International Journal on Neuropsychology and Behavioural Sciences

The Use of the Term Disorder as a Problem Rather than a Solution: an Approximate Proposal from Relational Frame Theory

Review Article

Volume 3 Issue 3- 2022

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Article History

Received: October 22, 2022 Accepted: October 31, 2022 Published: November 03, 2022

Abstract

Reducing the person who comes to a psychotherapeutic intervention as a set of signs and symptoms caused by a disorder is not only unscientific and biologicist, but also generates great harm to the client, motivating them to live at the expense of the disorder, having inherent self-declarations such as "I am bipolar", "I am schizophrenic", "I am depressive", among many others that make them feel "bound" or "fused", which will further hinder their treatment and the way they live their day to day lives. Diagnostic labels have often been used to diagnose indiscriminately, following the basis of biomedical models adopted by clinical psychology since the beginning of the discipline. This article seeks to articulate the relevance of generating behavioral changes by implementing different verbal behaviors typical of human language when categorizing or diagnosing using the word disorder, framing a differentiation for the non-use of the same and its whys, having as epistemic floor the Relational Frame Theory. Focusing on the tools of Clinical Behavior Analysis to propitiate a valuable life, rather than on diagnosis to reduce signs and symptoms will be more parsimonious. Separating Behavioral Analysis from biomedical models becomes imperative to avoid iatrogenesis and re-victimization in those seeking psychological help.

Keywords: Disorder, Relational framing theory, Functional contextualism, Human Verbal Language, Biomedical Model

Introduction

In 1952 the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) was published by the American Psychiatric Association (APA), since then there have been four new volumes and updates, reaching the current edition known as DSM-5 in 2013.

It is relevant to mention that the constant updating of the manual, despite being the most widely used diagnostic system in Clinical Psychology and Psychiatry, has been due to the large amount of criticism it has received by multiple personalities and scientists from different parts of the world [1-11], who have positioned the Manual and its updates as reductionist, adynamic, with a lack of emphasis between state and trait, disorganized and hegemonic classification methods, limitations of the categorical system, low classification thresholds that are juxtaposed with two or more diagnoses and generate multiple comorbidities, overdiagnosis and underdiagnosis, among other assertions that far from favoring effective treatment, hinder it and perpetuate the pathologization of inherently human conditions.

The function of this article is not to make an exhaustive critique of the DSM-5 or other diagnostic classification systems, but to focus exclusively on the use of the word Disorder as a classificatory and labeling system derived from the biomedical model, which is used to categorize a person with various conditions that interfere with their quality of life. Understanding that the word disorder describes a series of signs and symptoms that are experienced as aversive and are seen on a daily basis as synonymous with having something wrong with the brain, disorder or abnormalities.

From this premise, the person who is diagnosed with an affective, neurocognitive, psychiatric, personality, anxiety, neurodevelopmental, psychotic or dissociative disorder, etc., is confronted with two problems. The first is the way in which he will obtain the treatment to reduce the signs and symptoms that cause his disorder, (because it is what has been culturally taught) and the second is the internalization of the word, perceiving the term as part of himself, implicitly knowing that his culture dictates that he has something that makes him "abnormal", "crazy", "insane", "demented", "mentally ill", etc. and for the same reason; he will be singled out and even revictimized by society.

Strosahl, Robinson and Gustavsson [12] mention that seeing the person as a set of signs and symptoms caused by a disorder is not only unscientific, but also generates great harm to the client, since as men-

tioned above, the self-image of the person receiving the diagnosis will be affected in a negative way, and that, in addition, motivate them to live at the expense of it, having inherent self-statements such as "I am bipolar", "I am schizophrenic", "I am depressive", among many others that make them feel "tied" or "fused", which will further hinder their treatment and the way they live their day to day life.

