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ABSTRACT

Many counselors, social workers, and psychologists routinely use the DSM-IV-TR as a basis for most psychological diagnoses. This includes counselors' work with clients from diverse cultural backgrounds. Multicultural counseling theorists and practitioners are beginning to voice their concerns about finding a more appropriate alternative to the manual, a manual that is more inclusive of cultural differences while being compatible with counseling philosophy. Use of the DSM-IV-TR is a highly controversial issue in the counseling profession and yet the idea of an alternative may prove to be even more controversial. A review is included of some of the interdisciplinary social, cultural, and political issues surrounding its use as they pertain to any future alternatives. It describes some basic concerns that may be useful in understanding the nature of the controversy and in identifying any future alternative for multicultural counseling. It focuses on multicultural counseling as a human relations issue. (Contains 76 references.) (JDM)

ALTERNATIVES TO THE DSM-IV-TR FOR MULTICULTURAL COUNSELING: SOME PRELIMINARY CONCERNS

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Abstract

The Diagnostic and Statistical Manual (DSM-IV-TR) (American Psychiatric Association, 2000) is used as a basis for most psychological diagnoses in the United States. Many counselors, social workers, and psychologists routinely use the DSM-IV-TR in their work with clients from diverse cultural backgrounds. Multicultural counseling theorists and practitioners are beginning to voice their concerns about finding a more appropriate alternative to the manual, an alternative more respectful of cultural differences and more compatible with counseling philosophy. There are few issues in counseling as controversial as the use of the DSM-IV-TR, yet the idea of an alternative may be even more controversial. This article reviews some of the interdisciplinary social, cultural, and political issues surrounding the use of the DSM-IV-TR as they pertain to any future alternatives. It describes some basic concerns that may be useful in understanding the nature of the controversy, and in identifying and selecting any future alternative for multicultural counseling. The article focuses on multicultural counseling as a human relations issue.

Alternatives to the DSM-IV-TR For Multicultural Counseling: Some Preliminary Concerns

My friends, your people have both intellect and heart; you use these to consider in what way you can do the best to live.

-Spotted Tail, Sioux

(Quoted in Hifler, 1996)

Recently there has been some discussion in the professional literature about the need for a viable alternative to the Diagnostic and Statistical Manual of Mental Disorders IV (1994) [now DSM-IV-TR, American Psychiatric Association, 2000] in multicultural counseling (D'Andrea, 1999, May). The idea that the DSM-IV-TR contains cultural bias seems widespread among counselors who deal with multicultural issues and culturally diverse clients. This perceived bias brings into question the appropriateness of the manual as a basis for framing client assessments and interactions. This article seeks to describe some of the basic ideas that could be used as a philosophical and practical foundation in searching for an alternative to the DSM-IV-TR.

Advocating the need for alternatives to the DSM-IV-TR does not in itself create or test any new alternative. This article describes criteria to help counseling theorists and practitioners envision desirable characteristics for an alternative yet to be identified.

The central idea here is that the use of the DSM-IV-TR in multicultural counseling is a complex social issue whose alternative would be just as complex. The underlying goal would be to find an alternative that is somehow *more appropriate,* more oriented toward the human relations aspects of counseling. Put another way, the DSM-IV-TR was meant to be one of the important tools by which professionals might provide help to their clients through accurate assessment. If that tool is now considered inappropriate because of cultural bias or because of its limited relevancy to multicultural counseling, by which criteria might a new tool be identified, selected, and tested? This article presents a discussion of such criteria with the idea in mind that any alternative must still aid in the counseling process, must still benefit clients in direct ways, and must avoid the shortcomings for which the DSM-IV-TR has been criticized. The article does *not* present alternatives, but offers a discussion of some of the issues that matter in looking for an alternative. A review of the controversial social, cultural, and political issues related to the need for an alternative is included.

The American Psychiatric Association (2000) included in the current edition some discussion about culture and diagnosis. In fact, the manual cautions users who work with people from various cultural backgrounds that diagnoses may be difficult because of variations in human behavior. It warns that clinicians should be familiar with "*...the nuances of an individual's cultural frame of reference*...(p. xxxiv)." The tone of the warning is that the DSM-IV-TR may be used, but only if it is used carefully by knowledgeable clinicians. Read in another light, it would seem that psychiatry is also practicing applied anthropology by making assertions about culture – a reified, static view of culture (and identity) emerges to portray clients in specific ways. The manual

itself claims that wide-spread use "...suggests ...(p. xxxiv)" that the manual's classification system is useful in many parts of the world, and presumably in many cultures as well. However, popularity does not guarantee relevancy.

