxiety Disorders” or “Neurodevelopmental Disorders”) and then facilitate the identification and naming (diagnosis) of a specific disorder (such as “Selective Mutism” or “Attention-Deficit/Hyperactivity Disorder”). Such a system clearly facilitates the collection and organization of data.

The information generated by using the classification systems can be used to inform us, for example, of the rate (percentage of the total population) of a specific symptom (e.g. depression), its general aetiology, its course, and the success/failure of specific treatments, mortality rates and so on. It is also self-evident that clear categories are necessary for research. Further, the information provided by using the systems is important for governments and other public health planners in making decisions concerning, for example, the allocation of resources. These are not trivial purposes.

As noted earlier, the concept and activity of “diagnosing” consists of trying to match symptom descriptions offered by the client or patient to the descriptions found in the classification systems. This is not always easy. One of the problems, generally accepted, is that the categories themselves are rather unprecise: the two major issues are (a) that the

boundaries that should help separate the categories often fail to do so, and (b) the same identifying symptoms are often found in many categories (Allsopp et al., 2019). Some of this lack of precision is presumably an unavoidable consequence generated both by the nature of the data (self-referential, descriptions of subjective experience coded into language by individuals from different cultures, social classes, age-groups, genders and so on) and the subsequent efforts (again using language) of professional healers and researchers to categorize those descriptions. Just as interoceptive sensitivity differs from person to person, so does the meaning derived from it. It is also notoriously difficult to be precise concerning behavioural descriptions. Another more radical criticism suggests that the underlying assumption that behaviour, thoughts and feelings can be thought of to exist in the form of units or blocks is not sustainable.

Both systems use a form of redundancy as one attempt to compensate for this lack of precision. The individual syndromes in each major category contain too much information, and directions are included in the introduction to each separate syndrome which specify how to use this over-abundance. In other words, there are clear rules which must be satisfied before a match can be said to have been found. Once found, the match is then said to constitute a diagnosis.

There are two other major difficulties that can present a challenge to diagnosis. The first is that it is difficult to draw clear boundaries between the specific disorders contained in the sub-categories—in the real world, they tend to overlap with and glide into each other. The second is that it is common for patients to present “mixed” descriptions, meaning that their ongoing experience can fit with two or even more categories. When this is the case, it is referred to as comorbidity or co-occurring disorders—and indeed would seem to be the rule rather than the exception (van Loo et al., 2013). It may also be noted that such difficulties are relatively common in medical practice as well, even when signs (biomarkers) can be added to symptom descriptions. “Wrong diagnoses” are only discovered—if and when they are—through the wisdom of hindsight (Newman-Toker et al., 2020). It has been estimated that there are about twelve million wrong medical diagnoses made annually in the USA (Agha et al., 2022).

Some Reflections

One question of significance concerns the introduction of the term “diagnosis”. Once again, we may guess that the choice of language is generated by the professional identity of the constructors, revealing a bias towards a medical perspective, making it more accessible and user-friendly for the medical profession. Unfortunately, the usage of language associated with the medical profession often produces associative misunderstandings, leading many to assume that the categories are medical/biological phenomena in nature and origin. Which is rather a shame, as it contradicts the explicit ideas that lie behind their creation, as we have noted.

To develop, formulate and deliver psychosocial interventions, we psychotherapists need a classification system just as much as medical doctors do. It is worthwhile noting that, working with couples and families, we also have a need of extra categories—we strive to identify communication patterns, relationship patterns and organizational patterns quickly, so that we can begin to consider what kind of intervention might be most helpful. An example is given in the chapter by Sheehan in this volume (see Chapter 2) where he describes a model for systemic practitioners to diagnose parental alienation. Importantly, while the diagnostic categories of DSM and ICD are created to be applied to the individual, couple and family therapists are trained to embrace a broader view, to explore not only the working of the individual mind, but also the network of relationships within which that mind exists—the relational and interactional context that binds the psychological and sociological domains together. Indeed, one limitation concerning the use of ICD/DSM is that, as they are individually focused, over-reliance on using them as a base for choosing interventions may encourage a kind of blindness to the significance of social factors as causal and maintaining factors in human suffering.

Belief in the utility and importance of the ICD/DSM has justified involving hundreds of thousands of professionals in their work with millions of patients, consuming enormous amounts of money in the process. The uncertainty of the categories and the individual syndromes is a challenge for both clinicians and researchers. But science must begin

somewhere, and history tells us that mistakes made along the way are usually corrected sooner or later. However, there is a special challenge inherent in nature of the social sciences (and both DSM and ICD are essentially social science projects in their focus and methodology, albeit carried out under the aegis of the medical professional): we are often trapped in, and limited by, the recursive nature of language, lacking physical referents to which we can anchor our concepts and theories. Here we may perhaps be envious of our fellow scientists in physics or biology.

