Highlighting the DSM-V's Omission of Client Context[1]

Kevin Michael Stevenson, PhD, MIACP[2]

Abstract. The *DSM-V* is a product of a medical culture that holds individual symptoms as important within the search for biological indicators and psychopathological genetic etiologies (Van Praag, 1990, p. 21). Such an approach undermines the importance of context for understanding problems of living. This paper will look at three components in relation to *DSM-V*'s biological model to show how they exacerbate the promotion of medication treatment using the examples of OCD, social phobias, anorexia, and the therapy experience of U.S. military troops. First, it will look at the *DSM-V*'s categorical approach to diagnosis in juxtaposition to a dimensional/holistic approach, framing the former as an exacerbator of medical solutions to problems of living. Second, it will show that the abstraction required for the categorization inherent in the *DSM-V* does not rely on etiology, rather descriptions which lead to the discrete groupings of disorders for medical matchmaking. Finally, this paper will inform of the repercussions the *DSM-V*'s categorization and abstraction has on the interpretation of culture in relation to problems of living and why its stigmatization of such problems is an interpretation that contributes to the medicalization of treatment rather than a culture of commitment that incorporates holistic support.

Keywords: biological psychiatry, categorical diagnosis, dimensional diagnosis, DSM-V, holism.

---

[1] Paper presented at: 19th Days of Applied Psychology Conference, Transformative Processes in Society, Environment, Organization, and Mental Health Practice, September 29 – 30 2023: University of Niš, Faculty of Philosophy, Department of Psychology.

[2] Post-Doctoral Fellow: Faculty of Philosophy, Department of Logic, Ethics and Aesthetics, Sofia University St. Kliment Ohridski. PT Lecturer: Faculty of Education, Department of Learning, Society and Religious Education, Mary Immaculate College, University of Limerick. Lecturer: Irish College of Humanities and Applied Sciences.

DSM-V Categorization

Within the domain of mental disorders, both categorical and dimensional views provide advantages to diagnosis, as they can be necessary for a taxonomy that is comprehensive (Helzer et al, 2006, p. 17). Another dichotomy worth mentioning is the one between biology and psychology, as some experts view them as not only different levels of analysis on mental disorders, but also as distinct mechanisms of causation, with the former linking to categorical approaches and the latter to dimensional (Bloom, 2004, p. 40). Throughout its history the *Diagnostic and Statistical Manual of Mental Disorders* (henceforth: *DSM*) aimed for standardization of medical regulation in the 1980 *DSM-III* (APA, 1980), which was a more theoretical, objective and descriptive system for nosology than previous editions (Brown et al, 2005, p. 555). This has evolved into today's *DSM-V* published 2013 and *DSM-V*-TR (Text Revision) published 2022[3], both of which when addressing the severity of disorders, favour hierarchal diagnostic rules and exclusions. This leads to the notion that neither give adequate coverage for symptom presentations that are clinically significant, nor for those not meeting criteria for diagnostic categories (Brown et al, 2005, p. 552). Categories can be considered useful to the extent they form successful theories and laws, so stating what diagnostic concepts help progress in evidence-based practice, is to gamble on what categories form the components of successful theory for practice (Wakefield, 2013, p. 826).

The *DSM-V* can be considered limited in its approach to diagnosis due to acting as a descriptive tertiary sector instrument that seeks medical responses categorically through biological and genetic interpretations, rather than consider potential human-centred services as tools for secondary or primary prevention of mental disorders (Brown et al, 2005, p. 553). The *DSM-V*'s academic and professional content contributors recognize that its categorical approach to diagnosis can be too 'black or white' in its proceedings, by admitting that it does not for example consider zones of rarity between the diagnoses of mental disorders, nor does it recognize the requirement of intermediate categories (APA, 2013, p. 733). The categorical approach lacks treatment specificity for many diagnostic categories; however, the *DSM* does not claim that medication is ever ineffective for treatment due to such discrepancies (APA, 2013, p. 733). A primary example of this discrepancy is that the *DSM* rationale has historically never solved the problem of the overlap between bipolar and unipolar depression, nor between schizoaffective disorder and bipolar disorder (Vieta et al, 2013, p. 187). Due to such overlap, the categorical criteria for psychotic disorders for the *DSM* has historically been

[3] The *DSM-V-TR* included Review Groups that involved Sex, Gender, Culture, and Suicide. It also aimed to address potential misdiagnoses (First, M. B., Yousif, L. H., Clarke, D. E., Wang, P. S., Gogtay, N., & Appelbaum, P. S. (2022)). These features of the *DSM-V-TR* inform of its attempt to address some of the issues highlighted in this paper on the limitations of the *DSM*'s purpose and evolution.

inaccurate in terms of encapsulating the variability of symptom profiling, treatment response, and social outcome and function (Heckers et al, 2013, p. 183).