Being alive is a symptom-generating machine, since we are exposed to different circumstances throughout our lives, so seeking to offer treatment in the reduction of symptoms to return to the notion of being someone "normal" as suggested by the DSM`S is not the solution, let alone classification and diagnostic labeling [12]. The notion that symptoms must be eliminated or reduced in intensity to declare someone as "cured" has been widely promoted by the biomedical model and pharmaceutical industries, who have redefined human problems and categorized them as mental disorders, disorders or illnesses.

Functional Contextualism

Gifford and Hayes [13] use the term functional contextualism as a propositional alternative to the radical behaviorism of B.F. Skinner [14], understanding behavior in its context as its object of study, and seeking to obtain principles that are universally valid in order to predict and influence it [15].

Its construction, usually presented in the form of a "tree", alludes to a structure that begins its germinative process when the roots emanate, these being the experimental analysis of behavior, the trunk would have the equivalence of applied behavioral analysis, and finally the branches would be the analysis of clinical behavior. These branches represent the consistency and universality of principles derived precisely from radical behaviorism, as well as the understanding of every aspect of human behavior; motor, physiological and cognitive verbal [15]. Reyes-Ortega, [16] mentions that functional contextualism is the philosophy of science on which Contextual Behavioral Science is based, which, in turn, is concerned with analyzing the behavior of organisms in the context in which they occur and from the function they perform within it.

These principles serve for the formulation of theories that contribute to the understanding of diverse phenomena; the involvement of genetic change in learning, the understanding of verbal behavior and/or thought in different contexts, which are useful for their subsequent application in community, sociological, organizational and, of course, clinical settings; from which various contextual therapeutic models have emerged such as Acceptance and Commitment Therapy (ACT), Dialectical Behavioral Therapy (DBT), Functional Analytic Therapy (FAP), Behavioral Activation (BAT), among others [16]. These therapies have also been referred to as third generation or third wave behavioral therapies.

Contextual behavioral science involves analyzing the act in context, from a monistic view; behavior coexists with its context and cannot be separated from it, and making use of pragmatism, i.e., what works and does not work for the person, relying on the principles of precision, scope and depth generated from the experimental analysis of behavior [16]. Eliminating the word disorder from human verbal language is an extremely difficult task, normalizing it as something proper to phylogenetic and ontogenetic development, associated with socio-cultural changes or processes, is something more attainable, but re-defining it, re-conceptualizing it or re-framing it in a simple, straightforward, and parsimonious way is what would be ideal to achieve.

Understanding that Functional Contextualism focuses on transdiagnostic processes, not rigidly classificatory, nor focused on the reduction of signs and symptoms, but on the way in which the person relates to the world and their internal experiences, explaining and describing behaviors of approaching or moving away from what is valuable, in order to predict and influence their context, and how this is intended to be an approach to understanding human suffering and problems in order to always improve the person's quality of life [17].

Relational Frame Theory as an Illustrative Model of the Animus of the term "Disorder"

The Relational Frame Theory (RFT), an explanatory proposal of human language and cognition [18] that is synchronically rooted with Functional Contextualism can clarify the picture of why we have been deriving for many years the word disorder, with arbitrary relational equivalences of negative, aversive, or unpleasant content for the person, and why it is convenient to become aware of the same and modify such relationship. RFT is thus an explanatory proposal of language and human cognition, where a relational framework is understood as an arbitrarily derived applied relational response, and through the interrelation between stimuli as contextual cues, mutual and combinatorial relationships or the transformation of functions arise, which lead to human distress and suffering in a surrounding cyclical manner [15,19-25].

Although it is neither the objective nor the function of the present work to go in depth into everything related to TFR, since its theory is vast and dense, a hypothesis is generated that aims to elucidate the reason for the rejection and failure to use the word disorder, and the pragmatic functionality of discarding its use in the clinical setting.

The main relational frameworks and their basic postulates are shown below:

Table 1

Table 1: Types of relational frames [15].

Relational framework
Coordination relations
Opposing relationships
Distinguishing relationships
Hierarchical relationships
Temporary relationships
Spatial relationships
Conditionality and causality relationships
Deictic or perspective-taking relationships.

