Psychiatric diagnosis: More questions than answers

DAVID PILGRIM *argues that recent Society guidance on the use of diagnostic classifications in court misses the point.*

DIAGNOSIS is a medical task that creates a simple dichotomy between the sick and the well. By contrast, psychological formulations assume a continuity between the normal and the abnormal. The psychiatric question 'Is this person suffering from a mental disorder or not?' becomes transformed by a psychologist into 'How do we account for this person's actions and experience in this particular context?'.

Given that psychiatric diagnoses are at odds with context-specific formulations, why are they ever used by psychologists? This conundrum appears occasionally in our discipline, especially in the professional work of clinical, forensic and educational psychologists.

Recently, the Professional Affairs Board (PAB) formally endorsed diagnosis, giving new guidelines about the use of diagnostic classifications in court (*The Psychologist*, September 1999; see also box opposite). Only the first, very short, point of the statement puts the case (quoted in full) that '[p]sychologists normally provide formulations based on psychological models and theories'.

The bulk of the guidance is about why psychologists should deal in diagnostic labels as 'an aid to communication across disciplines'. However, most of the PAB guidance is not about the pragmatics of interdisciplinary communication but about the mandate to diagnose, which apparently we have if we are well trained.

This article will challenge the wisdom of the PAB statement on a number of grounds beginning with the scientific utility of diagnostic classification systems.

Counting angels on pinheads?

Diagnostic classifications based on the work of the psychiatrist Kraepelin (for now DSM-IV and ICD10) suffer all of the vulnerabilities of their founder's original logic. Kraepelin and his followers laboriously generated shifting diagnostic categories that lacked, and continue to lack, conceptual and predictive validity.

With regard to functional diagnoses, the bulk of psychiatry's bread and butter work, aetiological specificity remains elusive. Functional diagnoses have to be based on presenting symptoms alone as no definitive bodily cause has been proven. One after another exciting near-breakthrough in the explanation of the cause of mental illnesses like 'schizophrenia' comes and goes (Bentall *et al*., 1988).

More recent classification systems have improved inter-rater reliability, which is hardly surprising. Psychiatrists trained in the same checklists will tend to agree with the diagnoses of their colleagues. But, as we know, reliability is a necessary but not a sufficient condition for validity.

Despite the selling point of improved reliability, the fundamental question of poor or absent validity remains unanswered by systems such as DSM (*Diagnostic and Statistical Manual*) and ICD (*International Classification of Diseases*) (Wakefield,

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1999). In particular, the validity problem is highlighted by the difficulties in persuasively describing the symptom profiles that distinguish normality from abnormality and abnormal states from one another (Pilgrim & Bentall, 1998). A related complication is that of disjunctive diagnostic labels — two patients fulfilling criteria for a particular diagnosis may share nothing in common (Bannister, 1968).

The PAB statement (point 3.2) emphasises that current classification systems are atheoretical and descriptive. This appears to be offered a reassurance about their neutral scientific utility. However I would argue that it is because they are merely descriptive and not theoretically grounded or empirically validated that they are scientifically dubious (Mechanic, 1999).

Such systems have no advantage over ordinary language descriptions of madness, badness, sadness and fear. Ordinary people know that these aspects of the human condition come in all shapes and sizes and can offer a rich range of lay theories about their development and amelioration (Rogers & Pilgrim, 1997).

Psychiatric diagnosis and aetiological speculation compare poorly with lay accounts, which are more sensitive about the psychosocial context of behaviour and experience. Categorical descriptions are more reductionist, impersonal and stigmatising.

In earlier forms of DSM only categories were present. In DSM-IV a dimensional approach was added to qualify the categories; but, importantly, the latter remained. Thus diagnosis was fully retained and not displaced by the notion of psychological formulation I introduced at the outset.

For example, DSM-IV insists on depressed mood and four other symptoms to be present to diagnose major depression — but why four? Why not six or just one? Given the lack of hard biological signs, as ever in functional psychiatric diagnoses, how is this arbitrary decision making different from counting angels on pinheads or witch finding?

Calling madness 'schizophrenia' or misery 'depression' merely technicalises ordinary judgements. Lay people know when a person acts or communicates in an unintelligible way (Coulter, 1973), so what is added by calling unintelligibility 'schizophrenia'? Lay people know that rape is violent and antisocial, and that perpetrators are at risk of repeating their crime, so what is added by calling some (but not other) rapists 'psychopaths'? Put simply, does diagnosis add anything to ordinary language accounts?

'Mental illness': Circular logic?