In reality, people define themselves and change their own self-definitions according to their history, politics, and social class (Stein, 1989). When a dominant culture takes it on itself to define a subordinate culture, members of the subordinate group may be forced to identify themselves by a "default culture" not of their own making. For example, people with disabilities are often portrayed in professional literature as if they are a single group with a shared culture (Middleton, Rollins, & Harley, 1999), even though they are a heterogeneous group. Counseling literature acknowledges in this way that some clients are defined by society in *cultural* terms (as different). There may be strong social pressure for people in the defined group to conform to the stereotypes and assumptions held by the definers. The DSM-IV-TR implicitly participates in this way of thinking with a static view of culture --- portraying people as being so different that the usual standards do not apply.

However, the DSM-IV-TR has become so widely used in so many different settings, that the helping "industry" (including academic disciplines, public agencies, insurance companies, and professional practitioners) has adopted it as the almost exclusive basis for diagnosing problems and allocating services. In the United States, at least, the DSM-IV-TR has become the social, cultural, and professional standard of diagnosis. In its previous version (pre-TR edition) the original DSM-IV (American Psychiatric Association, 1994) contained twice the amount of text on disorders as did the earlier version, although there were only seven years between editions (Saleebey,

1997). Such expansion adds to the complexity of the social issues involved in the use of the DSM-IV-TR because the idea of "disorders" seems ever more solid. Yet few of the professionals using it have sufficient training in any field to be sufficiently familiar with "cultural nuances" as recommended in the DSM-IV-TR.

There is, then, a certain *imprecision* involved in using the DSM-IV-TR to diagnose people with diverse backgrounds. The rigor of science fades as imprecision mounts. To make things worse, there is no acceptable alternative diagnostic method for clinicians to use on a regular basis. Professional use of the DSM-IV-TR is so widespread that diagnosis by any other means might be unacceptable or suspicious. It is because of this widespread use that the DSM-IV-TR constitutes in itself a paradigm of diagnosis, one with no competition.

Fear of the DSM-IV-TR

Psychiatrists, psychologists, social workers, and counselors typically rely on the DSM-IV-TR as *the* authority for all diagnoses. Given its widespread use, why would some theorists now suggest that the DSM-IV-TR is inappropriate for use in multicultural counseling? The answer to this basic question is to be found in a complex mixture of history, cultural values, social experiences, and worldviews that help make up the context in which multicultural counseling takes place. Some counselors may distrust the DSM-IV-TR's applicability and some clients may distrust its purpose. Different cultures have different ways of meeting their own needs (Locke, 1992), ways that may be accidentally or purposefully misconstrued as pathology. With the DSM-IV-TR, human behaviors are reconstructed in biological terms (McNamee & Gergen, 1992), so that cultural variables or differences may be treated as minor issues. Psychology as a

discipline has itself been viewed as a culture, not unlike the cultures that arise within cults of one kind or another (Bock, 1995).

Psychiatry has greatly influenced professional counseling, partly with its diagnostic methods and partly with its political clout. Unfortunately, activities that practitioners view as science, clients may perceive as direct threats to their well-being. Sue (1981), for example, noted that traditional counseling has been oppressive to clients with cultural differences. Diagnosis has played an important role in this tradition because the path of "treatment" generally follows from diagnosis.

Diagnosis is an expression of political power that may subsequently be used bureaucratically as a basis for decisions about the person in question (Kleinman, 1988). In actual use, diagnosis may be made differently depending on a client's social class (Mausner & Kramer, 1985). Some critics view diagnosis as an expansion of the medical model into mental health, and believe it may deprive people of their uniqueness (Corey, Corey, & Callanan, 1993). The DSM-IV-TR translates a multitude of everyday problems of living into mental disorders, denying to many people the right to have such problems without first being labeled as mentally ill.

One woman of Asian descent referred to the DSM-IV as "A Bible without God" (personal communication, June, 1999). Another woman who described herself as a "psychiatric survivor" claimed that, "There is a place for all of us in the DSM" (personal communication, November, 1998). Such personal anecdotes suggest how some people who are culturally different may feel about the DSM-IV-TR. As a system of diagnosis, the DSM-IV-TR may appear even more sinister if it is viewed as a form of social control. Labeling people as "minorities" emphasizes differences that may then be

used as justification for unequal allocation of resources (Barnes-McConnell, 1989; Elster, 1992). Labels of mental illness may compound the marginalized status of many people who are culturally different.

Rosaldo (1989) suggested that some classes of Americans think of themselves as having psychology, and of others as having culture. *Culture* may be considered less worthy than *psychology* as a way of describing people. The implications of this observation are important to multicultural counseling. To the degree that we deny the diversity of American "selves" (Takaki, 1993), we may also deny to people who are culturally different the luxury of personal, mainstream-like psychology, insisting instead that they have *culture*. Such unconscious behavior may have the effect of equating culture with a marginalized status of inferiority, another expression of social Darwinism. If, even unconsciously, the DSM-IV-TR is used as a tool by professionals to draw negative attention to cultural differences, people who are different may never achieve equality or improved social status. Instead, members of the dominant culture (or profession) may ensure that such clients are always different from themselves, and deserving of diagnoses that reinforce that difference. This notion seems reminiscent of Benedict's (1989) idea that people divide themselves into two main groups --- the *chosen ones* and the *aliens* (p. 7).