4. What are the consequences of their implementation? How well do they match the intended purpose?

The diagnostic systems are relatively simple, and it might seem reasonable to assume that there should be few problems with applying them. However, research informs us that attempts to implement an idea or method into an established organization are often more complicated in both theory and practice than the actual idea that is to be implemented (Fixsen et al., 2005; May, 2013). National health services are huge conglomerates that include many discrete units all established to pursue their own specialty. Also, private health services exist side by side with public utilities. According to implementation theory, there will be a tendency for each organization to absorb any new idea by adapting it into their own established way of thinking and working. Thus, the fact that medical doctors will use the categories as a precursor to begin appropriate and recommended medical treatment should be no surprise. In a parallel manner, psychotherapists may use the self-same categories to help them identify relevant therapeutic approaches: the category “depression” for example, will require a different kind of thinking than that of “ADHD”.

To discuss whether the expressed purposes of the two diagnostic systems are being achieved would necessarily seem to rest upon the answers to two questions: firstly, have they been properly applied and secondly, does society benefit in terms of improved levels of health at the individual level?

Those responsible for both DSM and ICD seem to be pleased with the answer to the first question. The authors note that the systems are used

on a broad, international scale by more and more practitioners—and not only doctors, but also by nurses, psychologists, psychotherapists, counsellors and educational professionals, amongst others. And being used by such professional groups, one may assume that generally they are being applied in ways that would meet the approval of the authors. There also seems a high degree of enthusiasm amongst insurance companies, politicians, civil servants and other officials who are responsible for organizing and allocating the finite resources of the health services. A clear and strict diagnostic procedure that also helps identify specific treatment is of great value to those who must organize and finance treatment services, simplifying many aspects of their work.

The data required to answer the second question—does the application of the system benefit the general health of the population—is more difficult to find a clear answer to (Collaborators, 2022). But in general terms, the answer at present would seem to be no: while there are many difficulties in measuring the incidence of mental illness over time, there is a general consensus that there is an increase, although by how much is uncertain (Richter et al., 2019). Explanations for this are potentially many, varied and complex, and there is no space to discuss them in detail here. Perhaps the most extreme critical perspective concerning the role and value of diagnostic systems is that if they are based on false premises about the nature of human emotional suffering, their application will probably not be very helpful (Braslow et al., 2020; Niv, 2021). This criticism is often connected to what might be called the medicalizing and biologizing of human emotional suffering (Slife et al., 2010). Suffice it to say, those who favour the diagnostic-treatment system can only hope that the apparent negative feedback thus far obtained is simply a temporary trend, due possibly to the way the system is applied and how the effects are evaluated. Other purposes, regarding the collection of data on course, morbidity, mortality and so on, are obviously facilitated by having a clear diagnostic coding system. But once again, the radical critics suggest that the information obtained by using the systems as guidelines is irretrievably flawed—for the simple reason that they are based on premises that do not accurately reflect the nature of human existence.

The answers to our two questions would therefore seem to be mixed: while the system is being applied more and more, with the help of more

and more sophisticated instruments, positive results for the general population are doubtful (or at least unclear). What is clear is that a lot of statistical data is being collected and that much of the research in the field of mental health is anchored in the two systems.

Some Reflections

A systemic couple and family therapist will not always think in terms of individual diagnoses, as relationship categories such as conflict or crisis might be more appropriate. But whether introduced by the therapist (“Might I ask if you are feeling depressed?”) or by the client (“I think my child might be autistic”.) once an individual diagnosis is placed on the table, it can usually be weaved into the developing narrative of the systemic therapeutic process. As was noted earlier, no couple or family therapist can avoid using a system of categories, and at an individual level, and at the present time, the DSM/ICD system is the only game in town (even if there are several interesting competitors under development) that also has the benefit of connecting us to the dominant social and medical narratives (reflected in social praxis, laws and regulations), and thus may contribute to making life easier for the client in navigating the social system, as well as helping the therapist to search for relevant knowledge.

However, two ideas are of special concern for the CFT therapist, aware as she is of the power of sociological influences on the development of the individual: these are the ideas of the “normal brain” and the “normal mind”.

