This is the Author's Accepted Manuscript of R Cooper (forthcoming) "Commentary on Jonathan Raskin's 'What might an alternative to the DSM suitable for psychotherapists look like?'" Forthcoming in the *Journal of Humanistic Psychology*

Commentary on Jonathan Raskin's 'What might an alternative to the DSM suitable for psychotherapists look like?'

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Acknowledgements: I'm grateful to Roger Blashfield, who read and commented on a draft of this commentary.

Abstract

Many mental health practitioners find it necessary to use the DSM for insurance purposes but are unhappy with its basic assumptions. This raises the question – would it be possible to devise a new classification system that (1) could be used for insurance purposes, and (2) would be based on alternative principles? In the main, this commentary is pessimistic. Through considering the history of attempts to devise alternatives to the DSM, I will argue that it would be *extremely* difficult to develop an alternative to the DSM that could be used to fund psychotherapy via health care insurance in the US.

Commentary on Jonathan Raskin's 'What might an alternative to the DSM suitable for psychotherapists look like?'

Raskin has co-authored recent studies (Gayle & Raskin, 2017; Raskin & Gayle, 2016) of the views of psychologists and counselors on the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM (American Psychiatric Association, 2013). He found that many plan to use the DSM (to get paid) but would be keen for an alternative classification to be developed. Surveys of psychologists, social workers and counselors have found broadly similar results for decades. Going back as far as 1981, a study of clinical and counselling psychologists revealed that although only 17% considered the DSM-II (American Psychiatric Association, 1968) to be a satisfactory classification system, 90.6% used it, 86.1% noting that they were required to use it to obtain insurance reimbursement (Miller et al., 1981). Kutchins and Kirk (1988) asked social workers about their use of the DSM-III (American Psychiatric Association, 1980). 80% used it for insurance purposes, but 60% said they would not use the DSM if it were not required. Frazer et al. (2009) found similar results when asking about the DSM-IV (American Psychiatric Association, 1994), and Hitchens and Becker (2014) report that social workers continue to have reservations about the DSM.

These studies show that many mental health practitioners find it necessary to use the DSM for insurance purposes but are unhappy with its basic assumptions. This raises the question – would it be possible to devise an alternative to the DSM system that (1) could be used for insurance purposes, and (2) would be based on alternative principles? In the main, this commentary is pessimistic - I will argue that it would be *extremely* difficult to develop an

alternative to the DSM that could be used to fund psychotherapy via health care insurance in the US. I end on a more positive note. I suggest that those who would like an alternative to the DSM for administrative use in the US should concentrate on overcoming economic and administrative barriers to the adoption of a different system. An alternative option would be for psychotherapists to develop classifications designed for use in research only.

1. Why developing an alternative to the DSM is hugely challenging

Concerns regarding the DSM have a long history, and so to do attempts to construct alternative systems. Already in the 1970s, the American Psychological Association was becoming concerned that DSM diagnoses were increasingly being required by insurance companies and that the American Psychiatric Association controlled the DSM. In 1977 they set up a "Task Force on Descriptive Behavioural Classification" to develop an alternative to the DSM (Board of Directors Minutes, June 24-25 1977). The Task Force believed that the approach of the then proposed DSM-III was problematic for a number of reasons, including that "it is a disease-based model inappropriately used to describe problems of living," and that it threatened to be unreliable in application. (Task Force on Descriptive Behavioural Classification, July 1977, p.1). The Task Force planned to start work on a new classification. They set out a number of principles that they thought should be respected in its development. Many were similar to those suggested by Raskin, including the following:

1. The system to be developed is one which will include the identification of those external environmental events which influence the individual's functioning;
2. The schema is to be established in such a way so as not to be incompatible with existing psychological theories and points of view;
3. Level of inference is to be kept as low as possible. The classification is to be couched to the extent possible in observable behaviors as opposed to theoretical inferences;
4. The classification is to be established in such a way as to promote its effectiveness in communication among mental health professionals, with lay persons, and with clients.

(Task Force on Descriptive Behavioural Classification, July 1977, p.1.)