White, middle-class Americans sometimes seem preoccupied with maintaining social distance between themselves and others by insisting that others are culturally different. So *African American* may be a racial description more than a cultural one. Yet, in the context of American diversity there are many people of different ethnicity who share many common cultural ideas because they have shared similar histories. When

whites and blacks actually share culture, middle-class whites (like many professionals) may insist that black members of the same group are culturally different.

Thus, "culture" may be used euphemistically to denote racial differences that trigger the distinction between culture and psychology, a not so subtle shift in social status. In other words, white members of culturally similar group may have psychological problems, but they are not perceived as being culturally different. In this way, white people may be granted the status of "psychological person" while people of color in the same cultural group are confined to the less significant status of "cultural person." The word *culture* is often used in American society to mean *race* (Kuper, 1999)

At its best, the DSM-IV-TR cannot prevent ideology of this sort from creeping into the diagnostic process. To be seen as a "cultural person", then, may mean that one is seen as someone who lacks authentic *personhood*. The authors have observed counselors interacting with black clients as if they (the clients) had just arrived in America. Such behavior nullifies in an instant, hundreds of years of family history in America. In day-to-day counseling, people with "culture" may not be seen as real people and may thereby not be "awarded" authentic personhood..

Such ideas are to be found at the local level, expressed as personal sentiments. From teaching multicultural counseling in graduate school, the authors have noted how often American students of European descent say, "I don't have a culture, I'm an American." This is not mere ignorance of culture. The statement is typically made with complete candor, and sometimes with a hint of superiority. Within the context of the ideas expressed in the preceding paragraphs, these students seemed to be saying that

as Americans they do not *have* to have a culture in the same way that those different from them must have one.

In any case, the narrow view of human experience and behavior embodied within the DSM-IV-TR is not a simple requirement of science. The lack of cultural knowledge simply cannot be accidental. Anthropological information about culture has mainly been ignored by psychiatry and by psychology (Schwartz, 1992). Anthropology, in its study of culture, still ponders the difference between normal and pathological (Jenkins, 1994). Psychiatry once pondered the same issue (Horney, 1964), but both psychology and psychiatry seem now to act as if the matter has been settled once and for all. In that the DSM-IV-TR reflects ideologies about pathology and normalcy (ideologies now institutionalized into professional practice) there may be few reasons for clients or multicultural counselors to trust the DSM-IV-TR. The DSM-IV-TR almost invites abuse by its inability to make clear distinctions between normal and pathological, and between culture and psychology. Most patients in state mental institutions share characteristics that include poverty, lack of support, and homelessness (Breggin, 1991). These same characteristics can often be found among people who have been marginalized in society ---- many of whom may have cultural ways different from the norms of the dominant culture. Socioeconomic status may be transformed into a set of diagnosable symptoms.

The DSM-IV-TR incorporates a taxonomical system or view of reality, pathology, and behavior. Although this taxonomy does not offer a clear view of normalcy (wellness), it does constitute a closed system of logic and understanding about psychopathology. The authors of the manual warn that there are limitations to such a categorical

classification system, including the fact that the manual makes no assumption about the absolute quality of the boundaries between and among the various diagnoses (APA, 2000, pp. xxxi-xxxii). It is within a system of fuzzy boundaries that clients of all kinds may be diagnosed inaccurately.

If an alternative to the DSM is beneficial for those professionals who work with clients who have different cultural origins, the need for such an alternative may arise precisely because of the taxonomical system envisioned by the DSM. Years ago, Schultz (1977) speculated that there perhaps is no universal formula for the healthy personality, yet by default the DSM suggests that mental health is best defined by the absence of any categorical diagnosis or symptoms defined within its pages. In other words, the manual defines rather vaguely what a universal formula of mental health should be.

The Cultural Milieu of the DSM-IV-TR

Psychiatry itself developed in America during a time in which social Darwinism encouraged the idea that race and social class followed some type of natural selection process, and were *ipso facto* indicators of mental inferiority or of a propensity for mental illness (Hofstadter, 1992). The sheer ideological power arising from the routine nation-wide use of the DSM-IV-TR may border upon a form of social Darwinism in its own right.

