The Role of the *Diagnostic and Statistical Manual of Mental Disorders* in the Maintenance of the Subjugation of Women: Implications for the Training of Future Mental Health Professionals

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Abstract

Since the publication of the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1952), the diagnostic classification of mental health issues has been rooted in an individualistic view of mental disorders. Although many of the changes in subsequent editions have resulted in clearer diagnostic classification, this individualistic approach fails to take into account the context within which many of the symptoms of mental disorders emerge. While the codes of ethics of the mental health professions require a consideration of clients' socioeconomic and cultural experiences when diagnosing mental disorders, the research that contributed to the classification system often failed to take these experiences into account. This paper provides a look at the impact of social and political pressures on the diagnostic decisions made by mental health professionals, while also exploring the ways in which psychiatry's classification system has contributed to maintaining the oppression of women. The historical minimization of the effects of violence against women and the insidious trauma of sexism will be explored. Finally, the importance of teaching a contextual understanding of the DSM, as well as the impact of socially embedded cultural values and biases in regards to gender will be explored.

Much has been written about the history of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Feminist critiques are abundant. However, it appears that despite criticism of the medicalization of the field of psychology from psychologists, social workers, marriage and family therapists, and mental health counselors, the *DSM* remains the primary basis for the teaching of psychopathology to future mental health professionals. The reasons for this are complex. This paper attempts to elucidate the multiple social, political, and economic forces at work in maintaining the dominance of the psychiatric profession, with its medical approach to psychological distress, in the field of mental health. In addition, the effects of gender biases, both in the making of the *DSM*, as well as its use by professionals in the diagnostic assessment process will be explored. The dangers of a failure to take into account the context of women's lives will be included, as well as the role all of this plays in maintaining women's subordinate status in society. Finally, a discussion of ways that those endowed with the work of training future clinicians can incorporate a contextual view of the *DSM* in the teaching of

psychopathology, so as to maintain its usefulness while minimizing its negative impact, will be included.

History and development of the *DSM*

In order to understand the role of the *DSM* in the maintenance of gender biases and the subjugation of women, it is necessary to have an understanding of the developmental history of the manual itself. The original manual, published by the American Psychiatric Association in 1952, was based on psychogenic theory, rooted in a psychodynamic approach to mental health. This psychodynamic approach explained mental disorders in terms of an individual's intrapsychic conflicts. Based in Freud's theory of psychosexual development, all psychopathology was believed to reside in the individual's psyche, resulting in behavioral expression through neurotic conflict (Zur & Nordmarken, n.d.). The role of context, including violence and abuse, as well as the oppression of large groups, was overlooked. At that point in time, little to no psychological research had been performed on women. Theoretical understanding of mental distress was based on an understanding of male development, and then applied to women. Consequently, normative behaviors of women were easily pathologized, as they did not fit the male model of "healthy" behavior (Caplan, 1995; Chesler, 2005; Hirshbein, 2004; Kutchins & Stuart, 1997). Female gender role behaviors, such as the tendency to value emotional attachment and interdependence, the willingness to exhibit emotional expression, the internalization of emotional distress, and the tendency to be cautious in expressing disagreement with others were (and often still are) classified as personality disorders. On the other hand, those traditionally masculine gender role behaviors, such as autonomy and individualism,

competitiveness, a reluctance to express emotion, and the externalization of emotional distress continue to be viewed as healthy adult development. As Chesler (2005) stated: "Since clinicians and researchers, as well as their patients and subjects adhere to a masculine standard of mental health, women, by definition, are viewed as psychiatrically impaired—whether they accept or reject the female role—simply because they are women" (p. 174).

Difficulties arose in the use of the manual, as diagnostic categories were vague. Significant differences in diagnostic decisions between clinicians pointed to the unreliability of the manual in clearly identifying the nature of an individual client's difficulties, as well as how to treat these difficulties (Shorter, 1997). In addition, major changes had begun in the field of psychology. Since the 1950s, behavior therapy, which emphasizes objective observation and experiments focusing on learning and environment, gained popularity in the United States. As a result, psyhchoanalysis, which emphasizes consciousness, internal observation and instinct, lost its stance in the psychiatric community (Shorter, 1997).

However, a possibly more salient issue arose in the 1960s. Due to the fact that the study of human behavior had been extremely subjective, scientists within the other sciences tended not take psychology seriously. Empirical studies had been lacking, leading biologists and medical doctors to feel that psychology was not a science at all, and that psychiatry was somehow inferior to other branches of medicine. Thus, the field itself was in need of a revision that would attempt to classify mental disorders in more scientific terms, based in research that would enhance the validity and reliability of mental health diagnoses. At this same time, the use of psychotropic drugs became common, causing radical change in the treatment of mental illness. Biological research was stirred up by the emergence of these psychotropic drugs. The

advancement of biological research technology (e.g. for research of the brain and of genes) had a profound impact as well.