Now, based on some of these frameworks, the different relational responses arbitrarily applied and derived upon receiving a clinical diagnosis using the term "disorder" are exemplified.

See Table 2.

Table 2: Responses derived from the word "Disorder" and its different relational frameworks.

Relational Framework	**Relational response derived from "Trastrono".**
Coordination relations	Mentally ill → Faulty → Internal disorder → Brain malfunction
Opposing relationships	Worse than those without "disorders" → More serious than a "healthy" person.
Distinguishing relationships	Abnormal → Unadapted → Insane person → Insane → Insane

Hierarchical relationships	Abnormal → Unadapted → Insane person → Insane → Insane
Temporary relationships	Seeking a cure or treatment to "take away my disease".
Spatial relationships	Seeking a cure or treatment to "take away my disease".
Conditionality and causality relationships	Pathology → Pain → Suffering → Disabled → Death
Deictic or perspective-taking relationships.	I will make others feel sorry for me → Shame → Social prejudice → Discrimination

NOTE: Author's own model. Subject to the biases of the author's behavioral biography.

Approximate Proposal from the Theory of Relational Frames

The substitute word proposed in this article to reduce the arbitrary derivations of the interrelated ones to "disorder" is "adverse condition(s)", preferably to be used in the clinical setting.

See the following example of relational responses derived from the RFT perspective that are used daily inhuman verbal language and the proposed substitute alternative.

Disorder→ Insane→ Mentally ill→ Insanity→ Abnormal→ Pathological→Suffering→ Death

Condition→ Normal→ Tolerable→ Aggregate indistinct→ Neutral→Manageable

Adverse condition→ Problem→ Difficulties in context→ Finite→ Improvable→ Challenge→ Proper to human existence

It is of primary relevance to mention that this exemplification, the previous ones and the one that will be shown later are subject to the biases of the author's learning history.

Table 3

Table 3: Examples of some diagnostic categories seen from the traditional biomedical model (DSM-5) and the proposal formulated seeking to use the epistemic floor of TFR.

Proposal from the biomedical model (DSM-5)	**Approximate proposal from the RFT**
Mood disorders	**Adverse affective conditions**
Major Depressive Disorder	Depressive affective condition
Dysthymic Disorder	
Anxiety disorders	**Adverse anxiety conditions**
Social Anxiety Disorder	Anxiogenic condition of... (Social anxiety, anxiety, obsessions and compulsions, posttraumatic stress, chronic stress).
Distress Disorder	
Obsessive Compulsive Disorder	
Posttraumatic stress disorder	
Chronic stress disorder	
Psychiatric disorders	**Adverse psychiatric conditions**
Bipolar Disorder Type 1 and 2.	Psychiatric condition of... (bipolar, schizophrenia, schizoaffective, schizophreniform, delusional psychotic).
Schizophrenia disorder	
Schizoaffective disorder	
Schizophreniform disorder	
Psychotic delusional disorder	
Personality disorders	**Adverse personality conditions**
Paranoid disorder	Personality condition... (paranoid, schizoid, schizotypal, antisocial, borderline, narcissistic, histrionic, avoidant, dependent, with obsessions and compulsions.
Schizoid disorder	
Schizotypal disorder	
Antisocial disorder	
Borderline disorder	
Narcissistic disorder	
Histrionic disorder	
Avoidant disorder	
Dependent disorder	
Obsessive compulsive disorder	
Eating disorders	**Adverse food conditions**
Anorexia nervosa disorder	Eating condition of... (anorexia nervosa, bulimia nervosa, binge eating.
Bulimia nervosa disorder	
Binge eating disorder	

NOTE: It is transcendental to add "adverse" regardless of the condition presented, since this is what would allow the ideographic differentiation for the understanding of the life problems presented by the person beyond their "disorder". Example: A person with a bipolar condition may be largely functional in different areas of his life, which leads him to have a satisfactory life, while a person with an adverse bipolar condition may have an unrewarding life, with the above is intended to show that this problem is not endless or forever.

