Deconstructing Psychiatric Diagnosis

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Let me explain why technically speaking there is no such thing as a psychiatric diagnosis. The creation of a mythology of mental illness that lacks scientific credibility has led to dominant beliefs and practices facilitating the rapid growth of psychiatric diagnoses and the tendency to deal with what is conceptualised as aberrant behaviour or emotions through technical – often pharmaceutical – interventions, a phenomenon I refer to as the 'McDonaldization' of mental health. I recommend that for progress in mental health theory, research, and practice, we must remove the concept of a 'psychiatric diagnosis.'

Despite over a century of research to establish possible causes using psychiatric diagnosis as the framing, the cupboard of positive findings remains astonishingly bare. There are no markers, no genes (apart from a significant portion of those with a learning disability), and no identifiable characteristic brain abnormalities. Studies looking at outcome from treatment with either pharmaceutical or psychotherapeutic models matched to diagnosis have not shown outcomes improving over time. What has increased instead are the numbers who get a psychiatric diagnosis, the amount of psychiatric medication prescribed, the numbers who become long-term patients, and the numbers who claim disability allowances for a psychiatric problem.

If the concepts we used in mental health practice had a scientific basis and/or were clinically meaningful, then we should be seeing something very different in both the science and the outcomes. Why do we have such an impasse? To start with, we literally don't know what we're talking about when we refer to mental disorders and illnesses.

What sort of 'thing' is a mental health problem?

What do people mean when they talk about mental disorder, mental health, or mental illness? What sort of 'thing' is a mental disorder? Where are its boundaries? When does an experience or behaviour become abnormal, disordered, or pathological and who decides based on what?

While the issue of where to place boundaries between the ordinary and the not ordinary is something medicine often grapples with, when it comes to

what we label as ‘mental health’ we have a whole new level of potential confusion, uncertainty, and meanings to get through before we can assert something to be out of the ordinary, abnormal, or disordered. In psychiatry, the entire phenomena, and not just the boundaries, require interpretation.

The territory for what we call psychiatric ‘symptoms’ (or psychopathology) of a mental disorder are experiences and behaviours that have meanings and that may be interpreted differently by different cultures, different times, and in different settings. This means that psychiatry is an area of practice where there is not only disagreements and debates about where the boundaries of a condition are, but we also have to take into account the significance and relevance of the diverse meanings that can be attached to these symptoms, for example that they are interpreted as symptoms in one interpretive framework but not in another.

Is that patient in front of me who reports intense sadness, difficulty getting to sleep, waking up before five am every morning, and experiencing a poor appetite, suffering from a ‘depressive disorder’ or experiencing understandable heartbreak and grief after the breakup of a long-term relationship a few months back? If you argue that both can be true, then culturally-speaking both depression and grief may be said about the patient as what they ‘have.’ One however cannot be a diagnosis (depression) as it explains nothing, it just describes some aspects of the patient’s experiences, while the other (grief) could indeed be a “diagnosis,” as it **suggests an explanation**. The latter is much more like a “diagnosis” than the former.

Even though grief in the above scenario is being used as an explanation, in truth I have no access to the patient’s inner mental workings. None of us do. With grief, depression, or both, I still do not know what sort of a ‘thing’ I am dealing with. Is it a medical disease in her brain, is it the psychological process of grief, is it the loss of a social network that she had with that partner, is it her concern about how this is impacting her son, is it the fear of returning to work after a long absence, is it that she has come to suspect that she has ‘depression’ which is depressing her even further? Is it all of these things? In truth, I don’t know anything definitive about what has caused her presentation; and likely neither does she. I can’t escape my subjectivity; and I can’t escape the patient’s subjectivity, either. I can only guess at the ‘diagnosis’ (that is, the proximal explanation).

When it comes to our emotional experiences, we just have embodied experience. We then use words connected with cultural meaning-making systems to attach to that experience. The meaning scaffolding we then use can itself transform our experience of the experience. "*You are broken hearted*" creates a different scaffold to "*you are depressed,*" or to "*you are surviving and recovering from a painful experience*" or even to, "*I can see how your suffering has helped you see your life in a transformed way.*"

Labelling the experience as a diagnosis of 'clinical depression' thus creates a particular scaffold, rather than discovering any 'truth' about that experience. Our choice of scaffold has a potentially profound impact on how individuals then interpret their experiences, which in turn impacts on their subsequent feelings and behaviours.