The force of *collective intentionality* (Searle, 1995) seems at work in the DSM-IV-TR's popularity, as if the very issue of diagnosis has simply been settled by agreement. Each professional is free to carry out this collective intentionality in his or her work with clients. This leaves the client who is culturally different at a marked disadvantage. If his or her worldview is not reflected in the DSM-IV-TR, almost any behavior may be

construed as pathology. As Stein and Apprey (1987) noted, "Consensus is homeostasis that we mistake for sanity (p. 333)". When consensus of diagnostic method is taken as a professional norm, all who do not share the norm or all who are unaware of its existence may become social deviants who are less able to resist diagnosis and its consequences. Those with the least social power are those least likely to "out run" negative labels imposed on them by others. Psychiatry, however, has tended to endorse categorical assessment as if it were "true science" (Mirowsky & Ross, 1989). The endorsement may allow ideological beliefs to become social "facts."

Culturally speaking, professionals can be viewed as a dominant social class that has the power to control those who are subordinate to that class. The social system may perpetuate itself by reproducing the established order (Bourdieu, 1977), leaving professionals with little inkling of potential long-term cultural oppression. Additionally, psychiatric diagnosis may be skewed to maximize profits (Turner, 1995) - - a practice that may well increase the "severity" and the number of diagnosed maladies. Historically, the US has used technology for economic domination and for reinforcement of human relations (Takaki, 1990). In this sense, diagnosis has become a *technology* with the tendency to emphasize control over helping.

In the social sense, diagnosis is an act of deciding who is allowed to possess the status of *sickness,* a status that requires surrendering to social control agents a part of one's personal authority (Kurtz & Chalfant, 1984). Psychiatric diagnoses based on the biomedical model utilize "sickness" categories that are "...differentially distributed by gender, ethnicity, and class" (Turner, 1995, p. 80). Labeling someone as deviant (from

the norm) is made much easier if that person is culturally different from the diagnostician (Rubington & Weinberg, 1973).

The DSM-IV-TR contains language of power that affects the lives of clients. Although most professional counselors are taught the negative aspects of social labeling, it would seem that the language of the DSM-IV-TR is not considered labeling, given its popularity. Yet, its language speaks with the voice of labeling. In that official language is tied to delegated authority (Bourdieu,1991), the main diagnostic tool in the US has authority *over* clients, regardless of cultural background. If the DSM-IV-TR is viewed as a symbol of authority by the group that uses it, it would seem to confirm Stein's (1985) idea that group symbols are often used as *group defense mechanisms*, seeking to protect the entire group. Those with "psychology" can protect themselves from those with "culture". Those with psychology may be treated and cured, while those with culture may remain incurable or perpetually different.

The language of power, or rather the power of language, in the DSM-IV-TR conveys more than "scientific" diagnosis. A basic assumption built into the diagnostic categories is that all "disorders" reside within the self. Here again, culture becomes a problem -- clients who are culturally different may not possess or identify with the same sense of self. The abstract construct of a "separate and bounded self" (Gilligan, 1986) is derived from ideas peculiar to the Western tradition. People from some cultures may simply not respond to such a notion of isolated selfhood. Others may thereby see them as faulty selves, as imperfect persons.

The Counselor as Knower

Clearly, the use of the DSM-IV-TR as a basis for diagnosis in multicultural counseling is a topic that is both complex and controversial. The individual counselor may be at a disadvantage in trying to sort out the right and wrong of the DSM-IV-TR. Simply put, client welfare and norms of professional practice may be in direct conflict. The counselor may be responsible for formulating a diagnosis with the DSM-IV-TR, knowing that his or her client differs either historically or culturally from the mainstream client assumed in the manual. Yet the counselor may feel obligated to diagnose as a way of getting a client into the "system" that can provide help or funding. In this context the counselor may not become a "helper" until a diagnosis is completed. The counselor may be caught in a paradox here – wanting to help even if it requires a harmful or inaccurate diagnosis. In fact the counselor's main job here may be to get the client into the system. The counselor may not perceive an alternative to a diagnosis that must trigger any forthcoming help for the client.

The ubiquitous term *cultural awareness* suggests that the counselor should be aware of the client's cultural identity and sensitive to his or her worldview. Although this is a valid ideal, a more realistic starting point may be for the counselor to know what culture *is* as a concept. Still, the counselor may understand culture, the client, and the situation, and still not be able to avoid using the DSM-IV-TR as a diagnostic guide. Because such a complex situation is allowed to exist, the counselor remains ethically at-risk by making such diagnoses. In such instances, the counselor should know that the well-being of the client has become subordinate to the "rules" of practice. As a professional, the multicultural counselor should put the client's welfare above other

considerations (Weinrach & Thomas, 1996), but as a person working in a specific setting he or she may feel compelled to follow local rules of diagnosis.

