

**The nature of ‘diagnosis’ in psychiatry
by Suman Fernando, 1 February 2010**

The first thing to note is that no psychiatric diagnosis has an established biological maker; hence there is no way of proving objectively either its accuracy or indeed its scientific validity. Therefore the status of psychiatric diagnoses is that they are hypothesis or concepts that are used pragmatically. They have achieved some degree of prestige and acceptance through tradition and usage but are constantly questioned as to their real worth. One-time president of the Royal College of Psychiatrists, R. E. Kendell, wrote much about the process and meaning of psychiatric diagnosis. One of his last papers (co-authored with Jablensky) stated that ‘diagnostic categories are simply concepts, justified only by whether they provide a useful framework for organizing and explaining the complexity of clinical experience in order to derive inferences about outcome and to guide decisions about treatment’ (Kendell and Jablensky, 2003: 5). They warned of the danger of reifying a diagnosis by assuming that it is ‘an entity of some kind that can be evoked to explain the patient’s symptoms and whose validity need not be questioned’ (2003: 5). If and when their use is justified, it is because of their utility.

In psychiatric practice, unlike in general medical practice, symptom identification and illness recognition are not independent processes, the former following the latter; in psychiatry, *they actually occur concurrently*. As Kendell (1975) pointed out many years ago, decisions about diagnosis are made early in a clinical interview, before the psychiatrist makes judgements about the presence or absence of symptoms. So images that the psychiatrist has in his / her mind about the sort of person who is likely to be schizophrenic or depressive, etc. affect the judgements about presence or absence of symptoms and signs.

Psychiatric diagnoses are based on identifying ‘psychopathology’ and located in an individual. This is called the ‘mental state examination’. What the psychiatrist claims to identify are (mental) ‘phenomena’ judged (by the psychiatrist) to be abnormal (hence ‘pathological’) located in the individual’s mind. They are commonly called ‘symptoms’. These abnormal ‘phenomena’ are (traditionally) given names such as delusions, hallucinations, thought disorder, anxiety or depression – some of which (like the latter two) being also used to describe ordinary emotions that need not be pathological at all. The process of giving specific names to judgements about a person’s subjective feelings and beliefs is to seemingly objectify those feelings so that they can be dealt with as entities apart from the person. As Berrios and Chen (1993) note, calling them ‘phenomena’ implies that these judgements are objective facts. But actually, like illnesses themselves, they are hypotheses about a persons thinking and beliefs. The total process itself is based on a (psychiatric) tradition passed down through (psychiatric) training.

Cross-cultural perspectives

The evaluation of human features in the process of making diagnoses are inevitably value laden (Fulford et al. 1993), the values coming from the culture within which psychiatry has developed and the culture in which it lives and breathes. In other words, the way the human being is dealt with in the psychiatric process is firmly tied up with the thinking about the human condition during the (European) enlightenment of the seventeenth and eighteenth centuries (when modern psychiatry emerged) and

changes that have taken place since then. In other words, the diagnostic process (like psychiatry itself) is firmly embedded in what is roughly called 'western culture', incorporating its prejudices and beliefs about 'culture', race etc.

Understandably major problems have arisen when diagnoses and symptom recognition are applied across cultures. The basic problem was conceptualized by transcultural psychiatrist Arthur Kleinman (1977) as 'category fallacy' - the error of imposing a diagnostic category derived in one cultural context on the study of mental disorders in other cultures. However, the problems in transcultural practice and research are now recognised as much wider than just hinging on diagnostic issues. Cultural diversity in worldviews, the understanding of mental health and illness, and indeed of what constitutes the 'mind', all play a part in the issues reflected in attempts to apply psychiatry cross-culturally (see the vast literature referred to in for example Fernando, 2010).

Issues in British context

There have been many studies and a great deal of discussion about (what are called) ethnic issues in mental health during the past twenty-five years. One prominent issue is the high rate at which 'schizophrenia' and 'psychosis' is diagnosed among black people who are of African or Caribbean descent. Misunderstandings resulting from cultural differences may play some part but evidence from experience of service users and examination of what happens on the ground point to 'race' as the main explanation. Primarily, stereotypes and myths about black people – for instance about violence, anger and dangerousness - play through images and ideas people who practice as psychiatrists and, even more importantly, feed into psychiatric practice - whatever their ethnicity - carry in their minds; and these images are constantly re-enforced by media stories and depictions and the ordinary 'commonsense'. Efforts at being 'culturally sensitive' and 'anti-racist' among psychiatrists and others in the mental health field may attenuate their effects but unlikely to obviate them. Unfortunately, many psychiatrists feel they are 'above' being affected in this way imagining that their methods of diagnosis are 'objective'; so in many instances there is little effort made to even attenuate the influence of stereotypes. Most research tends to avoid facing up to investigate this type of institutional racism in psychiatric practice, largely because it is based on head counts of people already diagnosed or investigations of opinions of professionals with diagnoses themselves being taken as valid indicators of mental health problems – i.e. diagnoses be assumed to be valid, objective entities.