In addition to these concerns, the American Psychiatric Association was finding itself losing ground as the dominant practicing arm of mental health treatment. Economic pressures that arose as a result of the licensing of clinical psychologists, social workers, and later marriage and family therapists and mental health counselors, and the subsequent coverage of their services by insurance companies had a significant impact on decisions made by the American Psychiatric Association. Because psychiatrists were paid a larger fee than these other mental health practitioners, many clients were choosing to seek treatment from non-psychiatrists. Determined to maintain their dominance in the mental health profession, the American Psychiatric Association began a campaign for the usefulness of psychotropic medication in the treatment of most mental disorders. Due to the fact that they were the only mental health practitioners at that time who could prescribe medication for their clients, it behooved them to convince the American public that most mental health problems could be addressed with medication. This approach would then ensure the need for their services for anyone who was struggling with any kind of "clinically significant distress," a phrase that finds its place in the criteria of every mental disorder, and which is based completely on the subjective assessment of the practitioner.

At this point in time, the health insurance industry also played a significant role, as they began to require increasing specificity of diagnosis in order to authorize payment for treatment. This resulted in an increase in the number of available diagnostic codes from 297 in 1994 to 374 in 2000 (Zur & Nordmarken, n.d.). This is primarily an economic issue, as the insurance companies increasingly require evidenced-based outcome reports from professionals in order to cover mental health treatments. The easiest way to provide such reports is to establish a list of

symptoms and to be able to report a decrease in symptomology, preferably as a result of medication. This resulted in an even stronger pressure to change the focus of treatment from psychotherapy to medication management of behavioral symptomology.

Thus began the medicalization of mental health. Research began on brain studies that would enhance the understanding of brain chemistry disorders that caused everything from Schizophrenia to Anorexia. At the same time, the pharmaceutical industry had a significant stake in the outcome of theses studies. Wishing to create expensive medications that would treat every mental health issue possible, they funded (and continue to fund) much of the research that was done (Cosgrove, 2005). In fact, the *DSM* has often been referred to as the pharmaceutical companies' "bible", because without the diagnostic coding of the manual, there would be no drug trials. "Without medications, psychiatrists stand to lose their place in the treatment hierarchy, and the DSM would lose its legitimacy as a necessary biological-medical tool" (Zur & Nordmarken, n.d., p. 4.). The pharmaceutical companies fund and in turn reap major financial benefits from a significant amount of research that is used by psychiatrists who advocate for the inclusion of certain diagnostic labels in the *DSM*. Indeed, the pharmaceutical industry and the field of psychiatry have worked hand-in-hand to ensure the continuing predominance of psychiatrists in decision making around mental health.

This medicalized approach to psychology is problematic in that it continues the tradition in psychiatry of locating all psychopathology within the individual, while ignoring the context within which psychopathology emerges. In addition, it maintains the illusion that mental disorders can be quantified in scientific terms, thus ignoring the complexities of human behavior, as well as the inherent difficulties of researching such behavior. The dominant medical model of mental health is particularly oppressive to women, as it most often does not attempt to

understand, explore or analyze the reasons for a woman's "problems in living," preferring instead to reduce them to a biological explanation. According to Horsfall (2001):

> Within mainstream medicine, psychiatric disorders are considered to be objective, discernible categories that are neutral with regard to class, ethnicity, and gender. However, there is a dissenting body of sociological literature that considers psychiatric classification systems to be sociocultural constructions infused with assumptions arising from the discipline origins in northern and western Europe in the mid nineteenth century (Busfield, 1989,1996). Western beliefs held by the bourgeois men who were the seminal psychiatric theorists were incorporated into the epistemological foundations of the discipline at the outset (Horsfall, 1998). (pp. 422-423)

The elite nature of psychiatry

Psychiatry has always been a privileged upper class, white male profession. The male to female ratio of psychiatrists in the United States is approximately 2:1 (Hirshbein, 2004). On the other hand, the percentage of women in lower paying mental health related fields such as social work is about 68%. This is reflected in the pay structure in Community Mental Health Clinics in the United States. In a discussion of this pay structure with a Chief Medical Officer at a Community Mental Health Clinic in Washington State (Avery, 2004), I was advised that the only professionals in Community Mental Health that are paid what they are worth are the psychiatrists. He acknowledged to me that the therapists (masters level clinicians), who did the bulk of the front line work with clients, were not paid a living wage (at that time the starting wage for a masters level clinician was approximately $29,000 per year). When asked why this

was, I was told, "Because psychiatry is still considered a male profession, while psychotherapy is now considered a female profession. The logic is that women do not need to be paid as much for their services, because *their income is considered a second income. The assumption is that women have a man who is making a good income, and therefore they do not need to make as much money*." (Avery, 2004, emphasis added). Although this man also acknowledged that this thinking was sexist as well as unrealistic, he stated that change would have to be made at a societal level before pay structures such as these would change.

