



Symposium/Other Proposal

2018 APA Annual Convention

Proposal ID: sym18201

- Collaborative Justification:** This symposium addresses the topic of diversity as it relates to diagnostic theory and practice, so it was essential to assemble an interdivisional group of speakers with a broad range of views, perspectives, practices, and career stages.
- 1. Type of program:** Symposium
- 2. Title of program:** Diagnosing Diagnosis: Social Justice and Diversity
- First index term: 48 Multicultural
- Second index term: 33.1 diagnosis
- 3. Brief Content Description:** This symposium brings together national and international experts with a diverse range of perspectives on clinical diagnosis and social justice in the ‘psy’ disciplines.
- 4. Division to submit this proposal:** 32 - Humanistic
- Other division(s) appropriate for submission:**
- 17 - Counseling
 - 22 - Rehabilitation
 - 24 - Theoretical and Philosophical
 - 44 - Lesbian, Gay, Bisexual and Transgender Issues
 - 45 - Psychological Study of Culture, Ethnicity and Race
- 5. Length of time requested on program:** 1 hr. 50 min.
- 6. Chair(s) of the session:**

(1) Sarah R Kamens, PhD

(Submitter)

Mailing address: Psychology, Wesleyan University, 207 High Street, Judd Hall,
Middletown, CT 06457
Professional stage: Early Career Professional
E-mail address: srkamens@gmail.com
Phone numbers: 917-747-0119 (cell)
Institution/company: Wesleyan University, Middletown, CT
Membership status: APA Member

7. Participants:

(1) Peter Kinderman, PhD

Mailing address: University of Liverpool, Dover St, The Waterhouse Building, University of
Liverpool, United Kingdom L3 5DA United Kingdom
Professional stage: Advanced-Career Professional
E-mail address: p.kinderman@liverpool.ac.uk
Phone numbers:
Institution/company: University of Liverpool, Liverpool, United Kingdom, United Kingdom
Membership status: APA International Affiliate
Title of presentation: The legitimate functions of psychiatric diagnosis and the application of
psychological science

Electronic Archiving: Yes
Coauthor :

(2) Sand Chang, PhD

Mailing address: 4001 Howe Street, Oakland, CA 94611
Professional stage: Mid-Career Professional
E-mail address: sand.c.chang@kp.org
Phone numbers:
Institution/company: Private Practice - Training, Psychotherapy, Consultation, Oakland, CA
Membership status: APA Member
Title of presentation: Dysphoria in Diagnosis: Social Justice and Ethical Dilemmas in Diagnosing Gender Diversity

Electronic Archiving: Yes
Coauthor :

(3) Jevon Rice, MS

Mailing address: American School of Professional Psychology at Argosy University, 1005 Atlantic Avenue, Alameda, CA 94501
Professional stage: Graduate Student
E-mail address: JevonRice@stu.argosy.edu
Phone numbers:
Institution/company: American School of Professional Psychology at Argosy University, Alameda, CA
Membership status: APAGS Member
Title of presentation: Diagnosing the Underserved: Substance Use Disorders among Black American Emerging Adults

Electronic Archiving: Yes
Coauthor :

(4) Anne Cooke, MA, MS

Mailing address: Salomons Centre for Applied Psychology, Canterbury Christ Church University, 1 Meadow Road, Tunbridge Wells, Kent, United Kingdom
Professional stage: Advanced-Career Professional
E-mail address: anne.cooke@canterbury.ac.uk
Phone numbers:
Institution/company: Canterbury Christ Church University, Tunbridge Wells, United Kingdom
Membership status: Non-Member
Title of presentation: “But what about real mental illnesses?” Alternatives to the disease model approach to schizophrenia
Electronic Archiving: Yes
Coauthor :