Bock (1999) noted that the failure to see the origins of psychology in the assumptions of Western philosophy amounts to the "...cruelest kind of ethnocentrism" (p. 212). Additionally, LaFromboise, Foster, and James (1996) have observed that prejudices of one kind or another in society at-large can be replicated within the context of the counseling relationship. The DSM-IV-TR may play a role in this replication process. Some cultures define the origin of illness in terms of supernatural causality (Mullings, 1984). An American from such a culture might find that advancing such a view of illness in counseling could result in an additional diagnosis. The issue might depend on the counselor's knowledge of culture more than on his or her knowledge of DSM-IV-TR diagnostic criteria. In such an instance the client would be vulnerable.

The counselor as *knower* has a formidable task. The necessary skills base is comprehensive (Sue, Arredondo, & McDavis, 1992), the knowledge base requires an understanding of numerous existential schemata for living (see, for example, Herr, 1990), and the relationship between culture and healing is a complex one (see Kleinman, 1980). Knowing requires learning. True cultural awareness of one's own life-context is difficult in itself. Learning about culture, cultural differences, social policy, social justice, history, individual variation, sociopolitical dynamics, and oppression makes for a long journey. And yet, such knowledge is necessary before the counselor can formulate a context in which to understand that the DSM-IV-TR may have limitations that subvert the counseling process. As an advocate, the counselor takes on the task of helping people deal with oppression (Atkinson & Hackett, 1995). The

counselor must understand why many clients might distrust diagnoses foreign to their folkways, and must understand why clients might think of the counselor as an oppressor.

The authors believe that cultural awareness and sensitivity come most easily to counselors who see themselves as multicultural beings. Ironically, light-skinned American people from diverse cultural backgrounds may have been able to *pretend* uniformity of culture. Historically, they may have been able to hide their diverse backgrounds long enough to become the Americans they pretended to be. People of color, on the other hand, have often been treated as culturally different after hundreds of years of living in American society.

Principles and Visions For An Alternative

It is because so much is at stake for clients that an alternative to the DSM-IV-TR may seem important to many professional counselors. The first step toward an alternative might be to identify ethical concerns or principles about the relationship among counseling, culture, and client well-being. Multicultural counselors may understand that an alternative to the DMS-IV need not be another published manual to guide counselors through the diagnostic process. It is just as likely that a viable alternative may be found in new approaches to professional practice, approaches that are based on a better understanding of culture and of social behavior as they are expressed in individual lives. The following ideas represent some of the basic considerations that theorists and practitioners may find useful in identifying potential alternatives to the DSM-IV-TR:

Wisdom: A beneficial alternative should reflect human wisdom about how counseling and culture may be combined harmoniously. For example, Patterson (1996) explained the shortcomings of directive counseling in multicultural situations. Yet formal diagnosis by the DSM-IV-TR may be the activating event in a series of consequences for the client, all of which may be perceived as directive. Medication, counseling, labeling, and deterioration of social status may occur subsequent to diagnosis. Triggering such a chain of events may seem directive, indeed, to the client who sees the counselor as an authority with the power of dominant culture.

Understanding this kind of situation requires a degree of wisdom on the counselor's part -- wisdom consisting of more than professional knowledge. Wisdom here is the ability to anticipate how things may be viewed from different perspectives. Even a client whose socioeconomic status (same culture) is different from the counselor's may perceive helping that begins with formal diagnosis as colonialism and arrogance. Wisdom may allow the counselor to appreciate this view and to be most helpful by disclosing to the client an accurate understanding of his or her status within the system as well as the likely outcome.

The often used phrase *cultural sensitivity* found in counseling literature should be defined in broad enough terms to mean sensitivity to one's *own* cultural beliefs – allowing counselors to see clearly how their ways of practice affect others. If mercy first requires despair (Stein, 1998), such sensitivity might infuse wisdom with human mercy. Thus, the wisdom described here is the sort that encourages counselors to recognize and to feel some despair about historical patterns. Knowing that diagnosis is a political act and knowing about peoples' past experiences with oppressive counseling, the wise

counselor may have reason to pause before putting another client on the same path. The willingness to feel mercy figures into the counselor's sensitivity for the client as a human being.

Client Time: An alternative to the DSM-IV-TR should provide as part of the assessment process the understanding that the counselor must spend time with the client in a culturally relevant manner. Many cultures place great importance on the telling of stories about life events. Listening without making premature conclusions may be taken as a sign of respect. Additionally, listening to complete stories gives the counselor a much greater knowledge of the client's life-context, a context that may explain the logic of behavior in nonpathological ways.

Telling stories may set the stage for healing (Frank, 1995; Mechanic, 1999) and on the sociopolitical level may allow the client the dignity of preserving his or her own story of life problems in ways that are culturally meaningful. Helping professions have a tendency to rewrite the meaning of clients' stories in terms of psychopathology (Holmes, 1997), thus using diagnosis as a vehicle for subtle forced assimilation. In effect, professionals may convey to clients the idea that client stories or accounts are meaningless and irrelevant, and that only a story told in the language of Western psychology has merit. People seek to have their stories *honored* by listeners who will accept the facts and the perspective (Read, 1992). In essence, a DSM-IV-TR diagnostic label may be seen as a competing story or as one that the client must accept. In other words, the client's own story may be disregarded.