The male dominated APA maintains control in the decision-making process of diagnostic categories in the *DSM*. It is this elite group that decides what is included and what is not. According to Kirk & Kutchins (1992, as cited in Caplan, 1995) the DSM

> contains the official classification system of psychiatric disorders and as as such sets the boundaries of the domain in which psychiatry claims expertise and exclusive authority. The manual specifies the kind of behaviors and problems for which the profession's counsel should be sought and its voice heard [and]… is making a claim regarding psychiatry's authority within the broader community. (pp.28-29)

Despite the statement in the introduction to *DSM-IV-TR*, (APA, 2000): "Most diagnoses now have an empirical literature or available data sets that are relevant to decisions regarding the revision of the diagnostic manual" (p. xxvi), in reality much of the research upon which it is based is unpublished, and thus not available for scrutiny by the wider mental health community (Caplan, 1995; Kirk & Kutchins, 1992). In addition, according to Kirk and Kutchins (1992) the

development of the task force, dozens of work groups and hundreds of contributors contributes to the illusion that the *DSM* is actually the result of a massive research effort, when in fact it is not (Hernandez & Seem, 2001).

Defining mental disorder

According to the *DSM-IV-TR* (APA, 2000),

> the definition of *mental disorder* that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction of the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or

> conflict is a symptom of a dysfunction in the individual, as described above. (p.xxxi)

This definition is problematic on a number of levels. First, let us look at the statement "because it is as useful as any other definition" and the reference to the fact that it has been used to render decisions as to what is "normal" and what is not. In this statement the authors of *DSM-IV-TR* (APA, 2000) admit to the difficulty of defining the term "mental disorder," while at the same time admitting that this inadequate (and most likely inaccurate) definition is the basis upon which decisions are made regarding what diagnoses should be considered manifestations of abnormality.

Second, let us look at the statement that a mental disorder is a manifestation of a behavioral or psychological syndrome or pattern *in an individual*. Thus, those who use these diagnostic categories are looking primarily at the individual and the symptoms with which he or she presents, while ignoring the contributing factors. In essence, emotional distress and problems in living are reduced to a medical diagnosis found *within the individual* that is meant to explain the individual's difficulties. Third is the statement that a mental disorder cannot be "merely an expectable and culturally sanctioned response to a particular event." In other words, a mental disorder diagnosis is given to an individual because that individual is considered to be "abnormal" on some level. This very much ignores the fact that expressions of many of the "mental disorders" in the *DSM* are actually easily explainable (and indeed quite expectable and understandable) in light of the living conditions, oppression, and trauma experienced by many who present for help (Zur & Nordmarken,n.d.). In addition, it leaves the decision-making process of what is considered psychopathology very much dependent upon the cultural ideals of

normalcy. Consequently, if a culture believes that a certain behavior is abnormal, regardless of what forms the basis of that culture's opinion, then it can be considered to be psychopathology. Finally, the statement that whatever the cause, it must be considered a manifestation of a dysfunction in the individual, greatly misunderstands the etiology of many psychological difficulties, especially for marginalized and oppressed groups, including women. In particular, the insidious trauma of "isms" (e.g., racism, sexism, heterosexism) are frequently denied or minimized by clinicians.

In order to understand the term "mental disorder" we must also understand the term "normal." Indeed, normal is merely a construct. Whenever I ask students how they decide what is "normal" I am given a multitude of definitions. Ultimately the students reach the conclusion that "normal" is in the eye of the beholder. As Cosgrove and Riddle (2004) stated, "Although mainstream psychological researchers claim to be objective, supposedly value-free research is in fact influenced by assumptions about what constitutes normative behavior and by gendered (and many other) stereotypes" (p.128). If this is the case, then leaving the definition of the construct of "normalcy" in the hands of a small, elite, and powerful group of wealthy, white, heterosexual male psychiatrists would appear to be unwise at best, and dangerous at worst. By allowing this elite group to make these decisions, the truth of the experiences of the vast majority of those seeking help from mental health professionals is overlooked, ignored, or even worse, blamed on the individuals themselves.

In light of all of this, it would appear that the *DSM*'s categories do not reflect value-free truths, but rather are a compilation of sociocultural and sociohistorical means of defining behavior that has been constructed in the tradition of male privilege. Because of this, women, particularly those women who are not white, middle class, or heterosexual, are at great risk of

being pathologized. According to Usher (2000, as cited in Cosgrove & Riddle, 2004), the ever growing number of *DSM* categories sustains a view of mental disorder as "discrete, consistent, homogeneous, clinical entities which further have an identifiable etiology and *cause* the symptoms women report. This acts to deny the social and discursive context of women's lives, as well as the gendered nature of science, which defines how women's bodies are studied" (p. 128, emphasis added).

Pathologizing individuals in this way can become a form of retraumatization, and can actually be used to continue to maintain marginalized groups in a status of oppression (Cosgrove, 2005; Vasas, 2005). This kind of labeling, which blames the individual for their distress, completely overlooks the issues of racism, sexism, ageism, heterosexism, etc. According to Orr (2000, as cited in Cosgrove and Riddle, 2004) one can regard the medical model "as a discursive straitjacket which forces psychic disease to speak itself in the grammar of individualized, biological disorder" (p. 1229). Cosgrove and Riddle went on to state: "This way of speaking is enormously costly and oppressive, for it silences groups, individuals, communities; indeed it silences conversations about the connection between social injustice based on sex and gender and emotional distress" (p. 129). Thus, by maintaining a purely medical model of emotional and mental distress, and in turn drawing attention away from social and political contributing factors, the American Psychiatric Association, intentionally or not, has colluded in the maintenance of the status quo, that of the subjugation of women.

