
**Psychiatric Diagnosis**

**DEFINITION**
The application of a medical label to a psychological abnormality.

**KEY POINTS**
- The history of psychiatric diagnosis is summarized.
- Criticisms of psychiatric diagnosis are rehearsed.

During the nineteenth century, formal systems of diagnosis began to emerge in a variety of countries, as psychiatry developed as a specialism within medicine (Stone, 1997). Given that the new profession’s main preoccupation was the management of lunacy, it focused on the codification of madness as a medical condition. For this reason, modern psychiatric classification is usually traced to Emil Kraepelin and his work on dementia praecox (soon re-labelled schizophrenia’ by Eugen Bleuler) (see Bentall, 2003).

There had been many ‘alienists’ and ‘mad-doctors’ (terms used for medical specialists of the unbalanced mind) prior to Kraepelin, who had deliberated on diagnoses and their classifications, but most psychiatric textbooks now emphasize his seminal role. Currently, there are two main medically accepted systems of psychiatric classification: the World Health Organization’s (1992) *International Classification of Diseases (ICD)*; and the American Psychiatric Association’s (1994)
Both of these are reliant and build upon Kraepelin’s work and his successor in German psychiatry, Kurt Schneider. Kraepelin’s first major medical description of ‘dementia praecox’ suggested an early deteriorating condition of the brain, which led to and maintained a state of madness from early adulthood onwards. Kraepelin began an important trend not only in medically codifying and classifying madness but in assuming a neurological basis for the condition. He enlisted the help of Alois Alzheimer, a neurologist, who had already found changes in the post-mortem brain tissue of some of those dementing in old age. It is still the case today that most psychiatrists consider that schizophrenia has genetically programmed neurological or biochemical bases. However, they are less pessimistic than Kraepelin and do not assume it to be an inevitably deteriorating chronic condition.

Scull (1979) has pointed out that the beginnings of medical authority over madness required a twin-track professional strategy. The first was to wrest control of the lunatic asylums from lay administrators and establish a system of medical superintendents. The second was to install a form of classification, which asserted unambiguously that madness was a biomedical condition. Scull quotes an editorial from the Journal of Mental Science (now the British Journal of Psychiatry) in 1858 which captures these points: ‘madness is purely a condition of the brain. The physician is the guardian of the lunatic and must ever remain so’.

Today, assumptions about the biological origins of serious mental illness remain in a dominant position in psychiatry. However, its classification system eventually began to include conditions in which the primary role of biology was more ambiguous or even unlikely. For example, psychiatrists working with or as psychoanalysts developed a theory of neurosis which emphasized inter-personal and intra-psychic conflicts to account for mental abnormality. Also, behaviourist psychology began to provide its own environmentalist explanations for neurotic behaviour.

These psychological rather than biological accounts also led to a remaining and unresolved problem for psychiatry: the question of aetiology. The latter refers to the causes or origins of a pathological condition defined during a diagnosis. There are still strong disagreements between biological advocates and environmentalists. The biological, and still dominant, position is handicapped by its limited evidence base. For example, the bulk of diagnosed mental illnesses are still described as ‘functional’. That is, they are based upon symptoms of speech and action, not on bodily diagnostic signs. Because of these controversies, DSM at present makes no claim about aetiology and emphasizes, instead, behavioural descriptions of abnormal psychological conditions.

This limited descriptive emphasis can be criticized for its circularity. Symptoms are used to define a disorder but they are also accounted for by the presence of the disorder, using the following logic:
Q: how do you know this patient has schizophrenia?
A: because she lacks insight into her strange beliefs and she experiences auditory hallucinations.

Q: why does she have strange beliefs and experience hallucinations?
A: because she suffers from schizophrenia.

This circular logic is not a confident basis for making any diagnosis.

Since the days of Kraepelin, with his emphasis on madness (or psychosis), DSM and ICD have incorporated more and more diagnoses, which cover a range of phenomena, including forms of neurosis, personality problems, substance misuse and other forms of addictive behaviour. Of all those with these diagnoses, psychotic patients are defined by their lack of intelligibility to others and their lack of insight. By contrast, neurotic patients are aware that they have a problem (indeed, it often becomes a preoccupation to them).

However, neat dividing lines, based upon intelligibility or insight, do not conveniently exist. A psychotic patient with a circumscribed delusion may act, for the most part, in a way that appears normal to others. A very obsessional neurotic patient may be deemed by others to lack insight into their condition and act in a visibly odd, rigid and ritualistic way. A patient with a diagnosis of anti-social personality disorder may act so outrageously that others may not understand it (calling it ‘sick’ or ‘beyond belief’ and so suggesting a criterion for psychosis). Thus, insight and intelligibility largely mark off psychosis from other forms of described mental disorder, but not unambiguously.

By the late twentieth century, Fish (1967) provided a basic psychiatric classification which still resonates in highly elaborated forms in more recent versions of ICD and DSM:

1 Abnormal variations in mental life
   • abnormal intellectual endowments (‘learning disability’);
   • abnormal personalities (‘personality disorders’);
   • abnormal personality developments (e.g. the emergence of pathological jealousy);
   • abnormal reactions to experience (e.g. ‘post-traumatic stress disorder’, neurotic distress, paranoid reactions).