The *DSM-V* can be perceived to rely too heavily on medication by ignoring the variability inherent in problems of living due to mental disorders because it ignores the variable characteristics of an individual, like symptom severity, intensity, quantity of symptoms, duration, and type (APA ,2013, p. 733). This means that by disregarding such variations, the *DSM-V* can categorize individuals to a greater extent in order to reduce them to abstract concepts that are to match with the correct medication that the category of the person dictates. The extent of such biological categorization is seen in diagnostic disagreements within and between many categories in the *DSM-V*. Obsessive compulsive disorder and social phobias, for example, do not commonly involve boundary issues between themselves and other diagnoses, when if present, would decrease the monopoly of medication on their treatment; such boundary disagreements are due to issues in the definition and application of categorical thresholds on the duration, number, and severity of symptoms (Brown et al, 2005, p. 551). For the *DSM-V*, this dependence on medical treatment can be found in its bi-categorical levels that allow for cross-cutting measures, as Level 1 involves thirteen questions that occur within a brief survey of different symptom domains for adults and twelve for children and adolescents that are consequentially matched up with the appropriate medical response; whereas Level 2 involves questions that provide in-depth assessment within certain categorical domains (APA, 2013, p. 733). Such rigid categorical approaches for diagnosis can be considered descriptors that are symptom-based and polythetic, clustering together according to clinical consensus (Helzer et al, 2006, p. 18).

The categorical model of treatment prediction in the *DSM-V* limits itself to medication as the solution to mental health challenges. This can have dire consequences for treatment knowledge. We can sum up Sturmey's view on this, as:

- First: its use of Randomized Controlled Trials (RCTs) compare treatments with other procedures meaning it fails to include the impact of diagnosis via treatment interaction.
- Second: the model of predicting treatment involves responses to treatment effects that are always varied, as most participants can display improvement without any practical implications for a particular person, due to the average client being reduced to an abstract concept.
- Third: clinicians work with patients who have already proceeded through standard diagnosis treatment without providing meaningful responses
- Fourth, many patients match diagnostic criteria for numerous diagnoses

(Sturmey, 2009, pp. 4-5).

The *DSM-V*'s promotion of the abstract view on behavioural symptoms leads to more biological (physical and chemical) than psychological (social and personal) diagnostics. Such dependence means medication is considered more effective for symptoms because symptoms are nosologically described abstractly in terms of biology whereas alternatively, for the contextual concrete approach, it is done in terms of symptoms that are considered psychologically. The latter entails symptoms that are within a person in an instantiated manner, such as supported by the *Casebook for DSM-V* (1st Edition, 2016) and the *DSM-V-TR*, that have highlighted the importance of context and culture to a greater extent than the *DSM-V* and its previous versions. The former specifies behaviours by referencing individuals with the details of each case being taken from the context of the individual's life, whereas the *DSM*s describe behaviour by referring to categories or groups of individuals across contexts that are generalized (Kim et al, 2016, p. 39). Such generalizing by the *DSM*s serves the purpose of matching symptoms to medications, as symptoms are abstracted under biological terms and labelled as descriptors for an individual's biological composition. The consequences of such labelling can be highlighted as the *DSM-V*'s apparent failure at capturing individual difference between disorder severity and clinical features, as they are subsumed by other disorders or such features appear below conventional thresholds within any of the *DSM*s (Brown et al, 2005, p. 551).

The *DSM-V* in particular embraces categorical disorders that are to be treated, and this means it involves a formulation limited to abstract intellectualization and medication that is culturally neutral and perhaps even dehumanizing (Eells, 2007, p. 14). Current research shows that the different ways humans present disorders might provide differences in the causal attributes of symptoms (Kim et al, 2016, p. 43). The *DSM-V*'s abstractness inherent in its diagnoses, however, seen in its inter-individual frames of reference that compare individuals or samples with others, determines these subjects' existential standings as objects of diagnosis for medical responses (Valsiner, 1986, p. 23). The *DSM-V* diagnoses do not predict optimum human service engagement and thus do not support a holistic culture of commitment for individuals to consider. The *DSM-V* diagnoses are limited to framing lack of normal functioning and distress as problems of living, ignoring context and motivational commitment that could form the basis for commitment purposes (Primach et al, 2017, p. 161). The *DSM*s instead promote over- and under-pathologizing that can be viewed as synonymous with over- and under-categorization. Such 'black and white' diagnosis is based on a client's 'differentness' juxtaposed to concrete symptom co-existence and conflict that is intrapsychic. The former interprets the symptoms not the individual person in a holistic manner, and so the symptoms abstractly form the 'differentness' (Meehl, 1973, p. 20).