The only well- conducted piece of research into racial and gender bias in diagnostic habits of psychiatrists was reported by Loring and Powell (1988). Using carefully constructed vignettes (mini case histories) they researched diagnostic approaches of 290 black and white psychiatrists, to find that (a) overall, black clients compared to white clients, were given a diagnosis of schizophrenia more frequently by both black and white clinicians – although to a lesser extent by the former; and (b) all the clinicians appeared to ascribe violence, suspiciousness and dangerousness to black clients even though the case studies were the same as those for white clients (with racial identities obscured). Loring and Powell concluded that black and white people are 'seen differentially even if they exhibit the same behaviour' and that these differences 'are reflected and legitimized in official statistics on psychopathology' (1998: 19).

Racism and diagnosis

Racism enters the diagnostic process at a variety of levels, apart from its permeation via stereotypes. After all, diagnosis is always based on a personal interaction involving at least two persons, but often in a context where several others (giving their interpretations of behaviour and emotional states of the person concerned) that may include police, neighbours and general public with vested interests of various sorts. In such an interaction, images of black people must play a large part in the conclusions drawn about diagnosis - conclusions that lead to seemingly objective judgments made about 'symptoms'. Particular diagnoses carry particular images and the images about illness get confounded with images about people. For example, alienness - or 'otherness' is an attribute we see in people we see as different or appear foreign; and much of this feeling is connected with how people look - their 'race'. But alienness is also linked to images of the mad, the people beyond the fringe, the schizophrenic. Further, when there is a view of schizophrenia as being caused by a 'bad' gene (a view that is deeply imprinted in psychiatric thinking and the general public) the idea of genetic inferiority gets linked to schizophrenia; and the ideology that black people are genetically tarnished is not an uncommon concept that informs thinking about race anyway. This confounding of alienness and biological / genetic inferiority with race, and both with schizophrenia would promote a diagnosis of schizophrenia among black people. In my view, it is not strictly speaking a '*mis*-diagnosis' - i.e. a mistake in diagnosis; the way the diagnosis is made may well be in keeping with all the best traditions of psychiatry. Yet, the application of an inappropriate and unhelpful - even destructive - label is politically, ethically and morally *wrong*.

Diagnosis in 'management' (control) and treatment

But really what most people who access services are concerned about is *treatment*, what help they can get to their problems. It may even be said that the diagnosis does not really matter very much so long as there is some benefit to the 'patient' in the treatment that results. The traditional view is that treatment is determined by diagnosis, and so correct (*sic*) diagnosis is essential. In my view this is seldom the case. Although diagnosis plays a part in determining treatment, decision-making in this field is far more complicated in practice. How most services work is that a psychiatrist generally decides on what treatment should be given *and then* makes a diagnosis that fits with what can be offered. So if medication is much easier to arrange than (say) psychotherapy the tendency is to think of a diagnosis that responds to medication.

Then there is the issue of controlling behaviour of patients. In the case of someone who is agitated and perhaps frightened - and even angry - the context in which the psychiatrist makes the treatment decision is fraught. Here, the difference between treatment and control is likely to be very unclear. So if the psychiatrist wishes - or thinks it prudent - to give high doses of psychotropic medication because the patient seems to need 'control', the schizophrenia diagnosis - or at least a 'psychosis' diagnosis - becomes imperative. Black people get caught in these situations much more often than white people do; but even more importantly, stereotypes and images play havoc in such situations.

In the UK, psychiatrists - and indeed social workers involved in operating the mental health act - are only too aware that prolonged detention in hospital is only possible of

there is a diagnosis of 'psychosis'; prolonged detention of a person with a diagnosis of 'personality disorder ('psychopathy' according the 1983 Act) is not possible unless the person is deemed 'treatable'. It is significant that very few black people are given a 'personality disorder' diagnosis. That is while the original Act remained unchanged. The situation today (January 2010) is that the revised Act that came into force a few months ago removes the limitation on compulsory detention in the case of people diagnosed with 'personality disorder'. It remains to be seen whether this diagnosis (so far not applied very often to black people) would now be applied more frequently in the future – possibly with a corresponding fall in the 'schizophrenia' diagnosis.

This article is based on published material in my books, particularly *Cultural Diversity, Mental Health and Psychiatry* (Hove and New York: Brunner-Routledge, 2003) and *Mental Health, Race and Culture* (Basingstoke: Palgrave / Macmillan, 2010). For references see bibliography in these books.