No More Psychiatric Labels: Campaign to Abolish Psychiatric Diagnostic Systems such as ICD and DSM (CAPSID)[1,2]

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SYNOPSIS

This article argues that psychiatric diagnoses are not valid or useful. They neither help with building scientific knowledge nor with improving outcomes in clinical practice. The use of psychiatric diagnosis increases stigma, does not aid treatment decisions, is associated with worsening long-term prognosis for mental health problems, and imposes Western beliefs about mental distress on other cultures. Alternative evidence-based models for organising effective mental health care are available. Therefore formal psychiatric diagnostic systems such as the mental health section of the International Classification of Diseases (ICD) and Diagnostic Statistical Manual (DSM) should be abolished.

Modern Western psychiatry has secured many important advances in the care of people with mental distress. We have a variety of pharmacotherapies that can help manage distressing symptoms alongside an even greater variety of psychotherapeutic approaches that help people in distress make sense of their experiences and find new ways to deal with them. The old asylums have been emptied and community care has developed a variety of services from early intervention to crisis management. The academic community, studying mental distress from a variety of angles, has grown in numbers and sophistication, with many journals and thousands of articles being published each year. These are worthy achievements, and this progress has no doubt helped thousands of people across the world.

However, despite all these achievements, psychiatric theory and practice is at an impasse. Prevention has proved elusive, with mental health diagnoses becoming more not less common. There still isn't a diagnosis listed in the major psychiatric diagnostic manuals (such as ICD and DSM) that is associated with any sort of physical test or other biological marker and so, unlike the rest of medicine, psychiatric diagnoses do not have any pathophysiological correlates. Whilst reliability in making

diagnoses has improved for some research purposes, this has not translated to clinical practice, and the more important issue of validity remains poorly addressed. Most importantly there is no evidence to show that using psychiatric diagnostic categories as a guide for treatment significantly impacts on outcomes.

This campaign therefore proposes that the time has come to help theory and practice in mental health move beyond this impasse by abolishing formal psychiatric diagnostic systems like ICD and DSM. The campaign highlights the extent to which empirical data is inconsistent with the dominant, diagnostic-based medical model remaining as the organising paradigm for practice. Continuing to use formal diagnostic systems to organise research, training, assessment and treatment for those in mental distress is inconsistent with an evidence-based approach capable of sustaining improved outcomes. The important task of sketching out what services may look like once we discard ICD and DSM from routine clinical practice is not the primary purpose of this campaign and will not be covered in any depth. However, many alternative paradigms are already available and easy to incorporate into practice, and in a way that can improve outcomes.

Aetiology

The failure of basic science research to reveal any specific biological abnormality or, for that matter, any physiological or psychological marker that identifies a psychiatric diagnosis is well recognised. Unlike the rest of medicine, which has developed diagnostic systems that build on an aetiological and pathophysiological framework, psychiatric diagnostic manuals such as DSM-IV, the soon-to-be-published DSM 5, and ICD-10 have failed to connect diagnostic categories with any aetiological processes. Thus, there are no physical tests referred to in either manual that can be used to help establish a diagnosis. The critique that highlights the lack of progress on aetiology is not limited to those less biologically minded psychiatrists, as researchers in genetics are also arguing that the use of categorical diagnoses (such as schizophrenia) is handicapping their studies too.[3,4]

The one notable exception to the lack of aetiological organisation is 'post-traumatic stress disorder' (PTSD), which attributes symptoms to being the direct result of trauma. This diagnosis implies that trauma leads to a particular and identifiable constellation of symptoms. However, there is a substantial body of evidence linking states regarded as the most serious in psychiatry, such as the experience of hearing voices and psychosis, to trauma and abuse, including sexual, physical and racial abuse, poverty, neglect and stigma.[5,6,7,8,9,10,11,12,13,14,15]

Validity

If we were to apply the standards found in the rest of medicine, then the validity of a diagnostic construct depends on the extent to which it represents a naturally occurring category. If it can 'carve nature at its joints', then there should be some identifiable properties beyond symptoms or behaviours in those who have the diagnosis that can distinguish them from those who don't. Despite years of searching for biological correlates, however, the failure of basic science research to reveal any specific biological marker for any psychiatric diagnostic category reveals that current psychiatric diagnostic systems do not share the same scientific security of belonging to the biological sciences as the rest of medicine. Mainstream practice understandably views this as a problem. However, the attempted solution of continuing to spend the bulk of mental health research time and effort trying to correct this deficit by relentlessly searching for evidence of biological correlates continues to deliver nothing scientifically or clinically useful. Our failure to find biological correlates should not necessarily be seen as weakness. Instead of continuing with scientifically and clinically fruitless research, we should view this failure as an *opportunity* to review the dominant paradigm in order to develop one that better fits the evidence.