All policies contain stories (Stone, 2001). The DSM-IV-TR is able to compete with client stories because it contains stories of its own. These are story motifs of

Western tradition that are like dramas of how life should be played out (Nuckolls, 1998). Hidden as they are, they constitute embedded structures that infect diagnosis with cultural ideals. Following this line of reasoning, the dramas provide solutions to life problems much like Greek dramas once did – *Deus ex machina* – a god or other agent appears to resolve the dilemma. In this instance, psychiatry itself descends to provide solutions (diagnoses and treatments). This paternalistic role has been written into the cultural "script".

An alternative to the DSM-IV-TR that considered the etiquette and power of storytelling as authentic knowledge would automatically offer greater respect for clients. The cultural bias in the embedded motifs of the DSM-IV-TR would not serve as a point of comparison by which the client's life might be judged. In turn, trust between client and counselor could assume its therapeutic role and could lead toward human understanding that transcends everyday cultural differences. This is a simple matter; listening to life stories conveys respect and dignity, and allows all those involved to broaden their own knowledge of culture and selfhood.

The Counseling Relationship: If concern for client welfare is, in fact, the guiding ethic of the counseling process, then the relationship between the client and the counselor must be one that allows the counselor the *vision* to apprehend the state of the client's welfare. The counselor must understand the "personal" meaning that cultural identification has for the client (Christensen, 1989), without forcing him or her into diagnostic "boxes" that may have no cultural meaning to the client.

Using the DSM-IV-TR in multicultural counseling is not merely an issue of counseling theory, but also one of counseling ethics. In an age that seems committed

to a medical-psychiatric model and a managed care model of diagnosed-based helping, how are counselors to practice or display the ethical standards they have been taught? Key elements such as genuineness, authenticity, attending (see Brammer, 1988), and caring are jeopardized by diagnostic mandates.

For such reasons, an alternative to the DSM-IV-TR must allow for a human relationship between counselor and client. In that a diagnosis is *applied to the client*, the inherent power imbalance serves to undermine the counseling process itself. What is imposing itself here into the client – counselor relationship is a psychiatric/medical model that actively seeks client weaknesses over strengths. Although clients may seek counseling for the expertise it can provide, they still need an arena in which their own self-expertise will be valued. Without this arena the power imbalance may prevent the collaborative effort vital to the counseling process. Even some biomedical researchers are beginning to see "patients" as the authentic experts on their own lives (Lorber, 1997; Golin, DiMatteo, & Gelberg, 1996).

Weick and Chamberlain (1997) have summarized some of the ways in which the biomedical model has affected the helping process. If a DSM-IV-TR diagnosis is mandated by such a model and that diagnosis adversely affects the counseling process because of cultural bias or suspicions, what follows diagnosis will not be counseling. A more appropriate alternative would, by definition, allow counselors to give clients the best of what they have to offer.

Culture and Change: It is clear that human beings have the capacity to identify themselves as bicultural or as multicultural. Sowell (1994) has pointed out that people who have lost contact with their original cultural identities may sometimes cling to what

has been lost or even exaggerate personal identification with the lost ways. From a multicultural perspective, this is as it should be --- people continually *becoming* in the Rogerian sense (Rogers, 1951) by identifying themselves based on choice, family history, comfortability, and social milieu. The DSM-IV-TR has neither mandate nor authority to encourage people to identify themselves in any specific fashion. Services aimed at *helping* should recognize the culture, history, and strengths of the client group (Wright, Saleebey, Watts, & Lecca, 1983).

Psychological anthropology has recognized that there is variety of personality types in any given culture (Kracke, 1994). Every culture has some way of dealing with such variety, yet the DSM-IV-TR ultimately deals with all cultures by making them the same. Put another way, the standardized diagnostic process *makes a culture all its own*; both counselors and clients must adapt to it. Standardized diagnoses point to standardized solutions --- thus depriving clients of their native ways of dealing with variety. It is in this sense that the DSM-IV-TR promotes forced assimilation.

An alternative to the DSM-IV-TR would have to recognize such ideas and allow for self-directed assimilation. To function as a multicultural person is to choose how and when to change one's preferred ways of being. Some changes like language and business methods may be encouraged by environmental necessity, while more oppressive changes may simply be mandated by the more powerful culture. At a minimum, a diagnostic and helping system should be flexible and humane enough not to require that clients change their cultural ways just so they will better fit into existing diagnostic categories.