Work on a new classification began. But the project was soon abandoned. In 1978 The Board of Directors of the American Psychological Association disbanded the Task Force,

> It was the decision of the Board, after extensive discussion, that the likelihood of outside funding was slight, and, in addition, that the plans of the Task Force were unrealistic in scope. (Board of Directors Minutes, Dec 1-2 1978, p.11)

The American Psychological Association failed to produce an alternative to the DSM-III in the late 1970s. They couldn't afford it; developing a system like the DSM is hugely expensive. It also requires a ruthlessly efficient bureaucratic organisation. Since the 1970s, the situation has gotten worse for any group that would seek to produce an alternative to the DSM. Over time, the DSM system has become more expensive, more sophisticated, and more deeply embedded in administrative and bureaucratic structures.

I suggest that the American Psychiatric Association is presently uniquely well-placed to construct multi-purpose classificatory systems in mental health (i.e., classificatory systems which are like the DSM in being designed to be used for clinical, research and administrative purposes). Crucially, the American Psychiatric Association developed the DSM-III at just the right time to ensure its success. While insurance for mental health care was rare when the DSM-I was published in 1952, coverage gradually increased throughout the sixties and seventies, and had become widespread by 1980 (Cooper, 2005, pp.127-132). The DSM-III came to be used to provide the codes required by insurers. During the same period, those testing, regulating, and marketing psychopharmaceuticals came to present such drugs as being directed at specific disorders, as opposed to symptoms (Cooper, 2005, pp.112-118; Shorter, 2013, p.13). Researchers started to use DSM-III diagnostic criteria to pick out subjects for research; the FDA favored the use of DSM categories in drug trials; advertising started to promote the idea that psychopharmaceuticals treat specific conditions. The net result was that the DSM-III classification came to be much more widely used and more respected than its predecessors.

The successes of the DSM-III left the American Psychiatric Association in a much better position to construct successor classifications than any other professional organisation. Sales of the DSM-III brought in $9.33 million (Blashfield et al., 2014, p.32), some of which the American Psychiatric Association was able to reinvest in producing the DSM-III-R (American Psychiatric Association, 1987). Since then, each successive edition has made more and more money, and cost more and more to produce. Developing the DSM-5 cost $25 million (Frances, 2013, p. 175). The American Psychiatric Association is able to invest so much in the DSM because it can be confident that sales of each new edition will bring in a profit. The sums of

money involved make producing a competitor classification far beyond the reach of most other organisations.

Over time, the American Psychiatric Association has also built up the sorts of bureaucratic structures, networks and expertise that enable it to produce the DSM. When the DSM is revised, hundreds of experts become involved in a complex undertaking that takes many years to complete. Mostly, the experts who work to revise the DSM are unpaid. They are prepared to help with the DSM because they can trust that the DSM will be a successful, influential classification system.

The money, skills, and networks that the American Psychiatric Association has built up over time mean that it now has a huge advantage over other organisations that might attempt to produce similar classifications of mental disorder. An additional complication that has arisen since the American Psychological Association tried, and failed, to produce an alternative to the DSM in the 1970s, is that the US Health Insurance Portability and Accountability Act (1996) now requires the use of ICD codes for medical insurance claims. It is possible for mental health practitioners in the US to write down codes taken from the DSM on insurance forms because the DSM is designed to be compatible with the ICD. The DSM and ICD are compatible because these classifications are very similar and are developed in tandem. For any group to design a very different system *and also* to ensure compatibility with the ICD would be extremely difficult.

Some may doubt my pessimism and point out that the National Institute of Mental Health (NIMH) has recently launched the Research Domain Criteria (RDoC) project (N.I.M.H., no date), one of the aims of which is to produce a new classification of psychopathology. However,

I think it would be a mistake to take the launch of the RDoC to indicate that alternatives to the DSM might be developed more widely. The RDoC project is special in several ways. First, the NIMH has the budget to invest large sums. Second, the RDoC is designed for research only, and not also for administrative or insurance purposes – this can be expected to be much easier than developing a multi-purpose system. Third, it should be remembered that, as yet, the RDoC has not actually yielded a new classification, and there are no guarantees that the project will be successful.

2. Codes for "mental health concerns"

In his paper, Raskin discusses a suggestion recently made by Rubin (2017), who argues that the DSM should be replaced by a classification of "Mental Health Concerns." Examples of concerns might be "feeling sad," or "challenging life situation"'. Each mental health concern would have a numerical code that might be used on insurance reimbursement forms.

