Diagnosis and its Discontents: The DSM Debate Continues


When critics of psychiatric diagnosis insist that terms like “schizophrenia” or “bipolar disorder” are inherently stigmatizing, they are unwittingly perpetuating the very prejudice they wish to end. It is time to shine a bright light on this self-fulfilling prophecy.

“As to diseases, make a habit of two things—to help, or at least to do no harm.”

“Agnostic is someone who doesn’t know, and di- is a Greek prefix meaning “two.” So “diagnostic” means someone who doesn’t know twice as much as an agnostic doesn’t know.”
–Walt Kelly, Pogo

A funny thing happened to me on the way to the New York Times “Sunday Dialogue”—I made myself unclear.¹ This is not supposed to happen to careful writers, or to those of us who flatter ourselves with that honorific. So what went wrong?

In brief, I greatly underestimated the public’s strong identification of psychiatric diagnosis with the categorical approach of the recent DSMs. But whereas my letter to the Times was indeed occasioned by DSM-5’s release in May, my argument in defense of psychiatric diagnosis was not a testimonial in favor of any one type of diagnostic scheme—categorical, dimensional, prototypical² or otherwise. (I hope the present essay will save “The Committee to Boycott DSM-5” some time!). Each of these diagnostic schemes has its advantages and disadvantages. My personal preference is for a prototype-based schema, for everyday clinical use; and a DSM-type categorical schema for purposes of psychiatric research.² The categorical approach is usually preferable for most research studies, because it provides precise “cut-points” for entry criteria. But we should not suppose that our diagnostic categories necessarily “carve Nature at its joints,” in Plato’s famous phrase. Indeed, as philosopher Alexander Bird quipped, “The classifications of botanists do not carve nature at its joints any more than the classifications of cooks.”³ DSM-IV itself understood this, and explicitly recognized its own limitations. In the often-ignored introduction, DSM-IV stated:

Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable additional information about the person being evaluated beyond that required to make a DSM-IV diagnosis.⁴

And—while I have not seen the text—I expect that DSM-5 will be similarly cautious. I would add to this cautionary note the need for more than a symptom-based approach to diagnosis. In order to gain a full and deep understanding of the patient, psychiatrists must also delve into the patient’s “world view”—her way of “being in the world.” The phenomenologists therefore focus on the structure and contents of the patient’s conscious experience.⁵ ⁶ For example, does he or she invariably experience the world as a hostile and threatening place? Are all her relationships perceived as threats to her autonomy? And how do the patient’s spiritual concerns and beliefs shape his world-view?⁷ From the psychodynamic perspective, as Dr James Knoll observes, what are the wishes, fantasies, experiences, fears, and desires that shape the patient’s conscious and unconscious life? (written communication, March 26, 2013). Such depth-psychology is unlikely to be captured in either a categorical or a dimensional “diagnosis” of the patient. Deeper understanding demands that we enter into the patient’s way of “being in the world.”

Physicians, of course, have been reaching diagnostic conclusions since the time of Hippocrates—quite without the help of diagnostic manuals. The word “diagnostic”—notwithstanding Walt Kelly’s sardonic jab—may be understood as “knowing (gnosis) the difference between (dia-)” one condition and another. So, when we recognize that a patient’s auditory hallucinations are related to complex partial seizures and not a psychosis, we are engaging in diagnosis.

A diagnosis, however, need not name a “disorder” or disease. Our diagnosis of Mr. Smith may be, “Perfectly happy chap—nothing to treat here!” Sometimes, in my consultative practice, a patient would ask me for my diagnosis, and I might reply, “Well, I think you have a serious problem with regulation of your mood and your anger. I can give you a formal name for your condition, but I’d...
rather hear what kind of information you would find most helpful.” That, too, is a “diagnosis”—though not necessarily the “CPT code” an insurance company would accept.

Kudos and brickbats
Reaction to my letter was decidedly mixed. While most colleagues were very supportive, many comments in the blogosphere ranged from the dismissive to the abusive. Predictably, some critics trotted out the old war horses of anti-psychiatry (were these not led out to pasture decades ago?): psychiatry is not “scientific,” because it doesn’t have verifiable laboratory tests or biomarkers for its disorders; psychiatric diagnoses are just the “subjective impressions” of the clinician; psychiatry amounts to “totalitarian oppression,” etc.

These canards and slurs have been addressed in many other contexts, and I won’t belabor their fallacious assumptions here. Yet psychiatrists should not underestimate the deep currents of public anger and resentment toward our profession, and we must acknowledge that sometimes we have not served our patients well. Psychiatric diagnosis—like diagnosis in other fields of medicine—is sometimes premature. Psychiatric treatments—like many treatments in general medicine—are sometimes ineffective or injurious, despite our best intentions. Patients who have been hospitalized against their will—even when justified on the basis of imminent “dangerousness” and ordered through due process of law—may still have bitter memories of that experience. I truly believe that psychiatry is a force for genuine good—and sometimes quite literally a lifesaver—but I am also aware of the many challenges we face in building trust with the general public.

