The British Psychological Society

Response to the American Psychiatric Association:
DSM-5 Development

The British Psychological Society thanks the American Psychiatric Association (APA) for the opportunity to respond to the DSM-5 Development.

The British Psychological Society ("the Society"), incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. The Society is a registered charity with a total membership of almost 50,000.

Under its Royal Charter, the objective of the Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge".

The Society is committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research. The Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

We are content for our response, as well as our name and address, to be made public. We are also content for the APA to contact us in the future in relation to this response. Please direct all queries to:-

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This response was prepared on behalf of the Society by Professor Peter Kinderman, CPsychol, AFBPsS, Chair of the Division of Clinical Psychology (DCP), with contributions from Susan van Scoyoc, CPsychol, CSci, AFBPsS, committee member of the DCP and member of the Division of Heath Psychology (DHP); Dr David Harper, CPsychol, AFBPsS, Professor David Pilgrim CPsychol, AFBPsS, and Professor Richard Bentall, FBPsS, all members of the DCP; Lucy Johnstone, CPsychol, AFBPsS, committee member of the DCP; Dr Amanda C de C Williams, CPsychol, member of both the DCP and the DHP, and Professor Pamela James, CPsychol, AFBPsS, committee member of the Division of Counselling Psychology. We would like to thank Berry Neil for informing aspects of this response. We hope you find our comments useful.

Carole A Allan

Dr C A Allan, CPsychol, CSci, AFBPsS
Chair, Professional Practice Board

General comments
The Society is concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We therefore do welcome the proposal to include a profile of rating the severity of different symptoms over the preceding month. This is attractive, not only because it focuses on specific problems (see below), but because it introduces the concept of variability more fully into the system. That said, we have more concerns than plaudits. The putative diagnoses presented in DSM-V are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgements, with little confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations. Many researchers have pointed out that psychiatric diagnoses are plagued by problems of reliability, validity, prognostic value, and co-morbidity. Diagnostic categories do not predict response to medication or other interventions whereas more specific formulations or symptom clusters might (Moncrieff, 2007). Finally, disorders categorised as ‘not otherwise specified’ are huge (running at 30% of all personality disorder diagnoses for example). Personality disorder and psychoses are particularly troublesome as they are not adequately normed on the general population, where community surveys regularly report much higher prevalence and incidence than would be expected. This problem – as well as threatening the validity of the approach – has significant implications. If community samples show high levels of ‘prevalence’, social factors are minimised, and the continuum with normality is ignored. Then many of the people who describe normal forms of distress like feeling bereaved after three months, or traumatised by military conflict for more than a month, will meet diagnostic criteria. In this context, we have significant concerns over consideration of inclusion of both “at-risk mental state” (prodrome) and “attenuated psychosis syndrome”. We recognise that the first proposal has now been dropped – and we welcome this. But the concept of “attenuated psychosis system” appears very worrying; it could be seen as an opportunity to stigmatize eccentric people, and to lower the threshold for achieving a diagnosis of psychosis Diagnostic systems such as these therefore fall short of the criteria for legitimate medical diagnoses. They certainly identify troubling or troubled people, but do not meet the criteria for categorisation demanded for a field of science or medicine (with a very few exceptions such as dementia.) We are also concerned that systems such as this are based on identifying problems as located within individuals. This misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives.

The Society recommends a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience, and that psychosocial factors such as poverty, unemployment and trauma are the most strongly-evidenced causal factors. Rather than applying preordained diagnostic categories to clinical populations, we believe that any classification system should begin from the bottom up – starting with specific experiences, problems or 'symptoms' or 'complaints'. Statistical analyses of problems from community samples show that they do not map onto past or current categories (Mirowsky, 1990, Mirowsky & Ross, 2003). We would like to see the base unit of measurement as specific problems (e.g. hearing voices, feelings of anxiety etc)? These would be more helpful too in terms of epidemiology.

While some people find a name or a diagnostic label helpful, our contention is that this helpfulness results from a knowledge that their problems are recognised (in both senses of the word) understood, validated, explained (and explicable) and have some relief. Clients often, unfortunately, find that diagnosis offers only a spurious promise of such benefits. Since – for example – two people with a diagnosis of 'schizophrenia' or 'personality disorder' may possess no two symptoms in common, it is difficult to see what communicative benefit is served by using these diagnoses. We believe that a description of a person's real problems would suffice. Moncrieff and others have shown that diagnostic labels are less useful than a description of a person's problems for predicting treatment response, so again diagnoses seem positively unhelpful compared to the alternatives. There is ample evidence from psychological therapies that case formulations (whether from a single theoretical perspective or more integrative) are entirely possible to communicate to staff or clients.