The DSM and the ICD both already include codes fairly like some of those suggested by Rubin. The DSM has a chapter "Other conditions that may be a focus of clinical attention." This includes "V" codes that can be used for a wide variety of the sorts of "Mental Health Concerns" discussed by Rubin. For example, there are codes in this chapter for those treating a "child affected by parental relationship distress," for "discord with neighbour, lodger, or landlord," or for a "problem related to current military deployment status." The V codes look to be roughly in accord with Rubin's proposal – but although these codes are already included in the DSM in most contexts they are rarely used.

The problem with the V codes is that health care insurers in the US generally refuse to pay for care for such codes. Rubin suggests that insurance companies could be persuaded to pay for "Mental Health Concerns" as they would "readily come to understand, with a little explaining, that mental health service providers now using the current DSM/ICD approach do not turn anyone away who has mental health insurance coverage and comes to their office expressing what the CSM refers to as a mental health concern" (Rubin, 2017, p. 17). In other words, Rubin thinks that when a therapist is faced with someone with a "challenging life circumstance," they just write down the DSM code for Adjustment Disorder, or some other DSM-disorder, and get reimbursed. In his view, once insurance companies understand this is widespread practice they will decide to accept the "Mental Health Concern" system.

I think that Rubin's optimism is misplaced. The fact that some (but by no means all) therapists currently get away with recording DSM diagnoses to facilitate payment even in cases where diagnostic criteria may not be met will not be news to insurance companies. It is a practice that insurers have long known about and usually try to prevent. I think it unlikely that insurers would easily agree to cover Rubin's "Mental Health Concerns."

3. Possible ways forward.

To finish, I will offer some more positive suggestions. Many psychotherapists, and other mental health professionals, in the US want to find an alternative to the DSM. I suggest that, given that therapists mainly use the DSM for securing payment, those who want an alternative to the DSM should concentrate on solving the economic and administrative problems of using a different classification.

The DSM/ICD already include a chapter of codes very similar to the codes for “Mental Health Concerns” that Rubin suggests should be developed. However, medical insurance has tended not to cover such codes. Rubin’s optimism that it would be easy to persuade insurers to cover such codes is misplaced, I think. But, persuading insurers to cover V-codes might not be impossible. It might be possible to demonstrate to insurers that covering psychotherapy for V-codes is cost-effective (if, for example, it leads to a reduced need for treatment for DSM disorders). Alternatively, it might be possible to convince those who buy insurance that coverage for V-codes is something they should demand.

Another option is for psychotherapists to work on developing alternative models for funding psychotherapy. The Health Insurance Portability and Accountability Act (1996), which mandates the use of ICD codes applies to health insurance. However, in some cases there are other types of insurance that might be used to cover psychotherapy. The most obvious example would be bereavement counselling, which is already sometimes covered by life insurance. In such a system, there is nothing to stop non-medical diagnoses, or no diagnoses at all, being employed. In other contexts, other payers may be happy to pay for psychotherapy without requiring anything like a DSM diagnosis. Rubin notes that when he worked in student counselling, no DSM codes were required (Rubin, 2017, p. 14). Counselling offered via Employee Assistance Programs is often offered on a similar basis.

I acknowledge that my suggestions here are nothing new. The difficulties run deep and there are no easy solutions here. Psychotherapists have long struggled to develop non-medical funding models for psychotherapy, and many have already tried to persuade insurers to cover psychotherapy for “problems” as opposed to “disorders.” Still, I think is worth re-emphasizing

that in so far as psychotherapists in the US currently use the DSM largely for insurance purposes, the key problem for those who want to develop an alternative system is to work out how it will enable psychotherapists to get paid.

In Raskin's proposal he seeks a new classification of mental distress that can be used for third-party payment and that can *also* be scientifically based. I've said a lot here about insurance, and nothing about science. I have explained why it is that developing a new classification for mental health insurance would be difficult. When it comes to proposals to design classifications for research only, I am much more optimistic that developing alternatives to the DSM will be possible. Developing a classification for research only is much easier than developing a system that aims to be used for both research and for reimbursement.

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