Invalid anomalies are prevalent in DSM/ICD. For example, in DSM-defined 'depression', there is one exception to the diagnosis (even if the patient has the required number of symptoms for the required number of weeks) – bereavement. This is anomalous in at least two ways. First, it breaks the 'rule' that diagnostic categories in DSM are descriptors that do not imply aetiology. Secondly, because bereavement is considered a 'normal' reaction, even if the full complement of DSM-defined symptoms of depression are present, then one must ask: why is 'bereavement' specifically singled out? Why are many other life problems for which intense sadness is a common response – such as losing a job, break up of a marriage, bullying and so on – not also counted as legitimate exceptions?[16]

The frequency with which patients are given more than one diagnosis also raises a concern about the specificity of diagnostic categories. Widespread co-morbidity (making more than one diagnosis in order to encompass patients' problems) indicates basic

deficiencies in our understanding of the natural boundaries of even the most severe conditions we are diagnosing in psychiatry.[17,18,19] It is also common to find the 'dominant' diagnosis changing in any individual, almost exclusively on a subjective rather than empirical (such as physical test results) basis. Unlike in the rest of medicine where the reason for the patient's symptoms is clarified by a diagnosis, psychiatric diagnoses serve empirically as nothing much more than descriptors. Thus, when a clinician claims that a patient is 'really' depressed, or has ADHD, or has bipolar disorder, or whatever, not only are they trying to turn something based on subjective opinion into something that appears empirical, but they are engaging with the process of reification (that is, turning something subjective into something 'concrete'). The problem with turning concepts into something that appears as if it exists as a fact in the natural world is that it can cause 'tunnel vision' for all concerned; a dominant story that limits alternative, more functional possibilities for any individual.[20] Thus, if someone believes ADHD is a 'real' disorder that exists in their brains and is potentially lifelong, that person and those who know them may come to act according to this belief, thus helping to fulfil its prophecy.

There is also a poor correspondence between levels of impairment and having the required number of symptoms for many psychiatric diagnoses. Literature reviews and field trials to examine clinical significance criteria were not included in the preparation of DSM-IV. Thus, many below the threshold for a diagnosis have higher levels of impairment than those above, with many who reach the cut off for a diagnosis having relatively low levels of impairment.[21,22,23]

Reliability

Reliability is the extent to which clinicians can agree on the same diagnoses when independently assessing a series of patients. Improving reliability of psychiatric diagnoses was hastened after critics pointed out that many of the common diagnoses were meaningless because of poor levels of agreement between psychiatrists about key symptoms. Rosenhan's 1973 study spurred on new attempts to 'standardise' diagnostic practice after he demonstrated that psychiatrists were often unable to discriminate between sane and psychotic people.[24] Formal diagnostic systems like DSM and ICD attempted to address these problems by imposing diagnostic agreement on the profession through the use of standardised check-lists of symptoms for diagnostic criteria.

However, analysis of the studies involved in developing the first diagnostic manual that took this approach of 'operationalising' diagnosis through the check list of symptoms approach (DSM-III) found no diagnostic categories for which reliability in these studies was uniformly high. The ranges of reliability for major diagnostic categories were found to be very broad, and in some cases ranged the entire spectrum from chance to perfect agreement, with the case summary studies (in which clinicians are given detailed written case histories and asked to make diagnoses – an approach that most closely approximates what happens in clinical practice) producing the lowest reliability levels.[25] No studies of the reliability of DSM as a whole when used in natural clinical settings have shown uniformly high reliability, with many finding reliability ratings that are not that different from those in the pre-DSM-III studies.[25,26,27] To overcome this, developers of subsequent DSMs have simply de-emphasised the reliability problem, claiming this to have already been solved by the approach developed in preparing DSM-III.

Treatment and Outcome

The technological paradigm that dominates is predicated on the assumption that the technical aspects of medical and psychological care are of primary importance, and that making diagnoses allows rational choice of the correct technical intervention.