Given the PAB focus on the use of diagnosis in court, it is instructive to look at how ordinary language has been considered in law. For example, under the Mental Health Act 1983, mental illness is not defined at all and psychopathic disorder is defined in a circular way. The logic goes like this: Q. Why do some men molest children? A. Because they are psychopaths. Q. How do we know they are psychopaths? A. Because they molest children.

In court, mental disorder is what expert witnesses say it is; but judges and juries can accept or reject, on commonsense grounds, the opinions of mental health professionals.

The judgement on Peter Sutcliffe (the 'Yorkshire Ripper') shows that professional views can be rejected, even when defence and prosecution expert witnesses concur about the presence of mental disorder. He was sent to prison by the judgement of a jury. Forensic psychiatrists only negotiated his transfer to a secure hospital several months later.

If an accused serial killer pleads not guilty, and is consequently not examined by psychiatrists, the conditions for the diagnosis of mental disorder are simply pre-empted. So if the accused is found guilty a prison sentence is inevitable (as in the Harold Shipman case). In some cases of serial killing, such as Dennis Nilsen's, defence and prosecution experts may not concur. Nilsen went to prison, and not a secure hospital.

On the pragmatics of defining mental illness in court, in 1974 Mr Justice Lawton ruled that 'the words "mental illness" are ordinary words of the English language. They have no particular medical significance. They have no particular legal significance.'(As cited in Jones, 1991, p.15.) Lawton refers to an earlier opinion by Lord Reid, who, when making a judgement about a defendant's motivation, said:

> *I ask myself what would the ordinary sensible person have said about the patient's condition in this case if he had been informed of his behaviour. In my judgment such a person would have said: 'Well the person is obviously mentally ill.'* (As cited in Jones, 1991, p.15.)

This approach to judgements is called 'the-man-must-be-mad-test'(Hoggett, 1990).

THE GUIDELINES

1. Psychologists normally provide formulations based on psychological models and theories.

2. To facilitate cross-referencing with other reports, psychologists may use one of the diagnostic classifications (i.e. *Diagnostic and Statistical Manual-IV or International Classification of Diseases-10*). For example, in some circumstances legal proceedings may be greatly assisted by a psychologist offering a diagnosis based on DSM-IV or ICD-10.

3. It should be noted that:

   3.1 Neither DSM-IV nor ICD-10 is intended only for use by medical practitioners. The DSM-IV manual explicitly states that it is designed for use by psychiatrists, physicians, psychologists, social workers, etc. (p.*xv*). ICD-10 refers to 'use by mental health professionals' (p.1).

   3.2 Both are intended to be descriptive classifications carrying 'no theoretical implications' (ICD-10 classification of mental and behavioural disorders, p.2, para.4) and intended for 'clinicians and researchers of different orientations (e.g. biological, psychodynamic, cognitive, behavioural, interpersonal, family/systems) (DSM-IV, p.*xv*).

   3.3 DSM-IV (p.*xxvii)* states that 'the proper use of these criteria requires specialised clinical training'. It does **not** state that it requires medical training and is clearly not intended to imply this.

   3.4 The *Curriculum in Clinical Psychology* (Powell *et al.*, 1993) published by the Society includes reference to specialised clinical training, explicitly referring to both ICD and DSM (see p.113, c.1-1). Hence qualified clinical psychologists should have had such training. Other psychologists may have to demonstrate that they have had such training.

4. In conclusion, as in all aspects of preparing expert witness reports, psychologists have to ensure that they have the necessary training and experience to give an opinion. Given this, there is no reason why diagnostic classifications should not be used as an aid to communication across disciplines.

Thus, forensic psychiatric knowledge is both shaped and evaluated by lay accounts.

Time to reject diagnosis?

In the light of these tensions between ordinary language accounts and the opinions of psychiatric experts, do we not have a professional responsibility to challenge and expose the shortcomings of a diagnostic approach to the complexities of psychological abnormality?

Moreover, psychological formulations have much more to offer legal rulings than medical labelling. Rather than the first point of the PAB statement, cited earlier, being a cursory introduction, should it not have been the *main* point? This would leave the puny grounds for using diagnostic language as being residual and regrettably pragmatic.

In its current form, the statement gives the opposite impression — that we should be honoured to take part in diagnosis. Surely our main duty is to communicate with other professions, not to shore up medical reifications, but to demonstrate why formulations about specific presenting problems in specific contexts are more useful and compelling.

The current PAB position was not shared by many psychologists in the past. Eysenck, Shapiro and Raven in the 1950s, for example, did not provide diagnoses. Instead, psychometric data or formulations were given to psychiatrists, who retained the sole diagnostic mandate. In the 1970s, psychologists who explored forms of personal change, beyond the diagnosis-plus-treatment approach of the medical model, challenged its shortcomings (Pilgrim, 1983).