DSM-V Medical Matchmaking

Due to the difficulty of matching treatments to problems of living, biological psychiatric diagnosis is employed to predict treatment, and this can be stressed to reveal what underlies the problem of the *DSM-V*'s categorical-biological

approach, as it aims to treat effects (symptoms) that are abstracted for relevance, rather than consider underlying causes in the etiological sense. Although it may be important that both psychological and pharmacological (biological) treatments depend on diagnosis, it does not need to limit itself to a categorical style as found in the *DSM-V* (Sturmey, 2009, p. 4). We can see that the *DSM-V*'s limitation to categorization supports an abstract biological and psychiatric perspective. It considers cross-cutting symptom measurements modelled on medicine's review of symptoms to serve as approaches to review psychopathological domains. These 'black and white' reviews are then considered responsible for detecting difficulties in human day-to-day living in turn considering that it is imperative that these reviews are kept in mind for the detection of changes in organ systems that facilitate treatment and diagnosis (APA, 2013, p. 733).

The biological foundation of this approach is why medication is considered the best treatment, as problems of living are considered essentially biological problems that medicine can solve after such problems are reduced to concepts and thus abstracted for comprehension. Such abstract categorization does not base itself on etiology (causation), the latter of which being context dependent (i.e. environment, relationships, society etc). Categorization consequently increases the possibility of an individual who meets criteria for a diagnosis in the *DSM-V* to meet the criteria for other diagnoses, framing the *DSM-V*'s taxonomy as lacking in the prevention of the aggregation of psychopathology's breadth into disorders that are discrete rather than concrete (Helzer et al, 2006, p. 18).

The origin of this discrepancy can stem from Emil Kraepelin's work, which initiated the combination of a variety of discrete symptoms: hebephrenia, catatonia and paranoia, into categorizing them into one disease category of dementia praecox (Zubin et al, 1977, p. 104). In 1980, description orientation was then given prominence over etiology via the *DSM-III*, as etiology was confined to the background (Eells, 2007, p. 9). The *DSM-V*'s focus on description can provoke the need to involve more etiology for a potential revolution in nosology (Brown et al, 2005, p. 555). Psychopathologists could thus adhere to both etiological and descriptive nosology (Mack et al, 1994, p. 9). This is why it is important to compare categorical and dimensional approaches. The former's syndrome and medical based views on mental health disorders and problems of living are divided qualitatively between normal/abnormal functioning and between disorders; whereas dimensional psychopathological models reveal the *DSM-V*'s value itself of categorical approaches (Eells, 2007, p. 9). This categorical preference views diseases as pathological entities that only medicine can rectify, as it adheres to four notions. These can be taken as a) disease has predictable courses, causes, and outcomes, b) symptoms are mere expressions of some underlying pathogenic processes and structures, c) the primary province for medicine is disease not necessarily health, and d) disease is a phenomenon not based on social or cultural attributes (Eells, 2007, p. 9).

By giving abstract description primacy, the *DSM-V* works by describing discrete illnesses via symptom patterns that are shown in a multi-axial

classification, commencing with the *DSM-III*; symptom patterns show underlying brain disturbances and pathologies in neurotransmitters, in turn vouching for medical solutions, as these illnesses are supported by a vast array of biomedical investigation and psychotropic medical effectiveness (Sturmey, 2007, 2008, p. 20). Why the *DSM-V* is essentially categorical and abstract, in terms of the above, is its approach to supporting medical treatment based on a philosophy that Kohut had described as assuming symptoms, signs, and traits that are clustered together to form a whole that is considered greater than the sum of its apparent parts (Eells, 2017, p. 10). The diagnoses that occur via the *DSM-V* is limited by merely serving as conventions to manage psychopathology into discrete groups that hold meaning; hence when symptoms are relevant from various groups, both diagnostic labels are applied and subsequent attempts are made to declare which diagnosis from the batch of groups is considered primary; hence highlighting the imperfect science involved in the categorical groupings and overlap (Helzer, 2006, p. 20).