(5) Karla Caballero, MS

Mailing address: Our Lady of the Lake University, 411 SW 24th St, San Antonio, TX 78207
Professional stage: Early Career Professional
E-mail address: kvcaballero@ollusa.edu
Phone numbers:
Institution/company: Our Lady of the Lake University, San Antonio, TX
Membership status: APAGS Member
Title of presentation: Approaching Latina/o Mental Health: Culturally Informed Diagnosing and the DSM-5
Electronic Archiving: Yes
Coauthor 1: Ivette Salinas, MS, Our Lady of the Lake University, San Antonio, TX
Coauthor 2: Mary Baldwin, MA, Our Lady of the Lake University, San Antonio, TX
Coauthor 3: Alexander Young, MA, Our Lady of the Lake University, San Antonio, TX

(6) Ashley Whitaker, MA

Mailing address: Saybrook University, 475 14th Street, 9th floor, Oakland, CA 94612
Professional stage: Graduate Student
E-mail address: awhitaker@saybrook.edu
Phone numbers:
Institution/company: Saybrook University, Oakland, CA
Membership status: APA Student Affiliate
Title of presentation: Diversity and the I-who-feels

Electronic Archiving: Yes
Coauthor :

(7) Jeanne Marecek, PhD

Mailing address: 1771 Spruce Street, Berkeley, CA 94709
Professional stage: Advanced-Career Professional
E-mail address: Jmarece1@swarthmore.edu
Phone numbers:
Institution/company: Swarthmore College, Berkeley, CA
Membership status: APA Fellow
Title of presentation: Suicide-like Acts: Psychopathology or Social Suffering?

Electronic Archiving: Yes
Coauthor :

(8) Brent D Robbins, PhD

Mailing address: Psychology, Point Park University, 201 Wood Street, Pittsburgh, PA 15222
Professional stage: Mid-Career Professional
E-mail address: Brobbins@pointpark.edu
Phone numbers:
Institution/company: Point Park University, Pittsburgh, PR
Membership status: APA Member
Title of presentation: Diagnosis, Social Pathology, and Scapegoating: Clinical Work in the Service of Social Justice
Electronic Archiving: Yes
Coauthor :

8. Discussant(s):

(1) Frank Farley, PhD

Mailing address: College of Education, Temple University, 1301 Cecil B. Moore Avenue, Ritter Annex 213, Philadelphia, PA 19122-6091
Professional stage: Mid-Career Professional
E-mail address: frank.farley@comcast.net
Phone numbers: (215) 204-6024 (office)
Institution/company: Temple University, Philadelphia, PA
Membership status:

9. Accommodation request: None

10. Submit for CE: True

List three ways in which psychologists can approach clinical diagnosis when working with diverse and/or marginalized populations.

Discuss one way in which the current clinical-diagnostic paradigm might be improved using a person-centered, multicultural, and/or social-justice approach.

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Diagnosing Diagnosis: Social Justice and Diversity

The diagnostic landscape in the clinical ‘psy’ disciplines is rapidly changing. While many clinicians, counselors, and other practitioners continue to use the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in everyday practice, researchers are increasingly drawing upon new classificatory models such as the National Institute of Mental Health’s Research Domain Criteria (RDoC) project and the Hierarchical Taxonomy of Psychopathology (HiTOP) model. These new models have arisen in response to research indicating that the current paradigm does not “cut nature at its [empirical] joints” and thus inhibits progress in clinical research. Despite these historical shifts, both conventional and newly proposed classification systems do not explicitly incorporate research related to negative social experiences (e.g., discrimination and stigma), racial/ethnic disparities, and structural risk factors (e.g., socioeconomic inequalities and segregation). Further, despite improvements to cultural-formulation interviewing in DSM-5, clinical research has yet to address the ways in which DSM diagnoses reflect and extend the worldviews of the dominant culture. What happens when the act of labeling another person with a mental disorder contributes to their sociocultural marginalization by dominant institutions and structures? What does it mean when persons from marginalized groups do or do not identify with a diagnostic label? How can we reconceptualize psychological distress in a way that promotes social justice and cross-cultural understandings? This symposium brings together national and international experts with a diverse range of perspectives and practices related to clinical diagnosis in the ‘psy’ disciplines. The presenters will ‘diagnose diagnosis’ by addressing the implications of diagnostic systems for larger society and diverse populations within it, focusing on transgender communities, Latina/o populations, Black emerging adults, the Global South, and persons diagnosed with autism spectrum disorder or schizophrenia. Discussion will focus on a new movement to reconceptualize mental distress using person-centered, multicultural, and social-justice approaches.