Conclusion

A single syndromic approach to clinical diagnosis has been used for decades and has created a robust and progressive field of application for its use but has now reached a dead end [11]. Just as science is dynamic and constantly evolving, the use of the term disorder to refer to "someone with something wrong inside", and which reduces the human as a set of signs and symptoms that present topographically has to evolve and not remain anchored. People formulate symbolic rules through language where we constantly repeat to ourselves which mental or emotional states are "good and bad", which ones can stay, and which ones cannot. It is these same symbolic and arbitrary rules used in human verbal behavior that often generate, maintain and increase the feeling of suffering [21-23].

If we can somehow create some distance between the human being and the so-called disorders, so that these are not seen from an abnormal or unhealthy perspective, but as an adverse condition of the human being and the context in which it is immersed; "deliteralizing" the term [12,24-26] would be taking a big step that could even be revolutionary at the levels of understanding and comprehension in the way of offering therapeutic treatments in mental health and making diagnoses.

Discussion

The present document is a proposal, this proposal intends to generate changes by implementing different verbal behaviors, typical of human verbal language when categorizing or diagnosing using the word disorder, framing a differentiation for the non-use of the same, which could benefit the different users and professionals dedicated to the area of mental health. Although it is true that in some way the suggested proposal continues to classify or categorize ailments inherent to the experience of being human and alive, it is considered that these are done in a more inclusive way and without being perceived as labeled for those who listen to them or receive a diagnosis, which could facilitate the intervention process.

The biomedical model, which has been shown to be mechanistic and ineffective for this purpose, and which tends to label people with "internal faults" that produce their disorder, and which in parallel generate guilt and an accumulation of dysfunctional emotions and thoughts, would be reframed and reframed if we refer to such syndromic pictures only as adverse human conditions. Using a more parsimonious language to refer to human problems would be ideal for clinicians who perform process-based therapies and behavior analysts who seek to move away from biomedical paradigms. Following philosophies of science such as Functional Contextualism, which seeks to identify behaviors within specific contexts that are interfering with the life that the person wants to live, and not focus on the identification and reduction of confusing signs and symptoms that may occur in more than one diagnosis as has been done for many years.

Modifying the word disorder and reframing it as proposed, starting from clinical settings, and subsequently to educational, community, social, organizational, etc. settings. It could even have an impact on the understanding of the work of clinical psychologists, psychiatrists and physicians, professions that, to date, some more than others depending on the culture and context, are still seen in a stigmatizing, prejudiced and pejorative way, prevailing the internal struggle of the person to exhaust all alternatives in order to solve the problem that afflicts them, before being treated in any of these areas of health, even resorting before, to pseudoscientific practices that can generate iatrogenic.

Finally, it is conjectured and hypothesized that the fact that people generally go to these instances as a last alternative is due to the fear of being diagnosed with a disorder, as well as to the relational responses derived from the term; mentioned previously, and the avoidance and postponement of their professional attention in the pertinent places is working as a negative reinforcer. Such an assumption, however, lays the groundwork for other related prospective research, as well as the generation of another type of article than the present one.