The *DSM*s' biological categorizing model, unlike multi-perspective biological models such as psychological and dimensional ones, does not examine systemic and individual perspectives to provide context, nor does it consider varieties of orientations that would consider relevant the psychological, biological and social variables (Weerasekera, 2009, p. 145). This in turn ignores the culture in which they live and adheres to a genetic and in turn biological-medical approach (Weerasekera, 2009, p. 148). This approach implies that there is something lacking or mechanically out of order with an individual suffering a mental health disorder, in turn considering that culture cannot have any sort of impact on the maintenance of this problem of living; hence medication is exacerbated as being considered the most appropriate solution.

DSM-V Interpretation of Culture

Among some of the revisions in the 2022 *DSM-V-TR*, besides the addition of 'Prolonged Grief Disorder', there is evidence of concerted efforts to address the impact of cultural context on diagnosis in comparison to the *DSM-V*. Attention has been given to the risk of potential misdiagnoses in terms of evaluation of individuals from ethno-racial groups that are socially oppressed (APA, 2022). Individuals from specific challenging communities are thus considered to not have the impact of living in such an environment ignored, but also the social structures that can be interpreted to increase racial discrimination are not having their impact omitted in the process of diagnosis. This has led to expert reviews on the consideration of context and terminology in the *DSM-V-TR*, particularly in the update of Section 3's Chapter: "Culture and Psychiatric Diagnosis", where culture and social context has been integrated in the inclusion of more consideration of risk factors for specific ethnic communities; hence considering the impact of race, culture, and racism for diagnosis to prevent potential misdiagnoses (e.g. African Americans being misdiagnosed with schizophrenia and addressing gender dysphoria) (Moran, 2022).

Prior to the *DSM-V-TR*, the *DSM*'s theoretical basis created a culture based on a biological medical model where illness is taken to be the product of organs that are diseased and of processes that are pathological, as disease is taken as an abstract reductionist concept to be rectified (Eells, 2007, p. 8). This can be said to have derived from the historic 'De Sedibus Approach' to disorders derived from Morgagni, in which an index is used to search for a patient's symptoms to be cross-referenced with pathological processes; akin to the assumption that symptoms reflect the psychopathological structures and processes that underlie the disorder (Eells, 2007, p. 8). The *DSM-V* in turn exacerbates the need for medicinal solutions in its stigmatization around mental health disorders and the problems of living associated with them. This then increases the need for solutions which medicine can provide.

We saw above that the *DSM-V* labels a person as having a personality disorder who is to be treated medically, as the person is reduced to an abstract individual who is in possession of a personality disorder, and the stigma surrounding this in society increases feelings for the person of being defective, leading to potential demoralization (Eells, 2007, p. 10). For U.S. military personnel for example, the hostile environments where they were stationed is considered responsible for their health disorders, however, the response by practitioners following the *DSM-V* is to provide more medicine, and this is due to its categorization of mental health (Primach et al, 2017, p. 157). The categorical approach aims to target the correct medication to fix the mental disorder as a biological issue rather than look at the context.

The effect categorization and the stigma it provokes can be seen in the example of such U.S. military personnel where 45% of troops that maintained one *DSM* diagnosis and who accessed their prescribed treatment, reported less than three contacts with their treatment provider in one year (Primach et al, 2017, p. 163). This example is relevant because troops who serve in combat are arguably more in need of mental health treatment, yet stigma among other factors holds them back from seeking diligent treatment as they do not want to accept the abnormality that the *DSM-V* labels them with. Clinical experience can show that some individuals and their respective families are reluctant to use medication as there are concerns of stigma, low self-esteem, and identity, which may lead to non-adherence to medication and even to lack of help seeking in the first place (Abdel-Baki, 2012, p. 4).

The *DSM-V* does not consider these contextual factors that conversely are found in the 'The Health Belief Model Framework for Antipsychotic Adherence' for example. Within such a framework derived from the 1950's, the contextual factors of culture, socioeconomic status, and previous experience are taken account of holistically, along with the factors of the individual's insight of recognizing the need for the treatment or believing the benefits of treatment as outweighing risks (Abdel-Baki et al, 2012, p. 6). Addressing the neglect of the benefits that a holistic culture of treatment can provide for individuals, such as psychoeducation, motivational work, and commitment, should be taken into consideration for the treatment of any

DSM-V diagnosis. In early psychosis for example, non-adherence is commonly due to the extent that young patients aim to manage without medication once improvement occurs (Abdel-Baki et al, 2012, p. 9). Rather than consider non-adherence as part of the contextual problem with individuals who suffer from problems of living, the *DSM-V* takes a micro-biological approach that focuses on symptoms and their medical cures.