(1) The legitimate functions of psychiatric diagnosis and the application of psychological science

It is clear that psychiatric diagnosis serves many legitimate functions; functions that need to be understood and respected by those offering challenges to traditional approaches. Psychiatric diagnoses allow clinicians to communicate with each other, with their clients and with healthcare providers, and permit clients to access a range of social benefits, including but not limited to benefits and therapeutic interventions. Diagnoses also permit some level of understanding of the nature, etiology, and likely treatment options available to clients with a range of problems. However, traditional psychiatric diagnoses are also plagued by major problems. The validity and reliability of most common psychiatric diagnoses are extremely poor – a fact that fundamentally threatens the legitimacy of any purported beneficial functions (since how can communication of an invalid and unreliable diagnosis be helpful?). Psychiatric diagnoses are also associated with a range of unfortunate consequences for people in receipt of those diagnoses and, it is argued by many critics, support unsubstantiated assumptions about the medical nature of psychological phenomena. In this presentation, it will be argued that psychological science offers an evidence based alternative to the current bio-medical approach to diagnosis. Identifying, classifying (where appropriate) or assessing on continuum scales (where appropriate), psychological phenomena is the starting point for psychological science, and should be the starting point for clinical work. The legitimate functions of diagnosis can, evidence suggests, be met through the application of identifying, and assessing, psychological phenomena that cause distress or other problems, then using established psychological science to identify putative psychological mechanisms and causal factors that may precipitate or maintain these phenomena, and therefore likely evidence-based interventions. It is true that significant system reforms would be required to establish such an alternative model of care, but there are good reasons to press for such reforms.

(2) Dysphoria in Diagnosis: Social Justice and Ethical Dilemmas in Diagnosing Gender Diversity

The field of transgender health is fraught with layers of social justice, ethical, political, and human rights dilemmas. The existence of gender-related diagnoses is one of these dilemmas, which dates back to the removal of the formal diagnosis of homosexuality in the DSM. While some argue that a medical or mental health diagnosis is necessary and useful in gaining access to lifesaving medical interventions, others argue that this does not leave space for a disorder- and stigma-free transgender identity or experience. The medicalized narrative of trans health is one that is harmful and creates systematic exclusions of the most marginalized subgroups within transgender communities (i.e., poor people, transgender women/people of color, nonbinary people). This narrative and ensuing diagnosis of Gender Dysphoria creates challenges and power imbalances within provider-client relationships, which can result in the rejection of mental health services and, thus, the reinforcement of ableism. Transgender and gender nonconforming clients are often walking the line between “too sick” and “too well”, which further brings the reliability of Gender Dysphoria to question. In this presentation, I will speak from my experiences as a gender therapist working within transgender health and my involvement in co-authoring APA’s Guidelines for Psychological Practice With Transgender and Gender Nonconforming People. I will speak to how the diagnosis of Gender Dysphoria brings up issues of gatekeeping and I will speak about the ways in which psychologists can engage in advocacy toward a more socially just practice of inclusion of clients across the gender spectrum.