Tolerance-as-a-Right: The paternalistic ideology in the DSM-IV-TR follows that of the medical model in psychiatry. However, the imperialistic flavor that arises from use of the DSM-IV-TR with people of culturally diverse backgrounds may be even very subtle in terms of sociopolitical perception. Frankly, given America's historical record of dealing with "marginalized" peoples, it would take much faith for some not to perceive diagnosis as imperialism with a new face – one that "promises" to bring US-style mental health to the "culturally deprived." The importance of the history of inter-group relations and conflict (Triandis, 1994) cannot be overemphasized in this context – diagnosis is something *done to* another person. The nature of the diagnostic instrument may be questioned or avoided by clients because they remember negative interactions of the past.

Diagnosis may be perceived as forced assimilation, requiring people from diverse backgrounds to translate their own "illness" stories into those endorsed by the dominant culture. In this sense, the threat of assimilation becomes an attack on personal identity. Cultural variation in response to illness may be perceived by others as irrational (see Good, 1994). Given the complexity of the encounter between professional and client, there are many ways that diagnosis may cause harm without helping – many cultural ideas seem irrational to outsiders.

The issue of tolerance becomes important here. Although tolerance has been seen as a form of patronizing behavior in the past, it can also be viewed in the sense of *tolerance-as-right*, as a way of acknowledging humanness first (Yovel, 1998). For example, elevated rates of mental illness among American Indians may be due to their contact with industrial civilization (Gallagher, 1980). Some theorists want the DSM to

account for the effects of genocide and colonialism (Duran and Duran, 1995). A viable alternative to the DSM-IV-TR should be able to account for history in *people terms* – an account that would understand that history happened to real people and still lives within them. Tolerance-as-right gives voice to such histories.

Ethical Diagnosis: Diagnosis as formal assessment is supposed to be of some value to the client. With so many sociopolitical themes connected to the use of the DSM-IV-TR, counselors face a dilemma – they must have client trust in the counseling relationship, but they may also have to violate that trust with diagnoses that may or may not be accurate. In this context diagnosis resembles a dual relationship –that of *trusted helper* and that of *power authority*. Existential diagnoses that focus on universal humanness (Vontress, 1988) may help counselors avoid such a dilemma, but only if they are free to pursue alternative forms of assessment.

Taxonomically, naming a thing by categories involves saying what it is *not* (Shweder, 1990). Categorization is the same schema used in the DSM-IV-TR to identify various diagnoses. By saying that something is a disorder means that it is not something else --- like a unique cultural difference. For this taxonomy to work, the client's view of life-problems must be translated or transformed into an appropriate DSM-IV-TR diagnostic category. This in itself may constitute and be perceived as oppressive, unfair, or even as unethical by clients themselves. If the diagnostic imprecision of the DSM-IV-TR is ignored by professionals, clients have little opportunity to voice their own solutions.

An alternative to the DSM-IV-TR would have to function to protect the client by offering some sort of ethical diagnosis. Generally speaking, such a diagnosis would have resonance with the client's worldview and would not merely be a "scientific" label

superimposed on him or her. Redefining mental health and mental illness to apply to all cultures (Lewis, 1981) may seem to be an overwhelming venture, but the difficulty does not justify perpetuation of potentially oppressive definitions merely because they already exist. Ethically, multicultural counselors need alternative diagnostic methods that can distinguish between pathology and culture, between culture and ethnicity, and between ethnicity and wellness. At a minimum, counselors need methods that allow them to see clients as multicultural beings who are capable of variation in ways of thinking and doing.

Language: The DSM-IV-TR and its endorsement by service funding entities help maintain a paradigm in counseling and other professions that is a clear derivative of the medical model. This model allows social ills to be translated into personal illness through the lexicon of professional discourse (Holmes and Saleebey, 1993). Such discourse may be least helpful to clients because it is so often negative and deficit oriented. The discourse is constituted by language use geared toward cultural assumptions and social conformity.

Although it is vital for the counselor to understand the *meaning* of clients' ethnic identity (Hays, 1996), the meaning may be impossible to discern if the counselor's role is dictated by constrictive discourse about diagnoses. The medical model has helped produce a rather imprecise idea of illness. As Estroff (1981) observed, the disease status of psychiatric disorder is so ambiguous that even the inability to get well may be seen as a symptom. Ironically, there may be a tendency among professionals to imagine that a DSM-IV-TR diagnosis is an *intervention* --- a helping technique – that is so accurate that failure to respond by "getting well" may be seen as clients' failure.

Ideally, an alternative to the DSM-IV-TR would be built around language that is primarily communicative instead of ideological.

Conclusion

It should be obvious that the use of the DSM-IV-TR for psychological diagnosis of people with diverse cultural backgrounds is a complex social and political issue. From an ethical point of view, it would seem that the DSM-IV-TR might represent a clear and present danger to such clients. The manual itself may contain categorical and descriptive ideas that have little resonance with cultural reality for many people. Beyond this, however, is the issue of *how* the manual is used by thousands of professional practitioners. The probability of misdiagnosis is difficult to assess, but diagnostic labels may be immediately harmful to clients. Although some professionals may feel comfortable with the manual, counseling has an *ethical mandate* to guard the welfare of clients of all cultures.