Psychopathological conceptions have been known to be socially constructed, reflecting views that are derived culturally and held consensually in terms of what is abnormal and normal (Eells, 2007, p. 11). The *DSM-V* needs to be viewed as also holding a paradigm or worldview, thus one that could be shifted by embracing dimensional approaches to the diagnosis of psychotic disorders (Parker, 2014, p. 183). *The Cultural Formulation Interview* (CFI) in the *DSM-V*, though with the potential to embrace dimensional and macro-holistic approaches, merely asks for systematic assessment of the categories of the *DSM-V*, as it assesses the following in relation to culture: A) cultural identity, B) cultural conceptualizations of distress, C) psychosocial stressors and cultural features of vulnerability and resilience, D) cultural features of the relationship between individual and clinician, and E) overall cultural assessment (APA, 2013, pp. 749-750). Culture is only seen as providing negative contributions, as the *DSM-V* categorizes within its taxonomies: cultural identities such as race, ethnicity, or cultural reference groups that can influence their relationships with other people, their access to resources, and their developmental and current life challenges and conflicts. The type of involvement the individual partakes in with the host majority culture should be taken into account separately, as preferences and language capabilities are relevant in order to identify difficulties with accessing care, social integration, and the need for language interpretation; not to mention the importance of religion, socioeconomics, place of birth, migrant status, gender, and sexual orientations (APA, 2013, pp. 733-734).

Discussion

The culture that the *DSM-V* promotes should aim to be more holistic and committal by including more dimensionality as psychoeducation, with its involvement of awareness, problem detection, adherence compliance, avoidance of substances, habit regulation and stress management, are indubitably important for ensuring that treatment of problems of living is constant (Reinares et al, 2013, p. 48). There is hope for more dimensionality entrenching itself in the *DSM-V*, as though it is a categorical system, it can be viewed as aiming to encapsulate dimensional structures that underlie psychosis (Heckers et al, 2013, p. 1).

The reactionary spirit of the *DSM-V* can be considered attenuated in the *DSM-V-TR* as the ‘black and white’ categorization of the *Manual* is challenged through the inclusion of more appreciation of context, diversity, and culture. Any shift for the *DSM* to embrace more dimensionality should not be revolutionary but evolutionary, however (Helzer et al, 2006, p. 21). Despite these efforts, it can be framed as appearing to add an extra layer of abstract categorization as a solution to

the already inherent categorization to diagnosis it has adopted. Recognizing social backgrounds can be a step forward in increasing context appreciation and recognizing the challenges that confront a culture of commitment when it comes to care planning; however, categorizing an individual under one culture does not necessarily reflect an appreciation of their unique life narrative that is created in a dimensional context that cannot necessarily be described categorically. Such narrative appreciation requires a respect for the concrete individual person that is psychologically brought to the diagnostic process; an appreciation that values etiology and is less naïve than the *DSM-V* rationale, by respecting context dependent questions rather than abstract categorical answers.

REFERENCES

Abdel-Baki, A., Ouellet-Plamondon, C., Malla, A., (2012). *Research report Pharmacotherapy challenges in patients with first-episode psychosis*. Department of Psychiatry, Université de Montréal, Clinique JAP, Centre hospitalier de l' Université de Montréal (CHUM), Montreal, QC, Canada. McGill University, Douglas Hospital, Montreal, QC, Canada.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychiatric Association (2022). https://www.psychiatry.org/getmedia/f4057bcd-c345-4d81-a4ce-02c5eb29454b/APA-DSM5TR-AttentiontoCultureRacismandDiscrimination.pdf [accessed 23/09/2023].

Bloom, P. (2004). *Descartes' Baby: How the science of child development explains what makes us human.* New York, NY: Basic Books.

Brown, T.A., Barlow, D.H. (2005). Dimensional Versus Categorical Classification of Mental Disorders in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders and Beyond: Comment on the Special Section, *Journal of Abnormal Psychology* by the American Psychological Association, Vol. 114, No. 4, 551–556, DOI: 10.1037/0021-843X.114.4.551.

