What Would a Humanistic DSM-V Look Like?

— Andrew Bland

The title question was recently posted on a list-serve. Below is a composite summary of my responses. This is not intended as the final word—but rather as a collection of gut impressions and working notes intended to disrupt fixed systems of thinking and to inspire dialogue about diagnosis and classification of mental health and suffering in a way that is both clinically practical and sensitive to individuals’ lived experience. My primary proposal is that a humanistic DSM-V already exists in raw form. I have included both classic and contemporary references for conceptualizing mental disorders through humanistic, existential, and transpersonal lenses.

REGARDING THE DSM

To preface my thoughts about a humanistic diagnostic system, first I will identify a few assumptions.

First, the current DSM is necessary but insufficient. Diagnosis and classification are not inherently problematic; incorporating diagnostic descriptions into sessions can be most validating of clients’ phenomenological experience, affirming and normalizing their existence and their human struggles. Rather, what I find troublesome about the DSM is that its descriptions of surface conditions lend themselves to confusing the map for the territory, to limited therapeutic engagement, and therefore to the potential for poor practice outcomes.

Second, it is necessary (a) to ground a humanistic diagnostic system in language that is congruent and compatible with what is familiar to most conventional clinicians and to others who regularly utilize the DSM (e.g., managed care) and (b) to account both for conventional reality and the client’s reality without favoring one at the expense of the other.

Third, oversimplification should be avoided, and dimensionality and complexity embraced. (It was the desire for parsimony in the development of the DSM that got us in this mess in the first place!) The detached stance of the current and previous DSMs should be replaced with more compassionate I–Thou verbiage that promotes human dignity, that emphasizes the whole person in context, and that promotes clients’ freedom in and responsibility for their conditions.

A HUMANISTIC DIAGNOSTIC SYSTEM

Now I will provide some examples of key texts that form a basis for describing mental disorders from a humanistic angle while maintaining the structure of the current diagnostic system.

Axis I: Anxiety, Mood, and Psychotic Disorders

Rollo May’s The Meaning of Anxiety (Norton, 1977, revised edition), Viktor Frankl’s The Doctor and the Soul: From Psychotherapy to Logotherapy (Vintage, 1986, third edition), and Kirk Schneider’s Existential–Integrative Psychotherapy (Routledge, 2008) provide accounts of the succession from more healthy (e.g., constructive anxiety, phase of life problems, mild adjustment disorders) to less healthy (from anxiety to mood to psychotic disorders) on Axis I. May emphasized that there is “good” and “bad” anxiety, in the same way that the physical body requires a balance of high HDL and low LDL cholesterol, and that the denial of anxiety and of struggle as vital and essential aspects of the human condition lends itself to dampened sensibility (i.e. depression). In

[People’s] inner nature is in part unique to [themselves] and in part species-wide.

— Abraham Maslow
addition, as a guide for addressing concerns about cultural bias in the DSM, May identified numerous biological and cultural issues that help differentiate between aspects of health and pathology that arise across cultures and generations and those that may be flagged as facets of modern American cultural imperialism.

Frankl picked up where May left off, describing not only problematic anxiety as an existential crisis but also the further deterioration of the personality from inhibition (depression) into passivizing (psychosis).

May's and Frankl's ideas were further expanded upon in Schneider's conceptualization of mental disorders as imbalances along a continuum between dread of constriction to dread of expansion of one's energies and experiences—thereby accounting not only for anxiety and depression but also for mania and impulsiveness. His table of “Psychiatric Disorders and Their Associated Dreads” offered a simple yet resonant phenomenological vocabulary for improving the current DSM diagnostic criteria as I suggested above (e.g., obsessive–compulsive disorder as “dread of experimentation, surprise, confusion, and complexity,” p. 43).

Schneider also emphasized the developmental dimensions of psychological suffering as the outcome of layers of acute, chronic, and implicit traumas and their implications for how individuals engage and relate with the world. These ideas were further integrated with Eastern understandings of mind and consciousness in Paris Williams’ Rethinking Madness: Towards a Paradigm Shift in Our Understanding and Treatment of Psychosis (Sky’s Edge, 2012), and with emerging understandings of the role of relationships in brain development in Louis Cozolino’s Neuroscience of Psychotherapy (Norton, 2010, second edition).

Axis I: Addictions, Autism, ADHD
Gabor Mate’s In the Realm of Hungry Ghosts: Close Encounters with Addiction (North Atlantic, 2010) provided alluring epigenetic descriptions of substance abuse, autism, and ADHD. He utilized neuroscience and Buddhism as threads to weave attachment theory with Maslow’s theory of motivation, with Erikson’s psychosocial map of development, and with emerging ideas on moral and spiritual growth (and its truncation) throughout the human lifespan.