2 Mental illnesses
   • the functional psychoses (such as schizophrenia and bi-polar disorder);
   • organic states (such as toxic reactions, drug-induced psychosis and some forms of senile dementia).

Under DSM, many versions of all of the above phenomena are subsumed under the single over-arching heading of ‘mental disorder’. The latter includes a group
missing from the list Fish (1967) constructed – people with addictive problems. As an indication of the uncertain state of psychiatric classification, while most psychiatrists today still would agree on the separation of organic from functional conditions, many would describe ‘abnormal reactions to experience’ as ‘minor’ or ‘mild’ mental illnesses.

A further complication about classification is that we cannot assume that symptom descriptions in the past match those used today. For example, Boyle (1991) studied the descriptions of symptoms used when diagnosing the patients of Kraepelin and Bleuler and found that they did not reflect the current symptom checklist to diagnose schizophrenia. This type of historical analysis casts doubt on whether modern psychiatry can offer a credible and stable classificatory system. So too do forms of analysis which focus on the reliability and validity of diagnosis.

Not only does the same patient often get diagnosed differently over time (indicating poor reliability of diagnosis) but patients with different diagnoses may have symptoms in common (poor conceptual validity). Validity problems are also seen within specific diagnoses. For example, schizophrenia is a disjunctive concept (Bannister, 1968) because two patients with the diagnosis may have no symptoms in common. Reliability can be improved by psychiatrists being trained carefully in the use of common symptom checklists (for example, using-DSM). However, reliability (consistency between diagnosticians and over time in the same patient) is not the same as validity (whether a diagnosis has objective evidence to confirm it and whether it is conceptually separate from other diagnostic categories). A third form of validity is predictive validity (a diagnosis should predict the outcome of illness). Again, this is highly imperfect in psychiatry, because human behaviour (of any sort) is difficult to predict accurately.

While a valid diagnosis has to have good reliability, it is possible to consistently use a label which is still not valid (Bentall et al., 1988). These doubts about the validity and reliability of psychiatric diagnoses have led some to argue that mental disorder is very difficult to measure and that the dividing line between the normal and abnormal is fuzzy (Wakefield, 1999). As a consequence, estimating the incidence and prevalence of mental health problems becomes a precarious science.

A specific problem is pointed up by cross-cultural critics, who argue that judgments about what is normal or abnormal ipso facto reflect norms. If psychiatric diagnosis is about codifying non-conformity (rule breaking and role failure) in a particular culture, and cultures vary in their expectations of normal conduct, how can a stable and universal system of diagnosis be achieved? And when it is attempted (like in DSM and ICD), does this make it automatically insensitive to particular cultures in time and place?

Responses to these difficulties about the rationale for or the possibility of a stable universally valid system of psychiatric classification have varied:
Defenders simply argue for a greater refinement of systems like DSM and ICD and their consistent use in medicine;

Some critics argue for the wholesale rejection of psychiatric diagnostic categories in favour of presenting psychological difficulties. This criticism mainly comes from psychologists (e.g. Bruch and Bond, 1998);

Some defenders point out that DSM has moved beyond simple categorization (the logic of a disorder being present or absent) and has included a dimensional view. This tension between a categorical view (e.g. a patient suffers from phobic anxiety) and a dimensional view (e.g. we are all, to some degree, phobic about something) fuels an ongoing debate about diagnosis within psychiatry (Kendell and Zealley, 1993);

Some critics argue for the selective rejection of some types of people with difficulties from psychiatric jurisdiction. For example, some psychiatrists argue that only mental illness (psychotic and neurotic patterns of conduct) should fall within their remit. Those with acute transient distress, serious personality problems and substance misuse are not embraced and so are not really deemed to be worthy of formal psychiatric diagnosis. Other psychiatrists disagree and champion the treatment of these groups and so specialize in their diagnosis;

Some psychiatrists accept the principle of diagnosis but emphasize cross-cultural sensitivity.

A final point to make about psychiatric diagnosis is that it is a product of psychiatry (as its name indicates). While madness, sadness and fear have always existed, as part of the human condition, ‘mental illness’, or ‘mental disorder’ only exist as by-products of psychiatric activity. However, as I have noted elsewhere (Pilgrim, 2007), a number of interest groups, not just psychiatry, maintain the legitimacy of psychiatric diagnosis despite its many problems about the contested aetiology and the poor predictive and conceptual validity of its categories.

See also: fear; madness; personality disorders; sadness; substance misuse; the myth of mental illness.

REFERENCES


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**Psychiatric Epidemiology**

**DEFINITION**

The study of the incidence and prevalence of mental disorder in time and space.

**KEY POINTS**

- Psychiatric epidemiology is described.
- Its weakness compared to traditional medical epidemiology is discussed.

In medicine, incidence refers to the number of new or first cases diagnosed. Prevalence refers to the total number of cases present in a population at a point in time or for a specified period of time. Epidemiology is the study of incidence and prevalence of diseases in space and time. Estimates of both prevalence and incidence of mental disorders are not easy for the following reasons:

1. Some critics argue that it is inappropriate to count cases, other than those with true organic conditions, which are associated with psychological abnormality (Szasz, 1961);