Eells, T.D., (2007). Chapter 1 History and Current Status of Psychotherapy Case Formulation, *Handbook of Psychotherapy Case Formulation*, Tracy D. Eells (Ed.) 2nd Ed. Guilford Press, N.Y. USA.

First, M. B., Yousif, L. H., Clarke, D. E., Wang, P. S., Gogtay, N., & Appelbaum, P. S. (2022). DSM-5-TR: overview of what's new and what's changed. *World psychiatry : official journal of the World Psychiatric Association (WPA)*, 21(2), 218–219. https://doi.org/10.1002/wps.20989

Heckers, S., Barch, D.M., Bustillo, J., Gaebel, W., Gur, R., Malaspina, D., Owen, M., Schultz, S., Tandon, R., Tsuang, M., Van Os, J., Carpenter, W. (2013). Structure of the psychotic disorders classification in DSM 5, *Schizophrenia Res* 150:11–14.

Helzer, J. E., van den Brink, W., & Guth, S.E. (2006). Should there be both categorical and dimensional criteria for the substance use disorders in DSM-V?, *American Psychiatric Association. Journal compilation. Society for the Study of Addiction Addiction*, 101 (Suppl. 1), 17–22.

Kim, N.S., Woo-kyoung, A., Samuel G.B., (2016). The Influence of Framing on Clinicians' Judgments of the Biological Basis of Behaviors, *Northeastern University Journal of Experimental Psychology: Applied. American Psychological Association*, Vol. 22, No. 1, 39–47 1076-898X/16/$12.00 http://dx.doi.org/10.1037/xap0000070.

Kohut, H. (1971). *Analysis of the self*. New York: International Universities Press.

Kohut, H. (1977). *Restoration of the self*. New York: International Universities Press.

Kohut, H. (1984). *How analysis cures*. New York: International Universities Press.

Mack, A. H., Forman, L., Brown, R & Frances, A. (1994). A brief history of psychiatric classification: From the ancients to DSM-IV, *Psychiatric Clinics of North America*, 17, 515–523.

Meehl, P. E. (1973). Why I do not attend case conferences, *Psychodiagnosis: Selected papers* (pp. 225–302). New York: Norton.

Moran, M. (2022). Impact of Culture, Race, Social Determinants Reflected Throughout New DSM-5-TR in *Psychnews Psychiatry Online* https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2022.03.3.20 [accessed 23/09/23].

Parker, G.F. (2014). DSM-5 and Psychotic and Mood Disorders, *Journal of American Academic Psychiatry Law* 42:182–90.

Primach, J.M., Borsari, B., Benz, M.B., Reddy, M.K., Shea, M.T. (2017). Mental Health Treatment Utilization in OIF/OEF National Guard and Reserve Troops With and Without DSM Diagnoses, *American Journal of Orthopsychiatry American Orthopsychiatric Association*, Vol. 87, No. 2, 157–165 http://dx.doi.org/10.1037/ort0000226.

Reinares, M., Sánchez-Moreno, J., Fountoulakis, K. N. (2013). Psychosocial interventions in bipolar disorder: What, for whom, and when, *Journal of Affective Disorders.*

Sturmey, P. (2007). *Functional Analysis in Clinical Treatment*, Elsevier, Burlington, MA.

Sturmey, P. (2008). *Behavioral Case Formulation*, John Wiley & Sons, Ltd, Chichester.

Sturmey, P. (2009). Clinical Case Formulation. Varieties of Approaches. Edited by Peter Sturmey. Wiley and Sons, Sussex, UK.

Valsiner, J. (Ed.). (1986). *The individual subject and scientific psychology*. New York: Plenum Press.

Van Praag H. M. (1990). Two-tier diagnosing in psychiatry, *Review Psychiatry Res*; 34: 1–11.

Vieta E, Valenti, M. (2013). Mixed states in DSM-5: implications for clinical care, education, and research, *J Affect Disorder,* 148:28 –36.

Wakefield, J.C. (2013). The DSM-5 debate over the bereavement exclusion: Psychiatric diagnosis and the future of empirically supported treatment, *Clinical Psychology Review* 33 (2013) 825–845.

Weerasekera, P. (2009). A Formulation of the Case of Antoinette: A Multiperspective Approach, In Stumney, P. (Ed.). *Clinical Case Formulation. Varieties of Approaches* (pp. 145-156). Wiley and Sons, Sussex, UK.

Zubin J, and Spring, B. (1977). Vulnerability—A New View of Schizophrenia, *Journal of Abnormal Psychology*, Vol. 86, No. 2, 103-12.