Axis I: PTSD
Peter Levine’s In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness (North Atlantic, 2010) provided a re-conceptualization of post-traumatic stress disorder as post-traumatic stress injury—an “emotional wound amenable to healing attention and transformation” (p. 34)—via an organismic fear–immobility model. He proposed that the key to overcoming trauma paralysis and building resilience involves mending instinct–reason and mind–body rifts not only at the personal level but also in Western thinking.

Axis II: Personality Disorders
To overcome the debates over the existing classification system, I would suggest a switch to a new set of categories. The enneagram is an ancient system (based on Sufi wisdom) of personality development represented by a symbol signifying nine character orientations composed of habitual patterns of perception, emotion, and behavior. The parallels between the nine enneagram orientations and the current Axis II diagnoses are the subject of a growing body of research (see A. Bland [2010], The enneagram: A review of the empirical and transformational literature, Journal of Humanistic Counseling, Education, and Development, 49, 16–31). Meantime, arguably, the enneagram has stronger construct validity, it better accounts for both structure and dynamics in personality and personal growth, and it lends itself to a more legitimate dimensional model. See Don Riso and Russ Hudson’s Personality Types: Using the Enneagram for Self-Discovery (Houghton Mifflin, 1996) for a discussion about the levels of development from healthy to unhealthy in the enneagram system.
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Axis II: Cognitive Impairment
The current DSM relies on IQ scores as a basis for diagnoses of mental retardation. A more suitable basis for determining the extent of individuals’ abilities and limitations might involve Robert Sternberg’s triarchic theory of successful intelligence—which holds analytical intelligence in balance with creative and practical faculties (see Successful Intelligence: How Practical and Creative Intelligence Determine Success in Life, Plume, 1996).

Axes III and IV
The inclusion of medical and psychosocial concerns in a diagnostic impression is essential. Gabor Mate’s When the Body Says No: Exploring the Stress–Disease Connection (Wiley, 2003) provides compassionate accounts of how physical diseases can provide clues to specific areas of poor emotional coping. My only suggestion would be to add categories to Axis IV that account for existential and moral/spiritual crises; for meso-level cultural concerns; and for barriers to value systems, to creativity, and to other human potentials.

Axis V
Ken Wilber proposed an integral psychograph consisting of five developmental lines—cognitive, affective, spiritual, interpersonal, and moral—that follow a similar pattern of holonic development (see Integral Psychology: Consciousness, Spirit, Psychology, Therapy, Shambhala, 2000, p. 30). An accurate portrayal of individuals’ growth in each of these domains would resemble a series of sliders on a stereo equalizer to depict their levels of maturity in each area, with some levels tending to be more evolved than others. Such a multidimensional system would provide a richer sense of context to replace the oversimplified Global Assessment of Functioning scale.

Defining Psychological Health
A unique contribution that humanistic psychologists can make to the DSM-V would be an introductory outline of characteristics of psychological health, like Abraham Maslow and Bela Mittelmann used to lead off Principles of Abnormal Psychology: The Dynamics of Psychic Illness (Harper, 1951, revised edition). In a future article, I will propose such a list, updated to include areas associated with self-actualizing and self-transcendence that Maslow proposed in his later writings.

A Template
In this article I have suggested that the material for a humanistic DSM-V exists in raw form, and I have furnished some resources that could be woven into a cohesive narrative that appropriates and expands upon the existing DSM structure. For a model of what a finished product could look like, see the Psychodynamic Diagnostic Manual (Alliance of Psychoanalytic Organizations, 2006), an adaptation of the DSM-IV by psychoanalysts.

Conclusion: In But Not Of
The DSM-I and -II had a psychoanalytic bent, which became replaced with a cognitive behavioral leaning in -III and -III-R. DSM-IV was intended to have no underlying theory (just research). It was assumed that value-free science would prevail and that clinicians could operate using whatever theoretical orientation they prefer to address symptoms. However, like it or not, the research that fueled this endeavor was theory-driven, and the meta-analysis studies that were favored for their alleged ability to show patterns across time often mixed and matched studies from eras when depression and other disorders had different meanings at different moments in the historical evolution of the DSM.

That said, I believe that a humanistic DSM-V could be a great gift in that, by default, humanistic psychology is inherently an integrative psychology. Since its emergence as the third force in the mid-20th century, it has embraced the best of several orientations in the interest of clearing a space for additional areas of human existence and experience that had not been given due consideration by those orientations on their own. Moving this principle forward to today, this could be key to overcoming the sterility of the current DSM without moralizing, problematically pressing a political agenda, or reducing to a lowest common denominator.

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