We therefore believe that alternatives to diagnostic frameworks exist, should be preferred, and should be developed with as much investment of resource and effort as has been expended on revising DSM-IV. The Society would be happy to help in such an exercise.

References

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Comments on specific disorders		
Code	Title	Comment
A 00-01 A 02-08 A 09	Intellectual Developmental Disorders Communication Disorders Autism Spectrum Disorder	We have no specific comments on these disorders, other than to say that, in our opinion, the use of diagnostic labels has greater validity, both on theoretical and empirical grounds in these areas.
A 10	Attention Deficit/Hyperactivity Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. We have particular concerns about the inclusion of Attention Deficit/Hyperactivity Disorder in this categorisation. Many of the concerns about the scientific validity and utility of diagnoses per se (articulated above) apply to ADHD. We are very concerned at the increasing use of this diagnosis and of the increasing use of medication for children, and would be very concerned to see these increase further.

A 11	Other Specified Attention Deficit/Hyperactivity Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. We have particular concerns about the inclusion of Attention Deficit/Hyperactivity Disorder in this categorisation. Many of the concerns about the scientific validity and utility of diagnoses per se (articulated above) apply to ADHD. We are very concerned at the increasing use of this diagnosis and of the increasing use of medication for children, and would be very concerned to see these increase further. In addition, we have serious concerns about the widespread use of the 'other' or 'not otherwise specified' categories, which, in this context, appear to exacerbate all the problems of labelling with invalid diagnostic labels.
A 12-15 A 16-22	Learning Disorders (Learning Disorder, Dyslexia, Dyscalculia, Disorder of Written Expression), Motor Disorders	We have no specific comments on these disorders, other than to say that, in our opinion, the use of diagnostic labels has greater validity, both on theoretical and empirical grounds in these areas.

B 00	Schizophrenia	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The general concerns about the scientific validity and utility of diagnoses articulated above are particularly relevant to the diagnosis of schizophrenia. We note in particular, that the invalidity of this diagnosis is such that it is entirely possible for two individuals with the diagnosis to share no characteristics or symptoms. We also note the poor prognostic and therapeutic validity of this group of diagnoses.
B01	Schizotypal Personality Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The general concerns about the scientific validity and utility of diagnoses articulated above are particularly relevant to the diagnosis of Schizotypal Personality Disorder – as it suffers from the problems associated with personality disorder more generally, as well as problems associated with psychosis.

B02	Schizophreniform Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The general concerns about the scientific validity and utility of diagnoses articulated above are particularly relevant to the diagnosis of Schizophreniform Disorder, which appears to be a reflection of vague concerns about a person's mental health – effectively one of many 'catch-all' classifications.
B03	Brief Psychotic Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The general concerns about the scientific validity and utility of diagnoses articulated above are particularly relevant to the diagnosis of Brief Psychotic Disorder, given the problems associated with psychiatric labels, the particular consequences of a psychotic label and the known transience of many of these fleeting psychosis-like experiences.

B04	Delusional Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The general concerns about the scientific validity and utility of diagnoses articulated above apply equally to the diagnosis of Delusional Disorder.
B05	Schizoaffective Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The general concerns about the scientific validity and utility of diagnoses articulated above apply equally to the diagnosis of Schizoaffective Disorder.

B06	Attenuated Psychosis Syndrome	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. We have significant concerns over the inclusion of "attenuated psychosis syndrome". The concept of "attenuated psychosis system" appears very worrying; it looks like an opportunity to stigmatize eccentric people, and to lower the threshold for achieving a diagnosis of psychosis (and hence increasing the number the people receiving antipsychotic medication and a range of other social ills).
B07-14	Substance-Induced Psychotic Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The general concerns about the scientific validity and utility of diagnoses articulated above are particularly relevant to the diagnosis of Substance-Induced Psychotic Disorder. People take drugs; these drugs affect their mental state and can have long-term consequences. That appears somewhat different from a diagnosis of conventional medical illnesses.