There is no such thing as a psychiatric diagnosis

In medicine, diagnosis is the process of determining which disease or condition explains a person's symptoms and/or signs. ***Diagnosis is a system of classification based on cause***. Making an accurate diagnosis is a technical skill that enables effective matching of treatment to address specific pathological processes. Pseudo-diagnoses, like for example 'Attention Deficit Hyperactivity Disorder' (ADHD) or 'Autistic Spectrum Disorder' (ASD), cannot explain behaviours or experiences, as there are only descriptions and not explanations.

Even using the word 'symptom' is problematic, as in medicine symptoms usually refers to patients' suffering/experience as a result of an underlying disease process and is therefore associated in our minds with a medical procedure leading to an explanation for the symptom.

We are meaning-seeking creatures and so have used classification systems extensively to classify all manner of things. A **diagnostic classification** is a classification **by explanation**, in other words by cause. That's why we say "*My doctor said that the cause of my chest pain was acid reflux, not a heart attack.*" This way of classifying works well when we can measure and empirically test, in a reliable way, bodily functioning. Diagnosis then provides a framework for research into treatments that address causes. Scientific methodology can be used and will lead to the development of a technical framework for classifying and treating conditions that affect the human body. In this medical universe, we generally know what 'thing' we are dealing with.

Take for example the fairly straightforward situation where there is minimal confusion about what sort of 'thing' we are dealing with. Somebody has an accident and experiences extreme pain and some swelling in their leg and they can't walk on it. At the hospital, an X-ray reveals there is a fracture in the tibia (shin bone). In this scenario, the medical model is working at its best. The fracture of the tibia is what is known as a 'natural kind,' so in terms of classification the diagnosis explains an abnormality in the person's physical body which can be empirically verified and measured.

As a natural kind that can be seen, it exists out there in the world beyond our subjective hypothesis. It is a verifiable fact of nature and we can develop knowledge bases about fractures of the tibia by comparing many people who have the same condition, trying out different treatment approaches and combinations, grading different types of severity, and looking at the various factors (in the fracture, the body of the person, the type of accident, and so on) that might affect responses to different treatments. Medicine is particularly good at these emergency scenarios where there is an identified abnormality and where the treatment period is relatively short.

Not all presentations to doctors follow this easy-to-understand idea of what sort of thing we are dealing with. Let's take diabetes as an example. The connection between symptoms and the underlying cause may not be as immediately apparent. A diagnosis of diabetes refers to an abnormally high level of sugar in the blood and this can be measured (for example through a test of blood sugar levels after a period of fasting). Type II diabetes could present just as a susceptibility to infections, or generalised tiredness and so could go unnoticed for months or even years. Nonetheless, there is a physical parameter that can be measured and there is a physiological process present in the physical body and that exists in the world external to the doctor who carries out the diagnosis and is verifiable with independent data (blood sugar levels).

So, in this example, whilst the connections between symptoms and disease are not as clear, may involve other factors than just the sugar metabolism, and may be missed in the early stages or by a poorly trained doctor, the diagnosis again is explanatory. It is pointing to an abnormality that can cause symptoms in the patient and will cause more if not treated. But there are many disagreements in diabetes diagnosis and treatments; for example, when to consider the blood sugar has crossed a threshold justifying a diagnosis, whether to just use dietary approaches and for how long, when to use

medication, how to deal with complications, the psychological impact of having a chronic disease, the social dimension of long-term care, and so on. But still, we know what sort of 'thing' diabetes is.

Now we start to get into medical conditions which can have recognisable symptoms and sometimes physical signs and some objective tests, but in which there are mysteries as to the initial cause or explanation. Many types of headaches, such as migraines, are good examples of this category. Diagnoses such as "migraine" are mainly based on a description of symptoms. We are now moving toward a descriptive rather than explanatory system. However, given that there are characteristic physical symptoms (such as, in migraine, that you may get blurring of vision, pain behind the eyes on one side of the face, etc.), it is likely that there is physical pathology. The presentation tends to be characteristic and there are physical symptoms, and so it is reasonable to assume that it involves physiological processes. So, we 'kind of know' what sort of a 'thing' migraine is, though we are now getting into a rather fuzzier territory.

(Can you sense how we are slipping away from explanation toward description? And what problems this will cause?)

With pain and with the nervous system involved, psychological aspects are becoming more prominent. But the idea of diagnosis still stands, even if it's to conclude that while the migraine is a diagnosis (in that it explains the physical symptoms), it can be brought on or sometimes even mimicked by psychological factors. But psychiatric diagnoses do not do **even this much**. They do not explain symptoms **at all**.

Consider the following example. If we were to ask the question "*What is ADHD?*" it's not possible to answer that question by reference to a particular known pathological abnormality, as none have been found. Therefore, there are no medical tests for ADHD. Instead, to answer the question we will have to provide **a description**, and a highly socialized one at that, such as "*ADHD is the presence of 'abnormal' levels of poor concentration, hyperactivity and impulsivity,*" and so on.