In addition, by attributing women's emotional distress to biological causes, one could be led to believe that women are inherently weaker than men, due to the fact that far more women than men are diagnosed with many of the mental disorders listed in the *DSM*. This could in turn provide some justification for the subordinate status of women, thus resulting in the *DSM* being

used as a tool of further social control (Russell, 1995; Zur & Nordmarken, n.d.). In addition, the narrowness of focus on the individual can easily lead practitioners to diagnose mental disorder when there is a clash between a woman and her environment, and to direct treatment to the individual, when in fact what may need to be addressed is the dysfunction of the environment in which the woman finds herself, and with which she has difficulty (Russell, 1995). As Burstow (2005) stated in her critique of the diagnosis of Posttraumatic Stress Disorder, the medical model "frames people's experiences in such a way as to normalize injury. Moreover, most of the problems are not amenable to correction, for they are fundamental. They are an inevitable byproduct of constructing people's problems in living as though they are actually mental disorders" (p. 442).

Gender bias in psychiatric diagnosis

Multiple studies have been done both on the epidemiology of various mental disorders, similarities and differences in presentation between males and females, as well as gender bias as it appears in the use of diagnostic categories by mental health professionals. According to these studies (Horsfall, 2001; Skodol & Bender, 2003; Robison, Skaer, Sclar, & Galin, 2002; Reagan & Hersch, 2005; Mazure & Maciejewski, 2003; Crosby & Sprock, 2004; Nehls, 1998; Bertakis, Helms, Callahan, Azari, Leigh & Robbins, 2001; Bradley, Conklin & Westen, 2005; Blitz, Wolff, Pan & Pogorzelski, 2005; Beauchamp & Gagnon, 2004; Flanagan & Blashfield, 2005; Vedel Kessing, 2005; Wilhelm, Roy, Mitchell, Brownhill & Parker, 2002; Sachs. Amering. Berger & Katschnig, 2002; Sannibale & Hall, 2001; Jose & Ratcliffe, 2004; Kann & Hanna, 2000; Keenan, Loeber & Green, 1999; Piran & Cormier, 2005; Takkinen, Gold, Pederson, Malmberg, Nilsson & Rovine, 2004; Frayne, Skinner, Lin, Ash & Freund, 2004; Lindsay &

Widiger, 1995; Widiger, 2000; Norman, 2004; Starcevik, Djordjevic, Latas and & Bogojevic, 1998; Castillo, Fallon, C'DeBaca, Conforti & Qualls, 2002; Flanagan & Blashfield, 2005; Klose & Jacobi, 2004), females are far more likely than males to be diagnosed with depression, dysthymia, panic disorder with agoraphobia, eating disorders, borderline personality disorder and histrionic personality disorder. On the other hand, males are more likely to be diagnosed with Attention Deficit Hyperactivity Disorder, conduct disorder, substance abuse and dependence, and narcissistic and antisocial personality disorders. According to these studies, these differences in epidemiology between diagnoses are attributed to a number of causes, including male and female socialization, differences in how males' and females' symptoms present, and the gender biases of those assessing the subjects. This very much points to the lack of scientific "truth" in regards to these diagnoses. Is it really true that males and females differ that greatly in which disorders they have, or is it more a matter of social construction of what is normal for males and females (as well as social construction of how disorders such as borderline personality or major depressive disorder actually present)?

One question that regularly appears to be omitted in the research is that of attribution of these differences. The nature vs. nurture debate regarding mental health difficulties is far from over, despite the fact that many professionals will state that they believe that psychopathology is due to a mix of biology and environment. Indeed, with increased work in the field of Biological Mental Science and Neuropsychology, more and more studies are directed at brain chemistry, while often ignoring psychosocial aspects of a client's distress.

The impact of social and political pressures on the diagnostic decision making process

In order to further elucidate the problems inherent in the *DSM* classification process, it is essential to look at the social and political pressures that come to bear in the making and selling of the manual. Two cases in point are the development of the diagnosis of Posttraumatic Stress Disorder (PTSD), and the revisions in later manuals regarding whether or not to include homosexuality as a diagnosis.

The diagnosis of PTSD was included as the result of extensive lobbying efforts by veterans groups after the Vietnam War, as a means of gaining sufficient attention to and treatment of war-related mental health problems. It is interesting to note that the symptoms of PTSD have been manifested by individuals for centuries, however, until war veterans came home from Vietnam with these struggles, the diagnosis did not exist. In *DSM-III*, Criterion A stated that a trauma could be considered to cause the disorder if it was a "recognizable stressor that would evoke significant symptoms of distress in almost everyone" (APA, 1980, p. 238). This was amended in *DSM-III-R* to read "The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone" (APA, 1987, p. 250). This was followed by a list of qualifying stressors. According to Linder (2004): "The inclusion of the phrase *outside the range of usual human experience* was widely criticized, perhaps most vocally by the advocates for victims of sexual assault and domestic violence, who cited epidemiological studies showing the shockingly high prevalence of rape, childhood sexual abuse, and other forms of domestic violence" (pp 33-34). Criterion A was amended again in *DSM-IV* to read: "The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear,

helplessness, or horror. **Note**: in children, this may be expressed instead by disorganized or agitated behavior" (APA, 1994, pp. 427-428). Regular debate has continued to manifest over what actually constitutes a traumatic event that can cause PTSD. At this point in time, it would appear that the APA believes that only physical threat or injury constitute adequate trauma to create the syndrome of PTSD, thus denying the powerful traumatic effects of emotional and verbal abuse, covert sexual abuse, and nonphysical sexual harassment, to name but a few of the traumas frequently experienced by women in many, if not most, cultures. It also denies the insidious trauma of sexism, the ongoing demeaning and traumatizing effects of the objectification of women's bodies, and the inequalities in rights and privilege between men and women.