B15	Psychotic Disorder Associated with a Known General Medical Condition	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. These concerns include the association between physical and psychological health – where we believe it is unnecessary and misleading to represent such associations as 'psychiatric illnesses' – and 'catch-all' classifications such as 'unspecified' or 'other'.
B16	Catatonic Disorder Associated with a Known General Medical Condition	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. These concerns include the association between physical and psychological health – where we believe it is unnecessary and misleading to represent such associations as 'psychiatric illnesses' – and 'catch-all' classifications such as 'unspecified' or 'other'.
B17	Other Specified Psychotic Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. These concerns include the association between physical and psychological health – where we believe it is unnecessary and misleading to represent such associations as 'psychiatric illnesses' – and 'catch-all' classifications such as 'unspecified' or 'other'.
B18	Unspecified Psychotic Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. These concerns include the association between physical and psychological health – where we believe it is unnecessary and misleading to represent such associations as 'psychiatric illnesses' – and 'catch-all' classifications such as 'unspecified' or 'other'.

B19	Unspecified Catatonic Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. These concerns include the association between physical and psychological health – where we believe it is unnecessary and misleading to represent such associations as 'psychiatric illnesses' – and 'catch-all' classifications such as 'unspecified' or 'other'.
C00-06	Bipolar and related disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These general concerns about the scientific validity and utility of diagnoses articulated above apply equally to the area of bipolar disorder and related disorders.

D01-02 and D04-09	Depressive Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These general concerns about the scientific validity and utility of diagnoses articulated above apply equally to the area of depressive disorders. We note that, in this context, sadness and unhappiness which are deserving of help and intervention – are not best considered illnesses. We also note that, by regarding them as such, there is a danger of misunderstanding their nature and cause and applying inappropriate medical remedies.

D00	Disruptive Mood Dysregulation Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These general concerns about the scientific validity and utility of diagnoses articulated above apply equally to the area of depressive disorders. We note that, in this context, sadness and unhappiness which are deserving of help and intervention – are not best considered illnesses. We also note that, by regarding them as such, there is a danger of misunderstanding their nature and cause and applying inappropriate medical remedies. We have particular concerns at the inclusion of this diagnosis, whose essential characteristics: "...severe recurrent temper outbursts in response to common stressors...." appear to reflect exactly those normative judgements referred to above.

D03	Chronic Depressive Disorder (Dysthymia)	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These general concerns about the scientific validity and utility of diagnoses articulated above apply equally to the area of depressive disorders. We note that, in this context, sadness and unhappiness which are deserving of help and intervention – are not best considered illnesses. We also note that, by regarding them as such, there is a danger of misunderstanding their nature and cause and applying inappropriate medical remedies. We have particular concerns at the inclusion of this diagnosis, whose essential characteristics: "...depressed mood for most of the day..." certainly reflects a state of affairs that any humane individual should attempt to address, but does not appear to reflect any form of medical illness.

E00-14	Anxiety Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. The concerns noted above also apply to anxiety disorders. We note that many people have experienced, and live in, circumstances that reasonably induce normal and understandable anxiety. We further note that many of the specific diagnoses – particularly social anxiety and generalised anxiety disorder – appear, again, to reflect conditions that are understandable, and deserving of help and intervention, but are not best considered illnesses. We also note that, again, by regarding them as such, there is a danger of misunderstanding their nature and cause and applying inappropriate medical remedies.
F 00-09	Obsessive-Compulsive and Related Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. Although obsessive-compulsive problems appear to have more empirical validity than some other disorders, many of the concerns noted above also apply here – particularly the concerns over inappropriate medicalisation and potential over-reliance on medical interventions.

G00-08	Trauma- and Stressor-Related Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. Again, we have concerns in the area of trauma-related disorders. Obviously it is right and proper to recognise the effects of traumatic events on people, and to be able to offer appropriate help. In this context however, we fear that those benefits might be made more difficult if, instead of recognising the effects of traumatic events on people, these were considered to be 'disorders' or 'illnesses'. As noted above, there are more appropriate conceptualisations.
H00-05	Dissociative Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These concerns also apply to this area.

J00	Complex Somatic Symptom Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. Many of these concerns also apply to this area. It is good to see the assumptions implicit in 'somatization' terminology have been removed, but we retain concerns about the criteria used. Concern about medical seriousness arises from the universal experience of pain as a warning signal of something wrong, as in many acute pains. Until and unless an adequate explanation is given to the person with persistent pain, distinguishing it from the 'alarm signal' of acute pain, they continue to search for a medical explanation as is the case in acute pain. "Reassurance" that nothing shows on investigation often exacerbates the patient's concerns that what they have is hard to detect or diagnose. The judgment of what is 'disproportionate' or 'excessive' is a subjective, value-laden, issue.

