Psychiatric classification, stigma, and mental health

Work on DSM-5 and ICD-11, and the simultaneous development of alternative approaches to psychiatric classification such as the Research Domain Criteria of the National Institute of Mental Health[1], has led to renewed interest of colleagues, patients, decision-makers, and the lay media in psychiatric diagnosis. Psychiatrists find themselves reading rationales for these classification systems by those who have worked on them, as well as strong criticisms by those who have perceived key weaknesses. How should we respond?

How best to formulate psychiatric diagnoses, and how best to respond to public debate about our field are complex conceptual issues that overlap with major questions in the philosophy of medicine and psychiatry, and perhaps even indeed with some of the biggest questions that we can ask about life. In this brief editorial I will outline some of these ''big questions'', and suggest a middle path through what I see as some of the conceptual thickets surrounding them.

The aim of this editorial is to argue that the publication of DSM-5 and ICD-11 provides us a crucially important opportunity to decrease the stigma associated with psychiatric diagnosis and treatment, and to increase the mental health literacy of colleagues, patients, decision-makers and the general public. This requires us to acknowledge both the enormous progress that has been made in psychiatry, as well as the tremendous gaps in knowledge that remain.

Is psychiatry a science ?

For some (who take a ''classical'' approach), psychiatric disorders are like squares; they can be defined by necessary and sufficient criteria, and psychiatric science is a matter of figuring out, from the data of the world, what these universally applicable criteria are.[2,3] With enough data we will, for example, clearly be able to delineate depression from normality, likely using biomarkers. For others (who take a ''critical'' approach), psychiatric disorders are like weeds; their definition differs from time to time and place to place, due to variation in human societies and values.[2,3] Depression may well be a rational response to an irrational world, and the idea of biomarkers correlating with such a response is deeply flawed.

I have elsewhere argued in more detail for an integrative approach, which emphasizes that psychiatric science (like other sciences) is a social activity, that psychiatric diagnoses are complex constructs that rely on a rigorous weighing of both facts and values, but that over time we can develop better understanding of the mechanisms underlying mental disorders and achieve progress in nosology.[2,3] While we cannot carve a joint of ''depression'' out of nature, we have learned much about depressive symptoms, and there is diagnostic validity and clinical utility to classifying some individuals, for example, with a psychotic depression and others with an adjustment disorder and depressed mood.

Much of the critique of DSM hinges on whether the values embodied in psychiatry as a whole and in DSM in particular are defensible. Is a classification developed in the United States for use in a particular kind of medical system, for example, really applicable to the broad swath of people who reside in low-and-middle income countries and have little access to mental health care and other resources? Clearly there is much to be said here, but it is important to note some of the important laudable values embodied by the DSM-5; for example, the efforts to make the revision process evidence-based[4], efforts to ensure cross-cultural applicability[5,6], and efforts to post proposals on the web, for comments from professionals and patients.[7]

Should we medicalize abnormality?

The classical approach is comfortable with the medicalization of psychopathology. Indeed many psychiatric conditions can be viewed as ''typical'' medical disorders; it is clear that the person with a pneumonia or with schizophrenia is not responsible for falling ill, and that he or she deserves health care. The MEDICAL metaphor applies; there is some sort of ''attack'', ''breakdown'', or ''imbalance'', and this is rectified by a health care intervention.[3,8]

The critical approach is highly sceptical of medicalization, as medicine is just one of many approaches that the powerful use to address societal deviance. It is noteworthy that many mental disorders are not at all typical of medical disorders. Consider, for example, alcoholism; it seems that the person with alcoholism bears at least some responsibility for falling ill, and he or she must take a good deal of responsibility for staying sober. A MORAL metaphor seems to apply; where issues such as personal will and commitment are crucial.[3,8]

From an integrative perspective, good psychiatry requires a judicious balance of the MEDICAL and MORAL metaphors, encouraging medicalization at some times, and avoiding unsuitable medicalization at other times.[3,8] Much of the critique of psychiatric classification hinges on the idea that psychiatric diagnosis contributes to the inappropriate medicalization of life. Again, there is too little space here to address this issue in full. However, it is noteworthy that the process for adding new disorders to DSM-5 was a stringent one, and that this was only possible when the scientific data demonstrated diagnostic validity and clinical utility.[9,10,11]

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Stigma and mental health literacy

A classical approach emphasizes the importance of stigma. Schizophrenia, for example, should be considered a brain disease, and people with schizophrenia should be encouraged to seek help early on, in order to begin treatment as soon as possible. A critical approach has, however, often argued that psychiatric diagnosis is itself stigmatizing. There is little evidence, in this view, that schizophrenia has a unique neurobiology, treatments are often harmful, and approaches which emphasize individuals' autonomy should be encouraged.

From an integrative perspective, DSM-5 and ICD-11 provide us a major opportunity to address mental health literacy. Here the focus is on ensuring that colleagues, patients, decision-makers, and the general public have a good understanding of the prevalence of mental disorders, of their associated morbidity, and of the real benefits to both individuals and societies of psychiatric diagnosis and treatment.[12] It is a chance for us to describe the complexity of psychiatric research and services, noting where progress has been made, and emphasizing where further progress is needed. Whereas a biological perspective has emphasized the future incorporation of endophenotypes into classification systems, a public health perspective would be interested in more emphasis on exophenotypes or social risk factors for mental disorder.[13]

An emphasis on increasing mental health literacy is not to deny the importance of ongoing debate about the diagnostic validity or clinical utility of more atypical disorders, the possibility of false positive diagnoses and over-treatment in some countries, or the fact that psychiatry has a limited understanding of the causes of mental disorder and of optimal therapeutic approaches. Nevertheless, there have been ongoing advances in our understanding of diagnostic validity and clinical utility of a range of conditions across the globe, and there is strong evidence of under-diagnosis and under-treatment of mental disorders particularly in low and middle income countries such as South Africa, despite the availability of efficacious and cost-effective interventions.[14]

Conclusion

We should be wary of expecting too much from DSM and other classification systems[15], or of using them with too much deference.[16] At the same time, as we discuss advances and limitations in psychiatric classification, we should be wary of throwing out the baby with the bathwater. DSM-5 and ICD-11 will provide psychiatrists with an important opportunity to educate colleagues, patients, decision-makers, and the public about psychiatric disorders, about the advances that the field has made, and about the additional work that remains to be done in order to address fully the burden of mental disorder. We must continue to advocate for parity for mental health services, research, and training, particularly in low and middle income countries, where gaps in these areas are disproportionately large.[17]

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