The issue of homosexuality has an even more damaging history in the *DSM*. After having listed it as a mental disorder for over two decades, in 1974 the APA announced that it would be removing it from the *DSM*. This decision was made after an APA vote that showed 5,854 members supporting and 3,810 opposing its removal as a mental illness from the *DSM* (Metcalfe & Caplan, 2004). This is further evidence that ideas of normal and psychopathology are merely constructs that reflect the social and political forces of the period in which they occur. The statement that homosexuality would be deleted from the next *DSM* was not entirely true, as the diagnosis of "ego dystonic homosexuality"(homosexuality with which the client was not fully comfortable) remained in the *DSM-III* (APA, 1980). According to Metcalf & Caplan (2004):

> Mental illnesses in general are regarded as intrapsychic problems, so it is troubling

> that, in a homophobic society, the effects of oppression and marginalizing would be labeled a mental illness. Voting on what is a mental illness is bizarre, as is the fact that one day the APA called homosexuality a mental illness, and the next day, it did not" (p. 123).

In the *DSM-III-R* (APA, 1987), ego dystonic homosexuality is listed in the index with the instruction to "see Sexual Disorders Not Otherwise Specified" which is tantamount to continuing to state that homosexuality is a mental illness. In addition, because Sexual Disorders Not Otherwise Specified, and Paraphilic Disorders Not Otherwise Specified remain in the *DSM-IV-TR* (APA, 2000), clinicians are still granted ample leeway to pathologize homosexuality as a mental disorder.

These two examples greatly elucidate the social and political forces at work in the decision-making process of the making and selling of the *DSM*. Other diagnoses considered by the *DSM* Task Force for inclusion in the manual are Premenstrual Dysphoric Disorder (PMDD) and Self-Defeating Personality Disorder (SDPD). A great deal of debate ensued over these diagnoses, and it was only after significant events involving the media occurred that SDPD was discarded (Caplan, 1995). PMDD remains in Appendix B (Criteria Sets and Axes Provided for Further Study) of *DSM-IV-TR* (APA, 2000 p.771). However, it is then listed again under Depressive Disorder Not Otherwise Specified as an example. Therefore, although it is not listed as its own disorder (it no longer has its own numerical diagnostic code), women can easily be pathologized as premenstrually mentally ill, simply by being given the codified diagnosis of Depressive Disorder NOS. Indeed, many primary care physicians are already telling their patients that they have PMDD, and subsequently prescribing antidepressants.

Interestingly, the American Psychiatric Association has stated that the only viable treatment of PMDD is antidepressants, thus making it one more diagnosis that would require the care of a medical doctor. However Caplan (1995) stated,

> research has shown that those women who report premenstrual mood problems are more likely than other women to be in upsetting life circumstances. And the treatments that have been shown to be most helpful are changes in exercise, diet and nutrition, and self-help groups—hardly the stuff of psychiatric illness. Dr. Dodie Pirie, who runs such groups, has found through her research that one of the most important features of the groups is their reframing of the anger and irritability that the women believe is "too great"; thus, they come to understand that, as women, they have felt so ashamed of and frightened by their "negative" feelings and behavior that they have needed to attribute it to uncontrollable hormonal changes. (p.156)

By pathologizing women's anger and irritability as premenstrual mental illness, the APA has colluded in maintaining the general consensus that for a woman to be angry and irritable is abnormal, and therefore must be avoided at all costs, even if it means medicating them to keep them more docile. One also cannot help but wonder what part the funding of research by pharmaceutical companies may have played in the strong attempts to reify PMDD as a diagnosis by giving it *DSM* status. It is important to remain cognizant of the fact that whenever a medication is FDA approved to be used to treat a new diagnosis, the pharmaceutical company has an opportunity to extend its patent, thus ensuring them of even greater profits. If a pharmaceutical company's patent for a particular medication for depression is about to run out, it

would behoove them to have the psychiatrists, and later the FDA, on board for that antidepressant being used for PMDD. This could explain the APA's reasoning for listing the diagnosis under Depressive Disorder Not Otherwise Specified. It is of particular interest to note that symptoms of depression are not required in order for one to meet criteria for PMDD, yet it is listed as a depressive disorder. This would lead one to believe that indeed the pharmaceutical companies had a hand in this decision. In fact, as Zur & Nordmarken (n.d) noted: "Just as the patent protections were about to run out, Eli Lilly introduced a new trade name, 'Sarafem', for the antidepressant Prozac and now markets it for the treatment of PMDD" (p. 6).