Contrast this with asking the question, "*What is diabetes?*" If a doctor were to answer this question in the same manner by just describing symptoms, such as needing to urinate excessively, thirst, and fatigue, he or she could be in deep trouble as a medical practitioner, as there are plenty of other conditions that

may initially present with these symptoms; and diabetes itself may not present with these symptoms in a recognisable way.

In order to adequately and accurately answer the question, "*What is diabetes?*" you would have to refer to its pathology involving abnormalities of sugar metabolism, as in, "*Diabetes is a disease that occurs when blood glucose (sugar) is too high.*" In most of the rest of medicine, a diagnosis explains and has some causal connection with the patient's experiences and/or symptoms. "Real" diagnosis sits in a 'technical' explanatory classification framework.

The problem of using a classification like 'ADHD' to explain an experience (i.e., as a diagnosis) can be illustrated by asking another set of questions. If a doctor were asked by someone why his or her child is hyperactive and the doctor answered that this is *because* they have ADHD, then a legitimate follow-up question to ask is, "*How do you know that this hyperactivity is caused by ADHD?*" The only answer the doctor can then give to that question is that "I know your child is hyperactive because your child is hyperactive."

In other words, if we try to use a classification that can only describe in order to explain, we end up with what philosophically is known as a 'tautology.' A tautology is a circular thinking trap. A description cannot explain itself. Using ADHD to explain hyperactivity is like saying the pain in my head is caused by a headache or my cough is caused by a 'coughing disorder'. In psychiatry, what we are calling diagnosis will only describe but is unable to explain and therefore it isn't a diagnosis.

If the rest of medicine were practiced like psychiatry, then when you go to your General Practitioner (GP – this is the UK title for a primary care doctor) because you have a recurrent cough, the GP wouldn't examine you at all; he or she would just ask you questions about your cough and then some questions about your relevant history. He or she would then pronounce that you have a 'Recurrent Cough Disorder – RCD' and give you a steroid inhaler to take once a day. The inhaler has non-specific effects and will open the airways, so at least in the short-term there would be some improvement in symptoms for many patients with a cough.

However, if you had a chest infection, your condition would likely ultimately get worse. Furthermore, long-term steroids can have all sorts of unpleasant and dangerous side effects if taken in sufficient quantities. Thus, this sort of

negligent “treatment” will have every chance of making things worse, perhaps even fatally worse, in the longer term.

But you wouldn’t really expect your doctor to behave like that. At the very least, you would expect him or her to listen to your chest with a stethoscope, to seek out signs, and perhaps arrange further tests (like a chest X-ray) if he or she remained uncertain as to the cause of the cough. In the rest of medicine, diagnosis really matters. It will guide the doctor towards a treatment that addresses the initial cause of the cough.

The failure of decades of basic scientific research to reveal any specific biological or psychological marker that identifies a psychiatric diagnosis is well recognised. Unlike the rest of medicine, which has developed diagnostic systems that build on a causal and physiological framework, psychiatric diagnostic manuals have failed to connect diagnostic categories with any causes or physical markers. Thus, there are no physical tests referred to in any mental health diagnostic manual that can be used to help establish a real diagnosis.

Despite the belief that psychiatric disorders have a significant genetic loading, molecular genetic research is failing to uncover any specific genetic profile for any psychiatric disorder. Possible genetic abnormalities appear to account for an insignificant percentage of possible associated causal factors, and whatever genetic contribution has been found crosses psychiatric diagnostic categories rather than having a distinct profile for each diagnostic category. Similarly, brain imaging studies are coming up empty-handed, particularly once you control for possible learning difficulties.

The reason why there are no genetic screens, brain scans or indeed any other physical tests in psychiatry is that no one can find anything that can act as a physical marker. The evidence cupboard, despite the billions in funding allocated to such biological research, is empty. The most likely reason for not finding any evidence is that there are no genetic or other brain abnormalities causing what we call psychiatric diagnoses.

Tools with consequences

When we understand that all we really have are meaning-making tools with consequences, we can evaluate both the power of the interpretive frameworks we use and hopefully appreciate that, unlike kidney problems, what we say has

an effect on the person we say it to. Kidneys don't get delighted, anxious, offended, or decide to stick with me or desert me, if I read out the results of kidney function tests. However, if you tell me that a dangerous and paranoid state of mind caused me to write the above sentences, then the effects on my emotions, thoughts, and behaviours may be very different than if you told me that the above sentences are a "*breath of fresh air.*" The effects will be more marked the more power the person has (or I perceive them to have) over me.