In both psychiatry and in psychotherapy, there is often to be found an assumption that unwanted distress experienced by an individual (and/or that she causes in others) is a sign that “something” is wrong with her brain and/or mind. The logical assumption here is that if the individual’s brain is functioning “normally” then the individual would not experience personal distress or cause it in others. This idea would seem to hold the promise that, in the distant future, science might develop the means to keep everyone’s experience and behaviour within “normal” limits by, for example, balancing the biochemistry of the brain within specified,

“normal” parameters and thereby relegating a great deal of distress to an imperfect past. This is indeed the logic behind, for example, the medical treatment of depression. Unfortunately, despite many years of trying, researchers have not been able to find evidence for such a premise (Moncrieff et al., 2022; Nour et al., 2022; Schmaal, 2022; Winter et al., 2022). The opposing paradigm is that the idea of the normal brain is a myth: rather, it is the nature of living organisms to produce biological variety as the central motor in the process of evolution, a perspective known as neurodiversity (Singer, 2019).

An isomorphic argument sometimes appears based on the idea of a “normal” mind. In this case, it assumes that if the individual thinks/lives/behaves in a “right” way, then the result will be that she will feel little distress and have few problems (e.g. in the case of CBT, see Craske, 2012, Ch. 2 & 3). This idea is the basis of many psychotherapeutic and medical interventions and is applied to many issues, from phobias to schizophrenia. There is of course the common observation that might appear to affirm this belief: when an individual approaches a therapist and asks for help, the pathway towards eventual relief of suffering is often the apparent result of learning to think or behave in different ways. But such an observation cannot be interpreted to mean that suffering was the consequence of thinking wrongly, or of not possessing a normal mind. For most of us, the journey through life presents a great many challenges, threats and unpleasant shocks. We cannot be prepared for all of them. If we judge people who find themselves unable to cope with distress, solve problems or manage pain as being unnormal or wrong, then it may very well lead us into the position of considering them as being comparatively less competent, weaker and even inferior—as lacking something that non-sufferers and good problem-solvers possess. Such thinking has shamed many sufferers, adding a double burden to their pain, an example of blaming the victim.

The history of ideas teaches us that both the idea and nature of the individual may constructively be viewed as social constructs, meaning that the thoughts, feelings and behaviours that individuals use to identify themselves and others are supported or hindered by the combined will and response of the social groups in which they live (Berger & Luckmann, 1966; Hacking, 1999; Sveinsdóttir, 2015). In attempting to

understand human emotional suffering, we have suggested that any theoretical perspective that is based on only one of the three domains that are involved in the creation and maintenance of individual experience (the biological, the psychological or the sociological) will be incomplete. A pre-set belief used to identify and explain difference—for example, that emotional suffering is a question only of biology (or psychology, or sociology)—is not only truncated, but it may also be harmful. Truncated because all three domains are always involved in some way in the production of experience, and possibly harmful because ignoring up to two-thirds of what makes us human may produce a skewed understanding of the nature of suffering, leading to treatment interventions that may also be skewed. As with any other epistemological domain, the scope of human nature is so great that to try and understand it, we must begin by reducing its complexity and focusing on small pieces of it. But we should never forget that we have done so, thereby falling into the trap of believing that the cleaved part is the whole story—of mistaking an understanding of a part as constituting an explanation of the whole.

Labels that we use to describe ourselves or others are capable of being used either in a destructive or a constructive fashion, and this is just as true of everyday terms as it is of diagnostic labels, and observing communication patterns and how they are used to support or undermine others is a fundamental skill for a systemic therapist. While the implementation of ICD/DSM will not be a requirement of system-oriented psychotherapy as specified by its theory, it is easily integrated into its application where appropriate or necessary.

Final Reflection

The purpose of this chapter was to examine if systemic couple and family therapists can coexist with or even use the categories of ICD/DSM in our work, or if there are contradictions so great that it is neither possible nor desirable.

The three domains of biology, psychology and sociology are themselves categories: recognizing this starting point should ring warning bells, as the intellectual exercise of thinking of a human being as only

biological, or only psychological or only sociological is based on an artificial distinction—necessary for the existence of the disciplines themselves, but hardly relevant for life itself. However, to study human beings at all, we need a methodology, we need a way to bring some semblance of order and we need to simplify. But there can be no excuse for mistaking the tools that we use to study the world for the world itself, or as Korzybsky (1933/1958) said: “the map is not the territory, and the name is not the thing named”. We use categories to help bring order to our perception and to narrow our focus of study, but that order is not necessarily in the world: the world is not pre-packed into convenient boxes that have printed labels pasted on their sides informing us of the nature of the contents. However, as we noted in the beginning, one of the trickier and insidious aspects of using categories is that the more effective and helpful they prove to be, the more invisible they tend to become, until finally we may even forget about their existence and the roles that they play in organizing our cognition and perception (Bowker & Star, 2000). We may then make the error of thinking that the world really is the way that we have cognized it, forgetting about the mediating influence of the concepts we have used to guide and support our cognizing. We suggest that the two diagnostic systems are best seen as cognitive tools, not arbiters of reality, and when viewed as such they can help make our work simpler, and perhaps even better.

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