The conservative social and political forces of the 1980s also played a significant role in the medicalization of mental disorders. In a political period that stressed the importance of the individual over society, and in which the drive for extensive social change regarding the rights of women and other oppressed groups was taking a back seat to the needs of the individual (particularly those individuals with money and power), it became that much easier to insist upon an individualistic view of mental disorders, while ignoring the larger socio-political issues contributing to the problems in living encountered by members of oppressed groups. According to Ali (2004): "Another source of potential bias in psychiatric diagnosis is the risk of using the decontextualized nature of the *DSM* nomenclature to blame oppressed individuals for their identified pathologies" (p. 72). As Norman (2004) stated, "in focusing too exclusively on the individual, we simply 'blame the victim' and thereby worsen the depressive state or depressive vulnerability" (p. 39). Sadly, that same conservative social and political climate, which is much like the current climate in the United States, significantly contributed (and continues to contribute) to continued oppression of women and minorities, thus creating an even greater need for a more contextual approach to the mental health needs of members of these groups

Gender role stereotyping in the diagnostic decision making process

Many studies have been conducted regarding the role of gender bias and gender role stereotyping in psychiatric diagnosis. As stated earlier, the actual decision making process regarding criteria sets for the diagnoses in the *DSM* are biased in themselves. However, the problem is systemic, in that clinicians using the manual also bring their own biases to the decision making process. As Ali (2004) stated: "The notion of a fully objective and context-free model for evaluating individuals and their capacities … emerges as a fallacy, the adoption of which impedes the effort to provide caring and supportive environments for all clients" (p. 74).

According to Flanagan & Blashfield's (2005) study on gender bias in diagnosis of personality disorders, "gender appeared to affect the *interpretation* of diagnostic information and to affect the *interpretation* of nondiagnostic information that had a clinical valence" (p. 1494, emphasis added), and "perhaps this effect occurs because gender acts as a context in which diagnostic information is interpreted. Thus, the ways clinicians interpret diagnostic information are influenced by the gender context in which that information is presented" (p. 1496).

According to the American Medical Association's Council on Ethical and Judicial Affairs (1991, as cited in Bertakis, et al, 2001),

> gender bias may not necessarily express itself as overt discrimination based on sex. It may exist as social stereotypes, prejudice, or any other evaluation based on gender roles. Examples might include instances where physicians allow their attitudes or preconceived notions about female patients to affect how they assess their complaints" (p.696).

Bertakis et al (2001) went on to state, “Incorrect diagnosis may lead to women receiving inappropriate attention and psychotropic medication, whereas men may not be getting adequate treatment for depression” (p.696).

Gender bias is a particularly salient issue when it comes to diagnosing personality disordered behaviors. Many critics have argued that the diagnoses of histrionic and dependent personality pathologize traits that are stereotypically feminine gender role constructions (Caplan, 1995; Russell, 1995; Chesler, 2005). According to Busfield (1996, as cited in Horsfall, 2001), “some gendered behaviors are socially supported to a point, beyond which they become problematic and may be called mental illnesses…Gender differentiated expressions and behaviours that occur along a continuum can readily lead to psychiatrizing interpretations and consequent overdiagnosis” (pp.426-427).

In addition, Widiger (2000) stated: “Even if there is no bias in the definitions or in diagnostic criteria, there may be a bias in the way they are commonly applied,” and “clinicians must be cautious and self-critical, especially when diagnosing histrionic and dependent personality in women or narcissistic and obsessive-compulsive personality in men” (pp.6-7). Widiger encouraged the use of personality questionnaires as screening devices, but this in itself will not necessarily solve the dilemma, as some of these diagnostic instruments themselves have been found to exhibit a certain degree of gender bias in their construction (Lindsay & Widiger, 1995).

Gender issues are particularly significant to the diagnosis of Borderline Personality Disorder (BPD). According to *DSM-IV-TR* (APA, 2000), there is a 3:1 female to male gender ratio for this diagnosis. Skodol & Bender (2003) found: “Agreement between the ratings of the

DSM-III criteria for BPD and the clinicians' own diagnoses of BPD was modest" (p.354). Interestingly, in a study by Henry & Cohen (1983, as cited in Skodol & Bender, 2003), male students who were presumed to be "normal" exhibited more borderline characteristics than female students, leading the authors to conclude that these same characteristics are only considered pathological when seen in women, but not when seen in men.

These findings are particularly important in a discussion of the maintenance of the subjugation of women, as BPD is considered the most pejorative of all diagnoses. This diagnosis is considered so difficult, so resistant to treatment, and so highly negative that many clinicians refuse to see clients with this disorder in private practice. As a result individuals with this disorder are heavily stigmatized, often not taken seriously, and in many cases even abused by the mental health system. Indeed, there is a considerable lack of empathy that often results in misdirected treatment for individuals with BPD. This is particularly troubling, as "offering services devoid of caring deprives clinicians and clients of the perspective that only genuine concern evokes. When problem behaviors are seen as volitional and intractable, a sense of hopelessness about treatment prevails" (Nehls (1998), p.103). The finding that a significant majority of these clients have childhood sexual abuse histories (Soderberg, Kullgren & Renberg, 2004) is often ignored, resulting in a complete misunderstanding of their behavior and yet another case of "blaming the victim."

