

# **The New Zealand Psychological Society Te Rōpū Mātai Hinengaro o Aotearoa**

## **Position Statement on the DSM-5**

*January 2014*

The delivery of mental health services in Aotearoa/New Zealand have been more heavily influenced by the Diagnostic and Statistical Manuals (DSM) of the American Psychiatric Association than any other diagnostic and classification system. For practitioners such a system furnishes the words and concepts that can shape thinking, structure assessments, and provide direction for interventions. It influences both what we communicate and how we communicate. The DSM categorical system has proven to be a potent conceptual framework for thinking about mental illness and those who struggle to maintain good mental health.

For these reasons the release of the new *Diagnostic and Statistical Manual of Mental Disorders – 5<sup>th</sup> Edition* (DSM-5; APA, 2013) in mid-2013 has been of considerable importance. We acknowledge the efforts of the American Psychiatric Association to provide an update which reflects the current state of knowledge about mental disorders<sup>1</sup>. They have endeavoured to obtain consensus where much remains uncertain and provide a framework within which clinicians can work to enhance the well-being of service users. We are aware of the well documented difficulties experienced during the preparation of the new manual - within the sub-groups of the Task Force who developed the text, as well as the pre-emptive and reactive critique offered by commentators and organisations worldwide.

We agree with the position statement published by the Division of Clinical Psychology (DCP, 2013), a Division of the British Psychological Society and the Open Letter authored by the American Psychological Association's Division 32 Committee on DSM-5 (Division 32 Committee, 2011). We share their concern about both specific changes that have been implemented within the DSM-5 and the overall assumptions about the aetiology and resolution of mental disorders. The scope and scale of specific changes has resulted in many revisions lacking clarity, lacking broad empirical support and having little clinical utility. Most mental health services are delivered within primary care settings by practitioners with limited specialist mental health training. The categorical adjustments appear to do little to aid these practitioners in identifying and understanding the problems faced by their clients. Indeed, there is concern that there may be over pathologising of those seeking assistance.

The lack of a broad research base suggests that we are a long way from having a single bio-medical explanation for mental disorders, even if this is achievable or desirable. We ascribe to the view that while neuro-biological causes and associations of a minority of mental disorders may one day be uncovered, current research suggests that the vast majority of the challenges to good mental health experienced by service users result from a range of factors, including; social, cultural, political, psychological and biological. In order to respond respectfully and effectively to each individual service user and those that support them, the practitioner must look beyond the mental disorder and develop an appreciation of the complexity and uniqueness of the individual and their social and

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<sup>1</sup> This term is used here because of its general use within DSM-5. However, we recognise that this label is not value free and would not recommend its general use.

cultural context. In responding to the person rather than the disorder we work to reduce stigma and enhance personal agency and growth. A psychological framework goes a substantial way to achieving this through the process of case conceptualisation and the utilization of practice-based evidence to guide and support individually tailored assessment and intervention. This is the “paradigm shift” called for in the DCP statement and is one which we wholly endorse.

Finally, it may well be the case that the DSM-5 is ‘fit for purpose’ within the 3<sup>rd</sup>-party payer healthcare system found in the North America. This is not the system we currently have in New Zealand. To be competent practitioners we are required by the New Zealand Psychologists Board (2011, p4) to have an “...*appreciation of the cultural basis of psychological theories, models and practices and a commitment to modify practice accordingly.*” We believe that it is inappropriate and potentially dangerous to support the wholesale adoption of a categorisation system that was developed with no consideration of our local philosophical, cultural, and professional practice needs or wishes. We welcome alternative models developed in Aotearoa/New Zealand that embody the relational principles set out in Te Tiriti o Waitangi and broader concepts of hauora/well-being considering the needs of individuals in the context of their whanau/families, immediate and wider communities.

We recognise that our members and colleagues may choose, or be obliged by their employers and other agencies, to make use of DSM-5 diagnoses in their work. We urge them to do so cautiously and with awareness of potential pitfalls. For a reflective and culturally competent practitioner this will require a good understanding of the DSM-5 and the practical and ethical implications of its use. Psychologists should also be familiar with alternative classificatory systems, and the unique considerations and responsibilities associated with practice in Aotearoa/New Zealand.

## References

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*, 5<sup>th</sup> ed. Arlington, VA: APA.

Division of Clinical Psychology (2013). *Division of Clinical Psychology Position Statement on the Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses*. Retrieved from <http://dxrevisionwatch.files.wordpress.com/2013/05/position-statement-on-diagnosis-master-doc.pdf>

Division 32 Committee (2011). *Open Letter to the DSM-5 Task Force*. Accessed 17 May 2013, <http://dsm5-reform.com/the-open-letter-to-dsm-5-task-force>

New Zealand Psychologists Board (2011). *Cultural Competencies: For Psychologists Registered Under the Health Practitioners Competence Assurance Act (2003) and Those Seeking to Become Registered* Retrieved from [http://www.psychologistsboard.org.nz/cms\\_show\\_download.php?id=62](http://www.psychologistsboard.org.nz/cms_show_download.php?id=62)