Our ideas about human functioning also connect with our concepts of 'self.' In the West, we tend to think about the self in more logical, rational terms, often using the language of science while believing psychology to be a branch of science (because it uses the language of research and numbers) that helps us understand the human condition. Problems of the self (what we in the West call 'mental health') are then dealt with by experts who use this language of science and logic.

Western scientific beliefs have shaped our understanding of the self, out of which psychiatry and psychology create definitions of the abnormal. What we see come out of that is a focus on the individual as an entity that is separate from her context, with the idea that what is going wrong can be located as belonging to that individual (whether psychologically or biologically). This "going wrong" is thought of in material scientific terms, in other words as something that can be understood by applying the same principles we use for the natural sciences.

This way of thinking assumes we can shed light on experiences and behaviours considered 'abnormal' by measurement and experimentation and in that way, understand the rules that govern our individualist biology and psychology. Thus, we use words such as 'psychopathology,' 'dysfunctional,' 'dysregulated,' 'disordered', and so on to describe and classify mental phenomena considered to be problematic.

Many consequences flow from this way of trying to understand the 'normal' and 'abnormal.' For example, it results in an obsession with classifying as a starting point for making sense. The process we use starts with analysing the individual for signs of 'psychopathology,' 'dysregulation,' etc. It then uses these to slot them into a 'typology' (which, as I've discussed, we mistakenly call a diagnosis). The methods we use celebrate logic and thinking and see emotions as an obstacle to a rational way of living. Thus, much of psychiatric and

psychological technology is suspicious of what emotions do to us and uses interventions whose raison d'être is ultimately the control of emotions.

Another consequence of this way of constructing 'what it means to be human' is that we have outlined, classified, and advertised all sorts of ways that humans can go wrong mentally. In our psychiatric diagnostic manuals, the numbers of diagnoses that we can provide expands with each new edition, as do the boundaries for diagnosing these disorders. This creates a sense of vulnerability for all of us as disorder is felt to lurk around every corner and around every difficulty that we encounter in our lives.

The extended media coverage of a "predicted" mental health epidemic, anti-stigma campaigns, and the special pleading Royal Colleges like mine (the Royal College of Psychiatrists) that demand parity with physical health practitioners and more funding, without pointing out the catastrophic levels of failure of current approaches, all add fuel to the fire of panic and the belief in our individual mental fragility and vulnerability.

How we conceptualise the human condition and its problems cannot be separated from powerful forces that shape our subjectivity. Philosophers and sociologists refer to this as 'social construction.' Our understanding of how the world works, and how we work within it, is built up by the stories we are exposed to and how they interact with our real-life experiences. In that way of understanding, our psychology is the meeting point between our embodied experience (we are after all biological beings with hormones and instincts too) and the experience in, and messages we receive, from our social world.

We do not have access to infinite ways of making sense of experiences, but we inevitably draw on the "making sense" efforts of those we grow up with and other influences we are exposed to (such as the media). In any society, at any one time, there will be a variety of ways available to make sense of any dilemma; but some will be more dominant than others. Those with more power to sell their version of reality will have more influence on what that dominating story will be. The models we use to make sense will shape our experience, not explain it.

Conclusions

In terms of how we construct the 'mind' (the 'psyche,' if you want to sound scientific, or the 'soul,' if you prefer a religious frame) and the 'self,' we have

very few givens biologically. What we make of our embodied physiology relies on what paradigm we wish to super-impose on what we observe and experience. We have no scientific window on the mind; we can only measure (environmental) inputs and (functioning) outputs. We have no idea what goes on in between. Neither psychology nor neuroscience has been able to tell us anything particularly universal about that in-between bit.

Understanding the mind requires a different type of knowledge to that of the natural sciences. It needs to involve an appreciation of philosophy and the humanities – branches of enquiry that engage with the subjective nature of meaning-making. We are always involved in making sense, so that one of the few universal characteristics of the 'mind' is meaning-making. Our meaning-making frameworks (including the professional ones we use) are cultural models that provide us with meaning-making tools with consequences.

I have explained why psychiatric diagnosis only exists in the cultural sense: in other words, it exists because we talk about it as if it exists. But in scientific terms there is no such thing as a psychiatric diagnosis. As a system of meaning-making, psychiatric diagnosis has had a profoundly destructive impact. It has turned imagined ideas into assumed concrete reality without realizing that this is what it has done. This has led to unhealthy consequences for individuals, the profession, and our culture more broadly. This fraud must be uncovered. *Psychiatric diagnosis should be exposed for what it is – a dangerous deception – and should be banned from being used in research or clinical practice.*