References

1. Frances A (2010) Opening Pandora's Box: The 19 Worst Suggestions For DSM5. Psychiatric Times.
2. Caplan JP (2011) Science Isn't Golden: Who decides what's good science and treatment? Psychology Today.
3. Braunstein NA (2013) Classifying in Psychiatry. Siglo XXI Editores Mexico 1-142.
4. López-Santín JM, Molins Gálvez F, Litvan Shaw L (2013) Personality disorders in the DSM-5: a critical approach. Rev Asoc Esp Neuropsiq 33(119): 497-510.
5. Cooper R (2014) Diagnosing the Diagnostic and Statistical Manual of Mental Disorders. 5th (edn.), Karnak Books, London, England.
6. Esbec E, Echeburúa E (2015) The hybrid model of personality disorder classification in the DSM-5: a critical analysis. Actas Esp Psiquiatr 43(5): 177-186.
7. Artigas-Pallarés J, Paula-Pérez I (2015) Unresolved issues in the DSM-5. Rev Neurol 60(1): 95-101.
8. Mas Grau J (2017) From transsexualism to gender dysphoria in the DSM. Terminological changes, same pathologizing essence. International Journal of Sociology 75(2): 0591-05912.
9. Caponi S (2018) The psychiatrization of everyday life: the DSM and its pitfalls.
10. Llombart MP, Calatayud M, Amigot P (2020) Subjectivity, social inequality and gender maladies: a rereading of the DSM-V. International Journal of Sociology 78(2): 155-155.
11. Hayes SC, Hofmann SG (2020) Beyond the DSM: Toward a Process-Based Alternative for Diagnosis and Mental Health Treatment. Context Press, New Harbinger Publications, Oakland
12. Strosahl K, Robinson P, Gustavsson T (2012) Brief Interventions for Radical Change: Principles and Practice of Acceptance and Commitment Therapy. New Harbinger Publications, Oakland.
13. Gifford EV, Hayes SC (1999) Functional Contextualism: A pragmatic philosophy for behavioral science. Hanbook of Behaviorism 285-327.
14. Skinner BF (1950) Are theories of learning necessary? Psychologycal Review 57(4): 193.
15. Torneke N (2010) Learning RFT: An introduction to Relational Frame Theory and its Clinical Application. New Harbinger Publications, Oakland.
16. Reyes-Ortega M (2015) Institute of Contextual Therapy in Mexico. Functional Contextualism.
17. Levin ME, Twohig MP, Krafft J (2020) Innovations in Acceptance and Commitment Therapy: Clinical Advances and Applications in ACT. New Harbinger Publications, Oakland.
18. Barnes-Holmes Y, Hayes SC, Barnes-Holmes D, Roche B (2001) Relational frame theory: A post-Skinnerian account of human language and cognition. Adv Child Dev Behav 28:101-38.
19. Luciano C, Rodríguez M, Mañas I, Ruiz F, Valdivia-Salas S (2009) Acquiring the earliest relational operants: Coordination, distinction, opposition, comparison, and hierarchy. Derived relational responding: Applications for learners with autism and other developmental disabilities: A progressive guide to change. 149-172.
20. Gross AC, Fox EJ (2009) Relational frame theory: An overview of the controversy. Anal Verbal Behav 25(1): 87-98.
21. Ruiz FJ, Luciano C (2011) Cross-domain analogies as relating derived relations among two separate relational networks. Journal of the Experimental Analysis of Behavior 95(3): 369-385.
22. Luciano C, Ruiz FJ, Torres RMV, Martín VS, Martínez OG, et al. (2011) A relational frame analysis of defusion interactions in acceptance and commitment therapy. A preliminary and quasi-experimental study with at-risk adolescents. International journal of psychology and psychological therapy 11(2): 165-182.
23. Luciano C, Valdivia-Salas S, Ruiz FJ (2012) The self as the context for rule-governed behavior. The self and perspective taking: Research and applications pp: 143-160.
24. Gi E, Ruiz FJ, Luciano C, Valdivia-Salas S (2012) A preliminary demonstration of transformation of functions through hierarchical relations. International Journal of Psychology and Psychological Therapy 12(1):1-19.
25. Gil-Luciano B, Ruiz FJ, Valdivia-Salas S, Suárez-Falcón JC. (2017) Promoting Psychological Flexibility on Tolerance Tasks: Framing Behavior Through Deictic/Hierarchical Relations and Specifying Augmental Functions. Psychol Rec 67: 1-9.
26. Luciano C, Törneke N, Ruiz FJ (2021) Clinical behavior analysis and RFT: Conceptualizing psychopathology and its treatment. Oxford Library of Psychology pp: C5.S1-C5.S30.