However, there is little to suggest that a positive outcome is strongly related to selecting the 'correct' psychotherapeutic technique, and much to suggest that the 'common factors', such as developing a strong therapeutic alliance, are more important.[28,29,30] For example, several studies have shown that most of the specific features of Cognitive Behaviour Therapy (CBT) can be dispensed with, without adversely affecting outcomes.[31,32] The same holds for other forms of psychotherapy for depression. For example, The National Institute of Mental Health's Treatment of Depression Collaborative Research Project (TDCRP), the largest trial to date comparing different treatments for depression (CBT, Inter-Personal Therapy [IPT], anti-depressants, and placebo) found that patients in each group had significant improvements, with no overall difference in outcome between each treatment group. The best predictor of outcome across all four groups was the quality of the relationship between patient and therapist (as perceived by the patient) early in treatment.[33,34,35,36]

Meta-analyses have drawn similar conclusions. The quality of the therapeutic alliance accounts for most of

the within-therapy variance in treatment outcome, and is up to seven times more influential in promoting change than is treatment model.[28,37] Such data, when combined with the observed superior value, across numerous studies, of clients' assessment of the relationship in predicting the outcome, makes a strong empirical case that the non-specific aspects of psychotherapy, or 'know-how' in building a strong therapeutic alliance, are more important than specific techniques being used. This is also evident in 'real life' clinical encounters, not just research projects. For example, in a review of over 5,000 cases treated in a variety of National Health Service settings in the UK, only a very small proportion of the variance in outcome could be attributed to psychotherapeutic technique, as opposed to non-specific effects such as the therapeutic relationship.[38]

The same importance of non-specific factors can be found operating when using psychoactive drug treatments. Thus, a number of psychiatrists have argued that instead of correcting imbalances, the evidence supports the view that pharmacological agents may be conceptualised as inducing particular psychological states which, though not specifically related to diagnosis, are nonetheless the basis for their usefulness.[39] This reflects clinical practice where the few categories of psychoactive medications used in psychiatry (the SSRIs, major tranquilisers, benzodiazepines, Lithium and anti-epileptics) are often used in a non-diagnosis specific way. For example, SSRIs are claimed to be efficacious in conditions as disparate as borderline personality disorder, depression, obsessive compulsive disorder, anorexia nervosa, bulimia, panic disorder, social phobias and so forth. As a psychoactive substance, SSRIs would appear to do 'something' to the mental state, but that something is not diagnosis specific. Like alcohol, which will produce inebriation in a person with schizophrenia, obsessive compulsive disorder, depression or someone with no psychiatric diagnosis, SSRIs will also impact individuals in ways that are not specific to diagnosis. Similarly, major tranquilisers (misnamed 'anti-psychotics') have also been advocated for the treatment of depression, anxiety disorders, bipolar affective disorder, personality disorders and ADHD, as well as schizophrenia – a list that contains considerable overlap with that found for SSRIs.

Many psychiatric drug treatments, like psychological treatments, rely more on non-specific factors than disease-specific therapeutic effects. For example, it is generally assumed that drugs marketed as 'antidepressants' work through their pharmacological effects on specific neurotransmitters in the Central Nervous System, reversing particular states of 'chemical imbalance'. However, the evidence points to placebo effects being more important than any neuro-pharmacological ones. Thus, several meta-analyses have concluded that most of the benefits from 'antidepressants' can be explained by the placebo effect, with only a small amount of the variance (about 20 per cent) attributable to the drug, a small amount moreover that is unlikely to be clinically significant for the vast majority of patients.[40,41] Studies investigating the degree to which non-technical factors such as the therapeutic relationship affect outcome have found that even with psychoactive drug treatments, these factors are more influential than the drug alone. Thus, having a good relationship with the prescribing doctor is a stronger predictor of a positive response to an 'anti-depressant' than just taking the drug regardless of who prescribes it.[28,42]

The lack of treatment specificity is not limited to the more common and less severe presentations. Thus, although drugs marketed as 'antipsychotic' are often claimed to reverse a biochemical imbalance in psychotic patients, no such imbalance has been demonstrated. Furthermore, researchers have long been aware of a perplexing finding in cross-cultural studies. Research, including that carried out by the World Health Organisation over the course of 30 years and starting in the early 1970s, shows that patients outside the United States and Europe have significantly lower relapse rates, and are significantly more likely to have made a 'full' recovery and show lower degrees of impairment when followed up over several years, despite most having limited or no access to 'anti-psychotic' medication. It seems that the regions of the world with the most resources to devote to mental illness – the best technology, medicines and the best-financed academic and private-research institutions – had the most troubled and socially marginalised patients.[43]

Prognosis

Unlike the rest of medicine, no overall improvement in prognosis has been demonstrated in Europe and North America over the past century for those diagnosed with a mental disorder. Some studies indicate the opposite, that compared to the pre-psychopharmacology period, there are more patients who have developed chronic conditions such as chronic schizophrenia than in the past. For example, in 1955, there were around 350,000 adults in the US state and county mental hospitals with a

psychiatric diagnosis. During the next three decades (the era of the first generation psychiatric drugs), the number categorised as disabled from mental illness rose to 1.25 million. By 2007 the number of people categorised as disabled mentally ill grew to more than 4 million adults. Similarly, the numbers of youth in America categorised as having a disability because of a mental condition leapt from around 16,000 in 1987 to 560,000 in 2007.[44]