The power of context

All of this leads us to the importance of an understanding of context in both the etiology and effective treatment of mental disorders. According to Rutter & Maughan (1997, as cited in

Soderberg, et al, 2004) psychopathology is strongly linked to the cumulative effect of adverse events over the lifespan. Some of these adverse events that are of particular interest in addressing psychopathology in women include childhood sexual abuse, domestic violence, rape, and other forms of trauma, as well as the insidious trauma of sexism in society.

Childhood sexual abuse has been linked to multiple mental health issues, including mood, anxiety, somatoform, dissociative, eating, and personality disorders, as well as sexual dysfunction, and a number of medical problems such as fibromyalgia and chronic fatigue syndrome. Despite the fact that this form of abuse is frequently a core issue in the psychological makeup of these clients, it is also the most often unacknowledged, disbelieved, ignored, or put in the too difficult to address category. In fact, frequently questions regarding CSA are left out of psychiatric assessments, an oversight that is particularly significant in light of the fact that "direct questions on sexual abuse give much higher rates than spontaneous reporting (Briere& Zaidi, 1989, as cited in Soderberg, et al, 2004, p. 919). Thus, what is often the primary precursor to psychological symptoms is frequently left out of the equation by clinicians, particularly those who prescribe medication. While medication is often extremely useful, and sometimes even necessary to treat their mental health problems, it is sorely inadequate when addressing these clients' concerns and providing hope for full recovery or significantly improved quality of life. According to Walker, Carey, Mohr, Stein & Seedat (2004),

> it would seem that multiple trauma-related factors (frequency, nature, relationship to perpetrator, unexpected nature, social network, etc) independent of gender, increase risk for PTSD. In general CSA appears to be more prevalent among females and in turns seems to have a higher attributive risk for pediatric PTSD" (p. 118).

In addition, Soderberg, et al (2004) found that CSA predicts poorer outcome for parasuicide, regardless of what diagnosis the client has been given.

Numerous other researchers, including Romito, Turan & De Marchi (2005) and Demaris and Kaukinen (2005) have studied the effects of violent victimization on women's mental health (one can find numerous other studies referenced within these two articles). According to, Romito, et al (2005), "women who had experienced violence in the last 12 months are more likely than other women to be psychologically distressed, to evaluate their health as bad, and to take psychoactive pills" (p.1722). In addition, correlations have been consistently found between violent victimization in the past and current partner violence.

DeMaris & Kaukinen (2005) found that victimization in all its forms has a variety of negative effects on the mental health of women. For example, having been threatened or stalked has been related to increased depressive symptoms in the victim. Eating disorders and PTSD have been linked to sexual trauma and sexual assault both in childhood and in adulthood (Dansky et al, 1997; and Wonderlich et al, 2001, as cited in DeMaris and Kaukinen, 2005).

The insidious traumatic effects of the social construction of womanhood and femininity were discussed by Piran & Cormier (2005) in their study of disordered eating patterns. This article explored the powerful psychological impact of the internalization of complex social discourses that leads to women's excessive monitoring of their bodies, behaviors and social roles. These social constructs of female gender included the need to silence one's needs and voice, suppress the outward expression of anger, and the internalization of the objectified gaze toward one's own body. All of these forms of self-monitoring were found to be connected to eating disordered behaviors.

Women are socialized to put other people's needs ahead of their own and much of the work done by women is invisible or undervalued by others. Such socialization and cultural devaluation frequently contribute to low self-esteem, powerlessness, overdependence, feelings of worthlessness, and depression. In addition, it would appear that gender socialization and oppression contribute to women learning certain coping styles in order to survive, and that these coping styles may become embedded in their personality and later pathologized by mental health practitioners (Caplan, 1995, Chesler, 2005; Horsfall, 2001). Any of these social factors can increase the likelihood of gaining a psychiatric diagnosis, resulting in further stigmatization and oppression.

Implications for the training of future mental health professionals

Based on these findings, it is imperative that we take a hard look at the ways in which psychopathology, and in particular the *DSM*, is taught to future mental health clinicians. Sadly, despite the fact that over the past three decades a number of feminist psychologists have critiqued the making and selling of the *DSM*, these critiques have not made their way into how diagnostic classification and diagnosis are presented in undergraduate abnormal psychology textbooks (Wiley, 2004). In fact, decades of feminist criticism appear to have had little impact on the way the authors of abnormal psychology textbooks present the *DSM*. These glaring omissions serve to perpetuate gender and other forms of bias, and undermine professors' ability to train culturally competent, ethical practitioners.

It is imperative that professors of therapists-in-training have a solid understanding of feminist critique of the *DSM*. Knowledge of the history of its development over the past more

than fifty years, along with the cultural context in which it was developed and is used are essential elements in fully understanding how to ethically make use of this "bible" of psychiatric diagnosis. To omit these elements is to do a serious disservice to all of our clients, our female clients in particular. Unless future therapists are trained in solid critical thinking skills when making use of the *DSM*, we run the risk of eventually losing this critical view, and in turn doing possible damage to our clients by pathologizing them, rather than treating them with the empathy and understanding that they deserve.