The public’s misconception of “science”
One thing was abundantly clear from responses to my letter: the general public still does not understand that “science” is fundamentally a habit of mind and method—not a microbe in a dish, or a shadow on a CT scan. Recently, the British Science Council spent a full year developing a definition of “science.” Their conclusion was radically insightful: “Science is the pursuit of knowledge and understanding of the natural and social world following a systematic methodology based on evidence.” Specifically, science entails careful and systematic observation; hypothesis-formation; and repeated testing of one’s hypothesis, using empirical methods. In this sense, there is no question that psychiatry and psychology are sciences—though they are also more than that. That the concept of science is so badly muddled—even by some health care professionals—is testament to the baneful legacy of logical positivism, and its close cousin, scientism. These ideologies have led to the public’s abiding confusion between the physical sciences, like biology and biochemistry; and the sciences of human emotion and behavior—the domain of psychiatry, psychology, and related disciplines. Psychiatry, as a medical discipline, partakes of both the physical and human sciences. But psychiatry is not physics! As Schwartz and Wiggins have observed: Medicine is a science, insofar as its concepts, methods, and techniques are based on evidence, but it is a practical and not a pure science. Medicine is a practical science because its goals—the promotion of health and the amelioration of illness—are practical ones.

Of course, good clinicians know that there is also “art” in what we do, and that some subjective elements of the patient-doctor dyad are not easily expressed in the terms of science. Therein lies the art—and poetry—of our work with patients.

Are psychiatric diagnoses inherently “stigmatizing”? Other arguments put forth by my critics were more troubling. Many readers bristled at my claim that a psychiatric diagnosis is not inherently—that’s the key word—“stigmatizing” or “dehumanizing.” (The diagnosis, of course, may simply be incorrect). These critics pointed with understandable outrage to personal experiences of prejudice, discrimination, and mistreatment at the hands of people who learned of their psychiatric “label.” (It is interesting that nobody calls a diagnosis of migraine headache or epilepsy a “label”—the reasons for this discrepancy, however, would take us far afield). More subtly and poignantly, some readers described how internalizing their psychiatric diagnosis adversely affected their self-esteem and identity—stunting their emotional growth and depriving them of purpose, dignity, and worth. On one level, this should not surprise us. After all, hearing from an orthopedist that your ankle is broken is existentially different than hearing from a psychiatrist that your very self is broken.

And yet, I stand squarely behind my claim: there is nothing inherently stigmatizing or dehumanizing in the psychiatric diagnosis itself. If the patient feels diminished or dehumanized, it is largely owing to one or more of these factors:

• the patient has been subjected to bigotry, insults, or discrimination at the hands of ignorant and insensitive people
• the psychiatrist or clinician has (unconscionably!) presented the diagnosis in an overly pessimistic or depreciating way—one that leaves the patient feeling hopeless, disrespected or demeaned
•the patient himself has engaged in a process of *self-deprecation*

This last point needs clarification. I am not trying to “blame” the patient for feeling bad. However, I am suggesting that the patient who receives a psychiatric diagnosis *need not* feel diminished, dehumanized, or demoralized. So much depends on how the diagnosis is framed, both by the clinician and the patient. A patient may say to herself, “Well, the doctor says I’m a schizophrenic. That must mean I’m crazy, and no good to anybody! I’m nothing, a nobody. My life is over—I might as well pack it in.” Of course, this patient will feel dehumanized and demoralized. But another patient, given the same diagnosis, may think, “Okay, this schizophrenia thing is really upsetting and scary—but it’s not the end of the world. I can still be a creative, loving, and productive person. I’m still me, and I’m still worthwhile.” This patient is far less likely to be bludgeoned by the diagnosis. Indeed, such cognitive reframing is a critical part of the growing “recovery movement,” which emphasizes the patient’s *possibilities* rather than his limitations. For example, Bellack has noted that as many as 50% of people with schizophrenia actually have good outcomes. Ironically, when critics of psychiatry claim that a diagnosis is *inherently* “stigmatizing,” they undermine the goal of recovery in psychiatric patients. They implicitly deny that patients can “re-envision” the meaning of their diagnosis—surely a disparaging notion! That said, it must be admitted that some psychiatrists have been slow to accept the “recovery” paradigm, which often has been advanced by “consumer” activists outside the medical community. We need to do better in this respect. When we provide a diagnosis, we must also provide hope, comfort, and realistic optimism. But let us be clear: psychiatrists must not cease the activity of diagnosis, or be intimidated by unreasoning critics. To abandon diagnosis is to violate our most fundamental Hippocratic duty: *to help our patients.*

Or, as the poet, Allen Ginsberg, put it, in a different context: “Well, while I’m here I’ll do the work—and what’s the work? To ease the pain of living.”

**Recommended readings:**


**Acknowledgments:** I would like to thank James L. Knoll IV, MD, and Michael A. Schwartz, MD, for their helpful comments on an earlier draft of this article. Dr Sidney Zisook has been extremely helpful in developing my views on diagnosis. I also appreciate the many colleagues and readers who commented on my letter, and the careful editing of Sue Mermelstein at *The New York Times*. Thanks also to the American Psychiatric Association for taking note of my letter.

**Disclosure:** Dr Pies has had no official relationship with the committees or work groups responsible for the DSM-5. He is a member of the American Psychiatric Association.

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**References:**