(3) Diagnosing the Underserved: Substance Use Disorders among Black American Emerging Adults

The diagnosis and assessment of substance use disorders (SUDs) continues to be a controversial topic in the field of psychology. As the debate persists, lives continue to be lost to SUDs, especially those of Black American emerging adults. One state out of 50, and the District of Columbia, necessitate that psychologists be trained in SUDs to meet requirements for licensure. When psychologists are trained in SUDs, the information they receive in their training is based on the majority population, which is adult white males. Clients come from diverse backgrounds and the presentation of SUDs can be impacted by their diverse experiences. In 2015, NSDUH identified that emerging adults are the second highest age group to receive mental health treatment for SUDs among the Black American population surveyed (CBHSQ, 2015). The purpose of this presentation is to bring awareness to the needs of this underserved population by enhancing the understanding of SUD diagnosis regarding Black American emerging adults, as they are highly likely to be seen in treatment (CBHSQ, 2015).

(4) “But what about real mental illnesses?” Alternatives to the disease model approach to schizophrenia

The old dichotomy between ‘neurosis’ and ‘psychosis’ appears to be alive and well in the debate about psychiatric diagnosis. It is often suggested that while diagnostic alternatives may be appropriate for the relatively common forms of distress with which we can all identify such as anxiety and depression, psychiatric diagnoses remain vital for experiences such as hearing voices, holding beliefs that others find strange, or appearing out of touch with reality – experiences that are traditionally thought of as symptoms of psychosis or schizophrenia. Such experiences are often assumed to be symptoms of underlying brain pathology or ‘real mental illnesses’ that need to be diagnosed or ‘excluded’ (in the medical sense of ruling out particular explanations of problems) before deciding on the appropriate intervention. This paper argues that this belief is misguided, and that far from being essential, psychiatric diagnosis has the potential to be particularly damaging when applied to such experiences. It describes an alternative perspective outlined in a recent consensus report by the British Psychological Society Division of Clinical Psychology (Understanding Psychosis and Schizophrenia (Cooke, 2017) which has attracted significant attention in the UK and internationally. The report argues that even the most severe distress and the most puzzling behavior can often be understood psychologically, and that psychological approaches to helping can be very effective. It exhorts professionals not to insist that people accept any one particular framework of understanding, for example that their experiences are symptoms of an illness. This paper outlines that report’s main findings, together with their implications for how professionals can best help.

(5) Approaching Latina/o Mental Health: Culturally Informed Diagnosing and the DSM-5

Markowitz et al. (2008) asserts that presently, Spanish speaking populations encompass a growing majority of the United States population. As such, they surmise that this group has a greater inconvenience than most in obtaining and persisting in therapeutic or psychological treatments, much more in terms of reconciling symptoms as listed in the Diagnostic and Statistical Manual, 5th edition, (DSM-5). The occurrence of mental health issues differ among Latina/o subgroups and are a reflection of the diversity of circumstances and experiences. Acknowledging the amount of diversity that exists among the Latina/o population, it is essential to understand the influence that this diversity has on how others understand this population in regards to needing or seeking treatment (Fortuna, 2017). Cultural considerations may include the exploration of how Latina/o's understand and treat emotional and behavioral concerns within their own culture. Lilian- Comaz Diaz (2006) suggests many Latina/os’ prefer holistic interventions prior to seeking westernized interventions. Some unique Latina/o constructs include nervios, susto and mal de ojo. These beliefs bring forth the intersection of culturally sensitive practices and DSM-5 conceptualizations of mental health, thus challenging psychologists in integrating Latina/o client's values while concurrently abiding by the profession’s constructs (Cervantes, 2010). Therefore, our presentation will introduce perspectives of how Latina/os may perceive diagnoses as well as introduce considerations in how psychologists can work collaboratively with Latina/o clients in making culturally informed diagnoses.

(6) Diversity and the I-who-feels

Sela-Smith (2001, 2002) referred to the phenomenological experience of the individual as the "I-who-feels." This presentation discusses the implications for mental health practitioners of using the approach that J. F. T. Bugental called "presence" to actively to explore the lived experience of psychotherapy clients with Autism Spectrum Disorder. For clients experiencing diverse ways of what Heidegger termed "being-in-the-world," this approach is especially relevant from a social justice standpoint. It allows the space for the client's lived experience—as opposed to the stringent clinical etiology of mental health symptoms—to be acknowledged, valued, and given a voice. This approach can transcend beyond the contain or the psychotherapy room and impact how the client views and appreciates the benefits, and sometimes the adversities, that come with diverse ways of being. Autism Spectrum Disorder, in particular, presents unique challenges to being-in-the-world and the ability to communicate one's lived experience; attendees will leave with a better understanding of the phenomenology of the condition. Discussion will also focus on the implications and social justice ramifications of exploring lived experience in this population.