As mentioned, long-term outcomes for serious mental disorders are worse in more industrialised countries.[41] For example, the World Health Organisation's international outcome in schizophrenia studies found that after two years, about two thirds of the patients in less developed countries were doing well compared to only a third of the patients in the developed countries. The researchers concluded that 'being in a developed country was a strong predictor of not attaining a complete remission'.[45]

One problem with medical-model diagnostic approaches is that many of the diagnoses (such as schizophrenia, bipolar disorder, dysthymia, ADHD, autism, OCD etc.) are conceived as conditions that are genetic and lifelong in nature, where the best one can hope for is gaining some control over symptoms (through, for example, use of medications). As such, psychiatric diagnoses can foreclose meaning by transforming a range of experiences, and possible meanings that can be applied to these experiences, into a narrow disease framework, limiting the cultural imagination to expecting largely negative outcomes.

Prognosis for those with mental disorders is also further hampered by the stigma associated with the medical model.[46] Nearly all studies that have looked at the question of public attitudes towards mental illness have found an increase in biological causal beliefs across Western countries in recent years.[47] However, biological attributions for mental illness are associated with negative public attitudes, such as a belief that patients are unpredictable and dangerous with associated fear of them, and greater likelihood of wanting to avoid interacting with them.[48]

Similar findings emerge in personal stories of those diagnosed with a 'mental illness'. Through social action, the survivor movement has created safe spaces in which individuals can start the process of telling their own stories. Many of these stories describe how some users of mental health services felt stigmatised and marginalised by a psychiatric diagnosis.[46,49] Being labelled with a chronic 'genetic' condition such as 'schizophrenia' interferes with a person's identity and biography. Indeed, the presence of 'insight' (as defined by doctors) in schizophrenia has been found to be associated with lower self-esteem, despair and hopelessness.[50] Paradoxically, it has been found that the presence of this type of 'insight' (meaning accepting you are mentally ill and need medical treatment) is negatively correlated with emotional well-being, economic satisfaction and vocational status.[51,52,53] Thus, accepting the medical-model attitude to diagnosis can bring expectations of a gloomy outlook with lifelong dependency on psychiatric treatment and little chance of a good recovery. For some, therefore, rejecting the diagnosis may be understood as a positive way of coping with the implications of the diagnosis for personal identity.[52,53]

Colonialism

For the last few decades, Western mental-health institutions have been pushing the idea of 'mental-health literacy' on the rest of the world. Cultures are viewed as becoming more 'literate' about mental illness, the more they adopt Western biomedical conceptions of diagnoses like depression and schizophrenia. In the process of doing this we not only imply that those cultures that are slow to take up these ideas are in some way 'backward', but we also export disease categories and ways of thinking about mental distress that were previously uncommon in many parts of the world. Thus, conditions like depression, post-traumatic stress disorder and anorexia appear to be spreading across cultures, replacing indigenous ways of viewing and experiencing mental distress.[54,55] In addition to exporting these beliefs and values, Western drug companies see in such practice the potential to open up new and lucrative markets.[54,56]

A new global campaign for greater 'recognition' of mental illnesses in the non-industrialised world has developed, which assumes that ICD/DSM descriptions are universally applicable categories.[57] Like other marketing campaigns, this strategy has the potential to open up huge new markets for psychiatric drugs that may be ineffective and can have serious side effects, at the same time as painting indigenous concepts of, and strategies to deal with, mental health problems, as being based on ignorance, despite their obvious success for these populations.

The idea of the individual as the locus of the self is a relatively recent Western invention, and such a framework creates the psychological pre-conditions necessary for accepting the 'atomised' social worlds that have been created. Yet mental well-being seems closely connected

to social and economic factors. Several international studies have concluded that the greater the inequality (in economic and social resources) in any society, the poorer is the mental health of that society[58,59,60,61,62]

A more subtle source of impact on cultural beliefs is due to psychiatric diagnoses inadvertently setting standards for 'normality', by categorising what emotional and behavioural traits and experiences should be considered 'disordered'. As the criteria for diagnoses are arrived at by subjective judgements rather than objective evidence (being literally voted in or out of existence by committees), they will have an automatic bias toward the cultural standards found in economically dominant societies (who also tend to control what counts as 'knowledge' globally). This sets in motion a diagnostic system vulnerable to institutional racism in the dominant societies and colonialism in others, as other standards of normality will, at least to some extent, come to be viewed as 'primitive', 'superstitious' etc., and their populations will be viewed as needing to be (psycho)educated. As a result, then, for the majority of the world, all manner of complex somatic/emotional complaints have to be re-categorised, spiritual explanations have to be denounced, parenting practices viewed as oppressive, and so on.

