A farewell to psychiatric diagnoses

PERSPECTIVES

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Psychiatric diagnostic categories are neither valid nor stable. They tell us little about the causes of the problems, the prognosis or what treatment might be beneficial. A psychiatric diagnosis must not therefore be a prerequisite for providing proper health care.

Illustration: Marianne Gretteberg Engedal

Health authorities and supervisory authorities stipulate a requirement for thorough psychiatric diagnostic assessments in patient pathways (1), in clinical guidelines (2) and in regulatory investigations. In 2017, Hedmark's county governor argued that 'making a diagnosis is essential for being able to provide proper health care', even in low-threshold services in primary care (3). The Norwegian Appeal Board for Health Personnel writes that in order 'to prevent misdiagnosis and incorrect treatment, healthcare personnel are expected to make systematic differential diagnostic assessments' (4).

Diagnoses need to follow the international classification system ICD-10 (5), which is based on the third and subsequent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (6). Research findings suggest that these diagnoses are neither valid nor of much practical use.

Those responsible for regulating the medical field should take into account that there is little clinical evidence to suggest that correct diagnosis is a prerequisite for proper health care.

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Leading experts have become disillusioned with ICD and DSM. Thomas Insel, who was director of the National Institute of Mental Health (NIMH) in the United States from 2002 to 2015, believes that the poor results in mental health care require a new approach to diagnostics (7).

Invalid diagnoses

The criticism levelled at the ICD and DSM is from experts who defend the way of thinking that underlies these systems. When Kendell demonstrated the unreliability of such systems (8) this paved the way for criteria-based diagnostics, which had its breakthrough in 1980 with DSM-III. Kendell believes that the DSM has made diagnoses more reliable, but not valid. In his view, diagnostic categories are only valid if they are clearly distinct entities with natural boundaries to other disorders. However, this is not the case for most of the disorders (9). Allen Frances, who led the work on DSM-IV, has also been unable to find any mental disorders that are delimited entities with a common cause (10).

Even in the case of schizophrenia, it is unclear whether the term corresponds to something objective. Sir Robin Murray is perhaps the most prominent researcher of his generation in the field of schizophrenia in Europe. He posits that the term 'schizophrenia' is about to break down because it is not a discrete entity and that it will probably be confined to history in the same way as 'dropsy' (11).

The Superior Health Council, a body under the Federal Public Service Health, Food Chain Safety and Environment in Belgium, issued a report on DSM-5, diagnostics and classification. The Council claims that the classifications are based on the assumption that 'mental disorders occur naturally, and that their

designations reflect objective distinctions between different problems, which is not the case'. The report asserts that the classifications do not provide 'a picture of symptoms, management needs and prognosis because they lack validity, reliability and predictive power' (12).

Diagnostic instability

The symptoms that form the basis of the diagnosis can change unpredictably. The diagnostic categories are not stable, so they are not much help in predicting the prognosis.

A register study followed everyone born in the period 1900–2015 who was alive and living in Denmark in the period 2000–16 (13). Almost six million people were followed up for almost 84 million person-years. The study found that treatment in the specialist health service for a mental disorder increased the risk of all other mental disorders during the follow-up period. The authors write that their findings support 'the pluripotent nature of mental disorders', especially in the early stage of the disease (13).

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Ninety-one per cent of children born between April 1972 and March 1973 in Dunedin, New Zealand were followed in another study. The participants were examined in structured diagnostic interviews nine times before the age of 45. Ninety-four per cent of those who were still alive participated. Experts made their diagnoses based on interviews, medical records, comparative information and medication usage. By the time they were 45, 86 % of the participants had met the diagnostic criteria for a mental disorder, and 85 % of these had had more than one mental disorder. The symptoms fluctuated, and patients alternated between all types of mental disorders. This does not fit with the assumption that the various mental disorders have specific causes. The authors caution against relying too heavily on diagnosis-specific research and treatment, and recommend a transdiagnostic perspective (14).

Transdiagnostic approaches

The diagnostic paradigm is challenged by the fact that the processes that lead to mental health problems are transdiagnostic. Comorbidity is the rule and not the exception, an artefact that is due to categorical diagnostics. The categories are heterogeneous, with numerous ways of meeting the criteria, and the distinctions between them are hazy (15). The diagnostic criteria do not capture all of the important symptoms, and the pattern of symptoms varies (13, 14). Interventions are not guided by the diagnosis to any great extent (15).