J01	Simple Somatic Symptom Disorder	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. Many of these concerns also apply to this area. It is good to see the assumptions implicit in 'somatization' terminology have been removed, but we retain concerns about the criteria used. Concern about medical seriousness arises from the universal experience of pain as a warning signal of something wrong, as in many acute pains. Until and unless an adequate explanation is given to the person with persistent pain, distinguishing it from the 'alarm signal' of acute pain, they continue to search for a medical explanation as is the case in acute pain. "Reassurance" that nothing shows on investigation often exacerbates the patient's concerns that what they have is hard to detect or diagnose. The judgment of what is 'disproportionate' or 'excessive' is a subjective, value-laden, issue.
J02-06	Somatic Symptom Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. Many of these concerns also apply to this area.

K00-07	Feeding and Eating Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These concerns also apply to this area.
L00-01	Elimination Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These concerns also apply to this area.

M00-20	Sleep-Wake Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. These concerns also apply to this area.
N00-10	Sexual Dysfunctions	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. All the comments made earlier apply also here. Of particular concern are the subjective and socially normative aspects of sexual behaviour. It is a matter of record that homosexuality used to be considered a symptom of illness. The Society would not be able to support considering sexual differences as symptoms of illness.

P00-03	Gender Dysphoria	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. All the comments made earlier apply also here. Of particular concern are the subjective and socially normative aspects of sexual behaviour. We are very concerned at the inclusion of children and adolescents in this area. There is controversy in this particular area – the concept of a 'diagnosis' of a 'psychiatric disorder' disputed. Labelling people who need help as 'ill' may make supportive and therapeutic responses more difficult.

Q00-07	Disruptive, Impulse Control and Conduct Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. All the comments made earlier apply also here. Of particular concern are the subjective and socially normative aspects of conformist behaviour. We are very concerned that 'headstrong' behaviour is considered to be pathognomic of an illness (in Oppositional Defiant Disorder). Many people – many governments – would like children and citizens to be less defiant and more compliant. However, it is not a symptom of illness to be defiant. It may be a social or psychological problem to be addressed, but it may, in some circumstances, be a characteristic to be praised. An 'unspecified' disruptive or impulse control disorder, in this context, is even more subjective, value-laden, conceptually confused, and therefore worrying.

R00-31	Substance Use and Addictive Disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. We note with concern the concept of 'Gambling Disorder'. Gambling is a problem, and it is a social phenomenon and issue that requires study and response. However, we feel it is conceptually wrong to regard this as an illness with symptoms. We recognise that here – as in other 'disorders' – no concept of organic pathology is necessarily implied (DSM-V is, we recognise, intended to be a useful list of 'disorders'), but we also are aware that inclusion in such a list has implications, and we strongly feel that an alternative non-medical conceptualisation is called for.
S00-35	Neurocognitive Disorders	We have no specific comments on these disorders, other than to say that, in our opinion, the use of diagnostic labels has greater validity, both on theoretical and empirical grounds in these areas.

	Personality disorders	The Society has several concerns in this area. While a hybrid dimensional-categorical model for personality and personality disorder assessment and diagnosis may be welcome, little of that is visible. As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. We are particularly concerned that the system proposes to diagnose psychiatric disorder on a rating of "quite a bit" on personality trait domains.

U00-09	Paraphilias	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. All these comments apply also here. Again, of particular concern are the subjective and socially normative aspects of sexual behaviour. It is a matter of record that homosexuality used to be considered a symptom of illness. The Society would not be able to support considering sexual differences as symptoms of illness. We, finally, have severe misgivings about the inclusion of "Paraphilic Coercive Disorder" in the appendix. Rape is a crime, not a disorder. Such behaviours can, of course, be understood, but we disagree that such a pattern of behaviour could be considered a disorder, and we would have grave concerns that such views may offer a spurious and unscientific defence to a rapist in a criminal trial.

V01-06	Other disorders	As stated in our general comments, we are concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. We believe that classifying these problems as 'illnesses' misses the relational context of problems and the undeniable social causation of many such problems. For psychologists, our well-being and mental health stem from our frameworks of understanding of the world, frameworks which are themselves the product of the experiences and learning through our lives. Clearly it is good for healthcare professionals and others to recognise self-harm. However, we do not believe that self-harm should be classified as a symptom of a disorder. Rather we would support recognising this behaviour, understanding it and offering help. Similarly, a "pattern of falsification of physical or psychological signs or symptoms, or of induction of injury or disease" is a worrying and important phenomenon. But again it should be understood and responded to, not conceptualised as a symptom of an illness.