Despite these examples of psychologists traditionally holding back from the medical task, by the time the PAB statement is made in 1999 we still have no wholesale rejection of diagnosis by the leadership of our discipline. This suggests that earlier attempts to de-medicalise psychology or to proffer a division of labour to keep psychiatry separate from psychology were only partly successful (Eysenck, 1975).

The PAB endorsement reflects a wider cultural shift over the past 20 years. Some psychologists have used psychiatric constructs in their assessments and interventions when, for example, running randomised controlled trials on the psychological 'treatment' of 'schizophrenia' or 'diagnosing' 'attention deficit hyperactivity disorder' or 'post-traumatic stress disorder'. Psychology textbooks regularly reproduce DSM categories.

It seems that currently our discipline is in an ambivalent position towards psychiatry — wanting full professional independence but, at times of selective convenience, co-opting a medical knowledge base.

The PAB commends the American Psychiatric Association's (APA's) generous invitation to other professions to use DSM. However, British psychologists should be aware of the professional and financial context and consequences of this encouragement. The more that a multidisciplinary group utilises the logic of DSM, the more legitimacy it accrues. This legitimacy then helps to maintain medical dominance in the mental health industry.

Also, prior editions of DSM were pleasingly profit-making for the APA ($9.8 million for DSM-III) (Blashfield, 1996). Every time that DSM is relaunched in a new edition to create yet another psychiatric reality, a new opportunity for profit accrues.

Blashfield (1996) parodies the mindless empiricism of DSM when, using linear regression, he predicts that DSM-V will be published in 2007, with a brown cover and 1800 diagnostic criteria. Blashfield also predicts that it will generate $80 million in revenue for the APA.

An irresistible case?

In conclusion, there are three practical reasons why we should abandon diagnosis in favour of formulation. First, we should be in the business of understanding psychological difference, not reducing experiential and behavioural variations to fixed pre-emptive constructs supplied by professionals. With our clients, we should negotiate the meaning of madness and misery in a way that sensitively places behaviour and experience in its biographical and social context.

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Second, by shifting completely to context-specific statements about experience and behaviour, we will capture more accurately what are our clients need and we will optimise risk assessment. Recent government guidance on care co-ordination in mental health services recommends decision making based on estimates of need, risk and vulnerability, not on diagnosis or legal status (Department of Health, 1999). Calling a person 'schizophrenic' tells us nothing about their individual needs, nor is it a useful risk predictor.

Third, this emphasis on need, vulnerability and risk will generate more sensible service planning than psychiatric epidemiology. The latter has always been weak because it simply counts labelled cases. A strong epidemiology can map diseases (e.g. cancers or infections) by evidence of local variations in their causes (e.g. radiation sources or bacteria). This is not possible with mental disorder — so what exactly is 'psychiatric epidemiology' other than counting cases for the social administrative sake of it?

Each of these three reasons is enough to encourage us to abandon diagnosis. Together they make the case irresistible.

■ *David Pilgrim is Head of Adult and Forensic Psychology Services, Guild NHS Trust, Preston and Professor of Mental Health, Department of Sociology, Social Policy and Social Work, University of Liverpool.*

Response from the Professional Affairs Board

WHEN psychologists are asked to give evidence as experts in court, they are not so invited in order to give a lay opinion. In their evidence it is likely that they will 'technicalise' mental distress, whether they use psychological or psychiatric constructs.

The discourse of law, and hence of the courts, is generally categorical. In mental health law and compensation law it is the presence or absence of a 'mental disorder' that currently forms the basis for decisions about application of powers or judging the severity of an injury. Psychologists rightly argue for different models for the basis of such judgements (for example, in the Society's response to the Scoping Review of the Mental Health Act 1983 we argued for the use of dimensional as opposed to categorical models).

Psychologists may also argue for psychological models of understanding when reporting to the courts. To give the example of someone having suffered personal injury, psychologists will describe their difficulties in functional terms, such as the degree of disability and how this impacts on everyday living.

How then deal with the situation when the court requires a categorical opinion to inform decisions about whether a person has passed a threshold for the award of compensation? Should the litigant have to be put through a whole further assessment by a psychiatrist or should the psychologist provide a diagnosis using the recognised frameworks?

The PAB's *Guidelines for the Use of Diagnostic Classifications in Professional Reports Provided for the Courts* was written in response to the dilemmas faced by professional psychologists. The guidelines are thus pragmatic. However they do acknowledge that psychologists are able to recognise, understand and when appropriate use discourses other than their own.