Thus, imposing Western medical-model DSM/ICD-style psychiatry on non-Western populations risks a number of things, including: adoption of Western psychiatric notions of 'psychopathology' to express mental distress, the undermining of existing cultural strategies for dealing with distress, more not less stigma, and the imposition of an individualistic approach that may marginalise family and community resources and divert attention from social injustice.

Cultural and Public Policy Impact

Diagnostic thinking has had a significant impact on service provision and public and professional beliefs about mental distress. As a result of popularising the diagnostic systems, it is widely argued that a significant proportion of the population suffers from mental illness, that this amounts to a significant economic burden, and that there is a strong case for investing in improved mechanisms of detection and treatment for these disorders. Across several surveys in the industrialised nations, only about a third of those identified as suffering a mental-health problem (according to DSM/ICD criteria) sought, or were interested in seeking, professional help.[63,64,65,66] This has been interpreted as unsatisfactory case detection, provision and treatment, due to public and professional ignorance. However, there is little evidence to support the idea that popularising mental health diagnoses, convincing professionals and the public about the high prevalence of mental disorders, and convincing policy makers of the need to diagnose and treat more people, benefits the mental health of the society.

In order to increase rates of diagnosis and treatment, a variety of campaigns have been undertaken. For example, in the UK the Royal College of Psychiatrists and Royal College of General Practitioners launched their 'Defeat Depression' campaign in the early 1990s.[67] It was intended to raise public awareness of depression, reduce stigma, train general practitioners in recognition and treatment, and make specialist advice and support more readily available. Unfortunately, evaluations of treatment and education guidelines in the UK following the 'Defeat Depression' campaign failed to detect significant improvements in clinical outcome.[68,69,70] However, other effects of the campaign included a rapid increase in antidepressant prescribing and increased medicalisation of unhappiness and distress.

Unlike other areas of public health, mental health in those societies with the most developed services appears to be the poorest. In such societies, 'epidemics' of psychiatric diagnoses (e.g. ADHD, autism, depression, bipolar disorder) have only emerged and become popularised in recent years. Whilst there are complex political, social and cultural reasons for this, they are in part based on new categories and ideas about personhood, the nature of distress etc. and so are at least in part the result of creating, broadening and popularising psychiatric diagnoses.

Conclusion

For a diagnostic system to establish itself as scientifically useful, it should be able to reflect categories that 'carve nature at its joints'. For a diagnostic system to establish itself as clinically useful it should show that use of diagnostic labels aids treatment decisions in a way that impacts on outcome. As reviewed above there is little evidence to support either. There is much evidence to suggest that instead, they can cause significant harm. The only evidence-based conclusion therefore is that formal psychiatric diagnostic systems like ICD and DSM should be abolished.

Relying on DSM/ICD diagnostic categories to organise research, services and treatment does not contribute to improved outcomes for those experiencing mental distress and is associated with possible harms.

We can and should do better. We have all the evidence we need to work on re-organising our approaches locally, nationally and internationally to develop services that use evidence-based paradigms and can reduce the amount of harm DSM/ICD has caused at the same time as improving outcomes. Paradigms that draw on the existing evidence for what improves outcomes and that incorporates the views of those who matter most – service users – can easily be developed and implemented. The message from this research is that services can improve outcomes by concentrating on developing meaningful relationships with service users that fully include them in decision-making processes. International service user-led movements, such as the 'recovery' movement, that focus on the inclusion of people in recovery from mental-health problems as collaborators in research, service development and treatment model development provide good examples of how this evidence can be developed to change institutional culture.[71,72,73] Services in non-Western settings should be able to incorporate local beliefs and practices, and the wholesale export of Western ethno-psychiatry can be stopped.

The real gift of psychiatry to medicine is an understanding of the person in their context leading to an integrated whole-person model of healthcare. Psychiatry has to sit at the confluence of a variety of disciplinary discourses (sociology, anthropology, psychology, philosophy, biology, politics etc.), and it is this broader understanding of the person and their well-being that psychiatry brings. By lazily importing the diagnostic model from general medicine, we end up miss-selling and under-utilising the unique skills the profession of psychiatry brings to healthcare by the 'dumbing down' of what we do into simplistic, diagnosis-driven protocols that have more to do with successful consumer culture marketing than with science. Changing to more evidence-compatible paradigms is now long overdue. S

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