For very practical reasons, then, there seems to be convincing evidence that a viable alternative to the DSM-IV-TR is desirable. The issues discussed in this article are only some of those that may be important in contemplating any future alternative. Multicultural counseling, as a specialty area, has served as a voice in the wilderness on this issue, and may very well be called upon to lead the way toward an alternative to the DSM-IV-TR.

However, there are a couple of important issues not discussed so far in this paper. Yet, they will matter greatly in all future discussions about an alternative. The first of these is that in a very basic way, counseling and other helping professions have allowed themselves to be defined in large part by psychiatry, by governmental agencies,

and by the insurance industry. Counselors often discuss among themselves strategies by which they may fulfill the diagnostic requirements of funding entities without doing harm to their clients. Simply put, this is an intolerable situation for the profession.

The second issue is the question of whether the DSM-IV-TR really applies to *anyone* in a multicultural society. Regional and ethnographic nuances are to be found throughout the US. For example, people of Welsh, Irish, Scots, German, and other ancestry have had unique cultural experiences of their own, and they may be no less *different* from other US ethnic groups. This issue is vital because it, too, arises from a definition of culture that comes from the DSM-IV-TR instead of from members of cultural groups themselves. In this instance, the manual makes the assumption that all such groups are culturally the *same*. At a minimum, social justice requires that people identify themselves in ways that have meaning to them. On a professional level, the newly organized affiliate of the American Counseling Association, Counselors for Social Justice (Guerra, 1999), may deal with exactly these sorts of issues.

The shortcomings and criticisms of the DSM-IV-TR discussed here do not negate the fact of psychopathology. Psychological problems of one kind or another occur in all societies and in all cultures. In reality, professionals using the DSM-IV-TR are just as likely to mistake pathology for culture as they are to mistake culture for pathology. Neither error would benefit clients. Although schizophrenia may not vary much from culture to culture (Ingham, 1996), many "disorders" in the DSM-IV-TR may simply be worldview artifacts or assumptions made by a dominant culture. An alternative to the DSM-IV-TR should help professionals make clearer distinctions between culture and

pathology, or it should focus elsewhere ---- not on finding pathology but on helping in a constructive way.

It should be noted that the producers of the DSM-IV-TR do make provisions for cultural differences, but they do so with in a way that is consistent with their collective or institutionalized notions about culture itself. The bulk of the manual views humans as carriers of psychiatric symptoms more than as carriers of culture. For example, Appendix B (p. 811) offers a list of defense mechanisms. The list, however, is cross-titled as a list of coping styles. Although one might assume that there are other, more healthy coping styles extant in human behavior, the manual does not say so explicitly. So if there is no accepted, documented (consensual) cultural reason for people to behave in a particular way, the people may simply be employing one or more of these coping styles. Yet, if these styles are also seen as defense mechanisms, they somehow become linked to potential pathology. There is little room here to view humans as beings who cope with the world as best they can. These pathology-like coping styles (that once might have been considered normal human frailties) may be seen in any human's behavior. Cultural differences complicate such an "iffy" way of sorting out behaviors. Lack of complete, accurate cultural information might lead some diagnosticians to assume that a coping style is the same thing as a defense mechanism, and thereby should be taken as evidence of pathology.

People from various cultures may feel allegiance to their group of origin. Depending on a group's historical experiences in this country, feelings about the dominant culture may be generally negative. For example, issues of justice, identity, and legitimacy may characterize the psychology of ethnic struggle (Mays, Bullock,

Rosenzweig, & Wessells, 1998). These issues may play a major role in the counseling process -- the clinical actions of the counselor may be perceived in terms of history, oppression, suspicion, and so forth. So diagnosis that produces negative labeling may be seen as the antithesis of helping.

A specific dilemma for counseling revolves around the ethics of diagnosis as it is currently done. There is no doubt that the DSM-IV-TR is founded on (and expanded on) a deficit model. The tradition of growth and development theories within counseling seems out of place in such an arena. Christopher (1999) has noted the difficulties of conceptualizing psychological well-being as a value-free measurement. He has also suggested that cultural understanding is linked to perceiving in individual people the "...sense of self and good (p. 150)."

If an alternative to the DSM-IV-TR is to be a reality, it may well be the counseling profession that finds it or builds it. Psychiatry and psychology have evolved into professions searching for what is wrong in people, and they may have an interest in the continued use of the DSM-IV-TR. Professional counseling, however, emerged from education with a philosophy of growth and development. Such a philosophy is at home with any culture and with any people, simply because its practice concerns humans helping one another. In this philosophy there is but one enduring story – the client's quest for quality of life.

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