In order to address this, transdiagnostic approaches either cut across traditional diagnostic boundaries or completely disregard them.

Epidemiological data suggest that mental disorders, which have been explained by higher-order factors (internalising, externalising and thought disorders), are best explained by a general psychopathological dimension: the p factor [16]. High p scores are associated with life impairment, occurrence of familial mental disorders, developmental problems and impaired early-life brain function. The p factor explains why it is so difficult to find causes, consequences, biomarkers and treatments that are specific to individual mental disorders.

The National Institute of Mental Health considers DSM diagnoses a barrier to research. They write that the categories and criteria were formulated before the advent of modern neuroscience and are therefore unlikely to be valid [17]. They add that this has hindered progress, and that we need a new approach to move forward. Research Domain Criteria is the institute's transdiagnostic alternative, which maps six domains instead of diagnostic categories.

Scientific studies of treatments tend to exclude patients with comorbidities. Treatments therefore often take place concurrently or sequentially for what the classification system defines as different disorders. Transdiagnostic therapy, which is not specific for particular diagnostic disorders, can be a simpler alternative.

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The scope of this article does not allow me to present the treatment research in detail. I give instead a few examples that illustrate the difficulty of combining the findings from treatment research with the idea that the treatment must be based on diagnostic categories.

In relation to psychotherapy, the extensive meta-analyses by Wampold and Imel [18] indicate that the efficacy of psychotherapy does not depend on adaptation to the diagnosis. The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders uses the same protocol for depression, anxiety disorders and other disorders – instead of single-disorder protocols. One study found a similar effect, but a lower treatment dropout rate, when using the Unified Protocol than when using specific protocols for panic disorder, obsessive-compulsive disorder, social anxiety disorder and generalised anxiety disorder [19].

Treatment with psychotropic medications is rarely aimed at the diagnosis, but at the patient's signs and symptoms, such as anxiety or hallucinations [20]. The link is weak between the diagnosis and the medication used. Few of those who use antipsychotics have ever been psychotic [21], and antidepressants are used for a great many mental health problems, with or without documentation of efficacy.

Epistemic prison

A diagnosis is categorical, but reality is dimensional. No one is claiming that the causes of mental disorders respect the diagnostic classification system. The treatment is also not as closely linked to the diagnosis as many people think. Research indicates that the classification systems give us diagnoses that are neither stable, valid nor helpful in choosing treatment. It is difficult to see why such diagnoses have to be a prerequisite for providing proper health care.

«A diagnosis is categorical, but reality is dimensional»

Steven Hyman, director of the National Institute of Mental Health from 1996–2001, describes diagnostic classification systems as an 'epistemic prison' (22). The DSM versions were intended as practical aids for research and clinical practice, but are used as if the diagnoses are names of diseases. The diagnostic categories define research questions, and a DSM/ICD diagnosis is a prerequisite for approval, funding and publication of research and the starting point for approval of medications.

The classification systems represent a framework that governs the education of healthcare personnel, the design of teaching materials and how people think about mental disorders and assess and treat patients (15). They act as a guide for supervisory and regulatory bodies and even affect the outcomes of cases processed by the Norwegian Labour and Welfare Administration (NAV) and the Norwegian Health Economics Administration (Helfo). The system has become self-sustaining, not least because alternatives have been branded indefensible.

Gjerden points out that criteria-based diagnostics have not provided any clues about underlying causes or targeted treatments, and says that until now 'no one has been able to describe in more detail which phenomena and processes could possibly lie behind these constellations of symptoms. Nevertheless, textbooks, clinical guidelines and health bureaucrats maintain that classifying mental illness exclusively according to symptoms is a useful aid – almost a prerequisite – for effective treatment' (23).

Liberation from diagnostics according to the ICD and DSM can open up other ways of classifying mental health problems. It can occasion novel thinking about the types of processes that might lead to good and poor mental health, what triggers and sustains the problem, and what kind of treatments and recovery processes can help those struggling with their mental health (15).

The supervisory authorities believe that there is no justification for not using ICD-10 to make psychiatric diagnoses. However, research shows that the classification system is invalid. By asserting that a psychiatric diagnosis is the prerequisite for proper health care, the supervisory authorities are demanding that health care is anchored in invalid and unstable diagnoses of little practical use. Diagnosing mental disorders that probably do not exist can hardly be a prerequisite for providing effective treatment.

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