The War on Psychiatric Diagnosis

March 16, 2015 | Couch in Crisis [1], Career [2], Cultural Psychiatry [3]
By Ronald W. Pies, MD [4]

A recent report that argues against descriptive diagnosis in medicine is historically ill-informed and medically naïve, in the opinion of this psychiatrist.
Source:

One of the first psychotic patients I treated during my residency was a middle-aged man who was burrowing through the wall of his room. Yes, I mean "burrowing," as in using his bleeding hands, fists and finger nails to tear through the flimsy plaster and stucco wall of the clinic. Now, after reading the British Psychological Society (BPS) report on psychosis,[1] one might conclude that the way to help such a patient is to sit down with the poor chap over lemon tea; guide him toward a mature understanding of his problem; and allow him to decide what, if any treatment, he wants. (Presumably, this chat occurs after the patient burrows through the wall of one's office).

Of course, I am caricaturing the BPS report—which, to its credit, does contain several useful recommendations, as I and others have acknowledged. Where the report fails is in conveying the fact that psychotic-level illnesses are often devastating and even life-threatening conditions. Psychosis is not just an alternative life style or manner of viewing the world. In addition to the excruciating suffering psychosis often engenders, it is also independently linked with increased risk of suicide attempts.[2]

The BPS report has been roundly and rightly criticized by several eminent psychiatrists—and a few psychologists—and I won't repeat their arguments here.[3-5] Suffice to say that the BPS report radically misconceives the nature of psychosis by focusing on hearing "voices"—which is rarely the main source of dysfunction and incapacity in patients with, for example, schizophrenia. Schizophrenia is a global disorder of personhood itself, usually involving impaired cognition; difficulty in assessing risk; disturbed ego boundaries; interference with activities of daily living; and impaired ability to attain one's "prudential interests," as Dr Robert Daly has argued.[6][see pdf]

But there is a larger issue raised in the BPS report that goes to the very heart of psychiatric diagnosis, which the report tries to discredit with the following argument:

We normally expect medical diagnoses to tell us something about what has caused a certain problem, what the person can expect in future ("prognosis") and what is likely to help. However, this is not the case with mental health "diagnoses," which rather than being explanations are just ways of categorizing experiences based on what people tell clinicians. For example, someone who says that they are hearing voices might be given a diagnosis of schizophrenia. Since this says nothing about cause, it makes little sense to say that the person hears the voices "because of" the schizophrenia.[1]

Actually, it makes a good deal of sense, in precisely the same way it makes sense to say, "Mr. Jones has severe facial pain because he has *tic douloureux;*" or "Smith has severe left-sided head pain and nausea because he has *migraines.*" We still do not know the precise causes of these conditions;

moreover, the diagnosis of both tic douloureux (literally, “painful tic”) and migraine headache (etymologically, headache “in half the cranium”) is made almost entirely on the basis of “what people tell clinicians”—not on the basis of an abnormal laboratory value, X-ray, or anatomical finding. (Of course, certain tests, such as a CT of the head, can help rule out other diagnostic possibilities, such as a brain tumor).

Indeed, the history of medicine is replete with well-established diagnoses which, upon their initial description, were of unknown etiology; eg, James Parkinson’s description of the disease that now bears his name provided no conclusions as to its etiology: he merely characterized in rich detail what he called the “shaking palsy.” And recently, the Institute of Medicine identified chronic fatigue syndrome as a bona fide disease (re-christened, “Systemic Exertion Intolerance Disease”) without identifying its precise cause or causes.[7]

To be clear: I am not singing the praises of the DSM-5 or its (mostly) categorical approach to diagnosis. Like many psychiatrists, I have expressed criticism and reservations regarding both the categorical model and specific DSM-5 categories.[8] My point is that the BPS report’s argument against descriptive diagnosis in medicine is historically ill-informed and medically naïve.

Neither am I defending an obsessive preoccupation with diagnostic minutiae, at the expense of understanding the patient as a person. There is often truth in Osler’s famous teaching: “It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.”[9]

Often—but not always. Sometimes we must know the sort of disease the patient has in order to treat the disease. For example, a recently-characterized type of psychosis involves the production of auto-antibodies directed against the NMDA receptor.[10] Merely assembling a list of the patient’s symptoms or stated “problems” will not permit adequate diagnosis or treatment.

I also want to emphasize that the debate over diagnosis is not, fundamentally, a “psychiatrist versus psychologist” issue, though it sometimes appears to be. There are some psychiatrists who believe that formal diagnosis is neither necessary nor helpful, and some psychologists who believe that diagnosis—understood as “discerning or distinguishing”—is essential to effective counseling and psychotherapy.[11] Indeed, while many psychiatrists and psychologists dislike the DSM system, they would still acknowledge the need for “diagnosis” in the broad sense of that term; ie, as “knowing the difference between” (*dia*-across, between; *gnosis*—knowledge) one condition and another. Alternative diagnostic schemes that avoid “pigeon hole” categories are fine to consider[12]—but abandoning psychiatric diagnosis altogether is foolish and dangerous.

Is psychiatric diagnosis “stigmatizing”?

One of the perennial anti-diagnostic (and anti-psychiatry) arguments has to do with the notion of “stigma.” Now, it is undeniable that, for many in the general public, a psychiatric diagnosis carries with it a strong pejorative connotation, and leads to various forms of prejudice, mistrust, and discrimination. But this was once also true of leprosy,[13] and stigma continues to surround the diagnoses of lung cancer and epilepsy.[14[pdf],15]

The mere existence of societal prejudice and discrimination is not a valid argument against diagnosis—in psychiatry or in any other area of medicine. And “stigma” is not an inevitable outcome of psychiatric diagnosis per se; rather, it is the result of society’s benighted attitudes toward psychiatric illness, often internalized by the patient. (Ironically, as some writers have argued, repeated use of the word “stigma” in connection with psychiatric disease may only perpetuate the problem).[16]

In truth, patients may react in a wide variety of ways to receiving a psychiatric diagnosis, depending on how it is “delivered” and by whom—eg, a dismissive clinician hardly known by the patient, vs. a trusted physician/therapist. A recent study of patients with “mood instability” found that:

. . . some participants expressed shock and/or fear on receipt of a formal diagnosis, but for many, diagnosis was helpful and contributed to a meaningful explanation of their symptoms. Many participants felt the receipt of a diagnosis absolved them from feeling excessively responsible for their problems.[17]

Conclusion

If “war” seems a somewhat overheated term in the title of this piece, I would recommend perusal of some of the anti-psychiatry websites, on which the ritual evisceration of psychiatry and psychiatrists is unapologetic and unrelenting.* To be sure, the BPS report does not fit this description; it is merely patronizing and medically ill-informed.

Finally, while diagnosis is a necessary first step in helping the patient with emotional, cognitive, or behavioral problems, it is far from sufficient. We must enter empathically into the patient’s “inner world,” and provide a safe, trustworthy environment for the exploration of the patient’s troubles.

This takes time—it can't be done in 15 minutes!—and it requires what psychoanalyst Theodor Reik eloquently called, "listening with the third ear."
Acknowledgments: My appreciation to Drs Joe Pierre, Allen Frances, Jeffrey Lieberman, Bernard J. Carroll, and Mr Marvin Ross for their stimulating comments on various aspects of this issue. The views represented here, however, are solely my own.
*In my view, the Web site of "Mad in America" is particularly abusive toward psychiatrists, though it is far from the worst of the bunch.

Disclosures:

Note to readers: As with all of our blogs, the opinions expressed in this commentary are solely those of the author. Comments not followed by full names and academic titles will either be removed or heavily monitored. –*Psychiatric Times*

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