Despite the fact that *DSM-IV-TR* (APA, 2000) acknowledges context in a variety of ways, this recognition of culture and other contextual factors appears to be largely peripheral. Unless these variables are identified with the same degree of care as the diagnostic criteria for specific diagnoses, they are bound to be afforded secondary status in importance, at best (Hernandez & Seem, 2001). Thus, in training future clinicians in the use of the *DSM*, in-depth discussion about the insidious forms of bias is an important element. An overemphasis on intraindividual factors contributing to a client's distress needs to be challenged. As Cosgrove (2005) stated,

> faculty can discuss with students the limitations of a positivist focus on causality, and concomitantly the importance of appreciating the sociopolitical context in which symptoms are manifest…This conceptual shift, from uncritically accepting the positivist focus on causality to challenging it, helps students develop a more balanced view of diagnosis and treatment, a view that is congruent with the profession's developmental, preventive, and contextual approach. Also…this shift in thinking fosters an appreciation

> for the etiological role that social injustice and violence may play in the development of emotional distress. (pp 285-286)

When addressing the *DSM* in context, it is important to assist students in the understanding that historically what is defined as psychopathology has been those characteristics that differ from the dominant culture's construct of normalcy, and thus it has varied (and will continue to vary) over time and with culture (Hernandez & Seem, 2001; Zur & Nordmarken, n.d). In addition, when discussing the history of the *DSM*, it is essential to include an understanding of the people and culture in which it was developed, and the decision making process involved in the inclusion and exclusion of diagnostic categories, including the potential for conflicts of interest that arise when *DSM* committee members receive research funding from pharmaceutical companies (Cosgrove, 2005). This historical review of the *DSM* must also include a discussion of the interaction of power and dominance with psychopathology, as well as the social and political meanings of various labels (Kirk & Kutchins, 1992; Kutchins & Kirk, 1997). Future mental health professionals need to be able to look at the mental health system as it relates to the patriarchical structure of our society, so as to learn to make critical decisions about human behavior, thus avoiding labeling human differences as psychopathologies (Lev, n.d.).

In encouraging future mental health professionals toward critical thinking regarding diagnostic judgments, professors need to direct students toward awareness of their own values and beliefs about mental disorders and the sociocultural roots of those beliefs (e.g. gender role stereotypes, cultural expectations, etc.). In addition, it is particularly important to assist students in understanding that some diagnoses are more value-laden than others.

When training students in the diagnostic interview and assessment process, encouraging them to do a full cultural and ecological assessment that includes the meanings the client gives to their experience, as well as a detailed formulation of the client's presenting problem that addresses biological, psychological, environmental, social and cultural factors contributing to the client's difficulties is absolutely essential (Dziegelewski, 2002). Failure to do so runs the risk of a serious misunderstanding of the client's difficulties, which in turn can lead to ineffective and even damaging treatment strategies.

Future mental health professionals need to learn to be extremely judicious in their use of psychiatric taxonomy. One way to assist them in being so is to discuss such issues as how the diagnoses of PMDD or dependent personality disorder may contribute to a perpetuation of sexist stereotypes, thus leading students to think more critically about the "costs, benefits, and possible sociopolitical implications of using *DSM* diagnoses to capture the lived experience of emotional distress" (Cosgrove, 2005, p. 287). This and other debiasing strategies, along with discussion of common clinical judgment pitfalls will assist therapists-in-training in becoming more culturally competent and ethical clinicians.

Conclusion

The *DSM* can be a useful tool in assisting clients with mental health difficulties. At the same time, if not used thoughtfully and with attention to embedded biases in the sociocultural context in which it was formed, it will continue to play a role in the maintenance of the subjugation of women. As Dr. Ofer Zur so eloquently put it:

> Many clinicians have found artful ways in which to use the *DSM* as a tool of communication in service of the clients' ultimate well being. One must maintain caution, however, so that the distilled, conceptual jargon developed, in part, as a response to political, economic and social pressures does not confuse the larger contextual elements of truly helpful diagnosis. Used without benefit of critical, contextual thinking, the *DSM* can be unwittingly used as a weapon, perpetrating the violence of intolerance upon individuals and groups expressing diversity of any kind" (Zur & Nordmarken, n.d., pp.10-11).

Professors of psychology can play a significant part in minimizing the negative impact of the *DSM*. Attention to anti-oppressive, nongender-biased practice needs to become an important part of training programs for future mental health professionals. The deindividualization of clients' problems in order to see them in a wider social context can assist students toward a model of treatment that is more inclusive of the individual client's experiences and that incorporates a recognition of coping, and resistance to oppression. As students come to understand the impact of oppression on the availability of choices, on decision-making, identity development and behavior, they will be able to move from a deficit model that emphasizes women's "pathology" to a strength model that emphasizes their varied, skillful, and often creative modes of coping (Pollack, 2004). An empowerment approach to women's mental health issues that empathically reframes and normalizes their experience, while building on their inherent strengths, will go far in reversing the negative effects of the medicalization of mental disorders.

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