(7) Suicide-like Acts: Psychopathology or Social Suffering?

The DSM has long included suicidal behavior among the symptom criteria of a number of psychiatric disorders; the DSM-5 goes further to propose a new diagnosis called Suicidal Behavioral Disorder. But ethnographic evidence from parts of the Global South indicate that such a diagnosis reflects a US-centric standpoint that fails to acknowledge the culture-bound nature of suicidal behavior.

I am a cultural psychologist trained in clinical psychology. My research has been situated in Sri Lanka, where rates of fatal and nonfatal suicidal acts (typically involving pesticide ingestion) have long held world records. Considerable research has established that these suicidal acts typically erupt with little premeditation during family or marital disputes. These acts serve to express a grievance, register an injustice, call down shame on a wrongdoer, or gain leverage in an argument. They are barely concealed; sometimes they are performed in others' presence. As such, they can be thought of as "suicide-like acts"—actions intended to put the idea of suicide into others' minds. Furthermore, researchers working in Vietnam, the southern Indian states of Kerala and Tamil Nadu, Bangladesh, and Hong Kong have reported a range of motives, meanings, and social practices of suicidal behavior, which are culture-specific and tied to local economic and political circumstances. Rarely do clinical depression or psychiatric illness seem to play a role in these suicidal acts.

Declaring suicidal behavior to be a psychiatric disorder thus constitutes a form of epistemic violence. It imposes a US-centric meaning on considerable cultural variation. Moreover, declaring that suicide-like acts are indicators of mental disorders turns attention away from the gendered and generational power relations, as well as caste- and class-based inequities, that precipitate such acts. Moreover, the medicalization of suicidal behavior would almost certainly prompt an inflation in the indiscriminate prescribing of psychotropic medications.

(8) Diagnosis, Social Pathology, and Scapegoating: Clinical Work in the Service of Social Justice

In his 1967 address to the APA, Martin Luther King, Jr. admonished clinical psychologists for our tendency to interpret psychological suffering in terms of a discourse of “maladjustment.” When we conceptualize mental dysfunction in terms of “maladjustment,” the implied aim of clinical intervention becomes a practice of assisting suffering persons to adjust to cultural norms in order to function within the boundaries of social propriety. As King observed, however, some cultural norms in themselves can be pathological to the extent that the cause or perpetuate unnecessary human suffering. In such cases, the symptomatic person is called, rather, to remain “creatively maladjusted” to such cultural pathologies as racism, economic injustice, and cultures of violence (i.e., militarism). Nevertheless, contemporary psychiatric approaches to diagnosis tend to conceptualize psychopathology as primarily situated within the individual, who is assessed in terms of his relative maladaptation to a norm. When a person suffers not from an individual defect, but rather from the consequences of social dysfunction, the defect tends to be located within the individual rather than the more appropriate site of blame, the social system. In such cases, certain groups of individuals, who are victims of social dysfunction, can become scapegoats--designated patients whose symptoms signify a particular sensitivity to the cultural pathology. By participating in diagnostic systems that scapegoat individuals for social rather than individual pathologies, clinicians can unwittingly serve to maintain a dysfunctional status quo, merely adjusting the individual to the harmful social system. They thereby contribute to maintenance of the social pathology rather than to its dissolution. In order to redress this problem, clinical psychologists must join forces with community psychologists and applied social psychologists, to develop approaches to diagnosing pathological social systems and to develop social interventions to protect citizens from the psychological harm that results from them.