

Is diagnosis dead? Discuss.

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Summary:

The health of psychiatric diagnosis has come under attack in recent years. This essay considers two threats to the practice: the charges of invalidity and lack of utility. The first threat is championed by Thomas Szasz, who has famously argued that mental illness do not exist, but were invented by physicians and state officials, driven by non-scientific motivations. If we discard our categories of mental illness, then we also lose contemporary diagnosis. The second threat is advanced by Gerdner Hesslow, who argues that the concept of disease is not practically useful and should be abandoned. Without disease, diagnosis *qua* disease attribution will surely have to be abandoned. I argue that the solution to both these threats is identical. Both Szasz and Hesslow are motivated by the imperfections in binary distinctions: Szasz by the bodily/mental illness distinction, and Hesslow by the health/disease distinction. Their responses are to discard the concepts that make up these distinctions (mental illness and disease). I do not deny that these distinctions are plagued by problems, but I believe there is a more attractive alternative. These imperfect binaries suggest that we should instead change the way we think, talk, write and perceive of mental illness. Rather than reject the biomedical paradigm completely, we should look to *extend* medical discourse to include discussions of meaning and values. A patient's values form a crucial part of their experience of illness, and so should not be overlooked. Diagnosis is not dead, but in need of an upgrade.

Introduction

Diagnosis involves the attribution of illness to an individual, and has enjoyed a relatively healthy existence since the time of Hippocrates. At present, diagnosis seems to be rocketing exponentially; Whitaker (2011) points out the three-fold increase in the diagnosis of disabling mental disorders in the US. At face value, then, diagnosis might seem to be alive and well. There are, however, two ‘illnesses’ that currently plague diagnosis: *invalidity* and *lack of utility*. In this essay I consider the nature of these afflictions and look to uncover whether there is substance behind these threats: is diagnosis really diseased, and will diagnosis ultimately die out? I focus my investigation on *psychiatric* diagnosis, for this is the part of diagnosis that has come under greatest attack.

The prognosis I will deliver for diagnosis is a positive one. In §1, I examine the work of Szasz (2010), who argues that the diagnosis of mental illness is invalid. I argue that psychiatric diagnosis can remain valid *relative to scientific discourse*. In §2, I consider the attack of Hesslow (1993), who argues that we should discard the concept of disease because it is not useful. I argue that his argument fails to establish a lack of utility - diagnosis *qua* disease attribution *is* a useful procedure. I contend that in both cases the correct response is not to reject our current concepts, but rather to encourage the development of a new psychiatric discourse that is sensitive to issues of meaning.

1. Szasz and the Validity of Psychiatric Diagnosis

In this section I first explicate the Szaszian argument against the existence of mental illness (and hence the diagnosis of such illnesses). I then show that Szasz’s stance is unattractive because it requires drawing false binary distinctions, in particular the distinction between bodily and mental illness. I then argue that Foucault’s work can

provide the foundation for a more attractive option; we should look to develop a new discourse for psychiatric treatment, in line with the critical psychiatry of the Critical Psychiatry Network.

1.1 The Szaszian Argument

Szasz's (2010, p.270-283) critique of psychiatry can be seen as composed of two separate parts: a conceptual critique and a moral-political critique. The latter part argues that coercive psychiatric treatment of individuals who are deemed insane denies individual's moral agency. I will however focus on Szasz's conceptual critique, because I would argue that it is the more convincing and provides the greater challenge to current psychiatric practice. I summarise his conceptual argument as follows:

- P1. Mental illnesses are either brain diseases or do not exist.
- P2. Mental illnesses are not brain diseases.
- C. Mental illnesses do not exist.

Let us examine why this disjunctive syllogism is *prima facie* convincing. Let us first define what Szasz understands by the terms used in the above argument. Mental illnesses are those illnesses treated by psychiatrists - they are disorders of thought, mood and emotion. Szasz endorses Virchow's model of disease: they are 'demonstrable anatomical or physiological lesions that may occur naturally or be caused by human agents' (p.276). Brain diseases, then, are lesions of the brain.

Let us consider P1. Szasz contends that illnesses only exist if they have a corresponding disease, and that one can only have a disease of physical things. It is therefore not

possible to have a disease of mood, thought or emotion, as these terms are conventionally understood. Szasz then asks us what we *actually* mean by mental illness. At this point it seems we have the two options presented in P1: we may concede that when we speak of illnesses of the mind what we actually mean is illnesses of the *brain*, or we may maintain that mental illnesses are illnesses of the *mind*. Since, for Szasz, illnesses only exist if they have a corresponding physical disease, mental illness *qua* thought and mood disorders cannot exist.

What about P2? Many would reject this premise, claiming that mental illnesses are brain diseases. Torrey (1975), for example, predicted that psychiatric practice would eventually fuse with neurology as more and more mental illnesses are revealed to have specific underlying brain pathologies. Szasz, however, contends that for even the most paradigmatic mental illnesses, such as depression and schizophrenia, our understanding of their pathological basis is still lacking, forty years after Torrey's prediction. Szasz claims (pp.276-281) that this is not simply slow progress, but because mental illnesses are invented. They were created, in the same way as laws are created, motivated by legal, political and personal reasons rather than scientific ones. They are not diagnosed by identification of brain pathology, but instead by examining the patient's behaviour. However, 'the criteria for what behaviours count as abnormal are cultural, ethical, religious, and legal, not medical or scientific. Hence it is a priori absurd to explain all abnormal behaviours by attributing them to brain disease' (p.296).

Szasz therefore provides a convincing argument for the non-existence, and therefore invalidity, of mental illnesses and their diagnosis. I will now explain why I think that the above argument still fails to establish the invalidity of mental illness.

1.2 *The Myth of the Mind-Body Distinction*

Let us reconsider the disjunctive syllogism in §1.1. The very structure of this argument makes one thing clear: we seem to only have two choices. Mental illness must either affect the body, or the mind. If we choose the body, then we speak not of mental illness but brain disease; if we choose the mind then we must face the uncomfortable truth that our diagnosis seems to be entirely based upon behaviour, the abnormality of which is relative to the ethical, cultural, and religious, but not scientific, norms. The question I wish to pose is this: can such a distinction between mind and body really be drawn?

Szasz certainly thinks that such a distinction can be made. He writes that ‘bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television program’ (2007, p.6). In the same way that two different discourses are required to describe the quality of a television set and quality of the programme it transmits, and one cannot improve the quality of the programme by rewiring the television, he contends that treating the body cannot cure psychological problems. These ‘problems in living’ do not require medical intervention but rather a nonmedical voluntary ‘autonomous psychotherapy’ (2003, p.203).

However I find this analogy and its attempt to create a binary distinction between mind and body unconvincing. As Bracken and Thomas note, ‘[h]uman reality is an embodied, ‘en-cultured’ reality’ (2010, p.222). Individuals do not experience pain as either bodily or mental - they experience pain in a single, integrated modality. The pain of an illness may be partially accounted for by pathological change, but this is not

enough to account for the entirety of pain experienced by a patient – the culture in which an individual exists also contributes to the way they experience pain. The analogy with the television set breaks down because a television set and programme are independent of one another in a way that mind and body are not. Whilst the programme exists independent of the set, one cannot have mind without body, or vice versa. Mind and body are dependent on one another, interacting to produce a unified experience. We should therefore be sceptical of attempts to attribute pain to either the mind or body. I therefore reject P1 of Szasz's argument because it relies upon a false binary distinction between illness of mind and body.

1.3 Towards a Foucaultian Approach to Psychiatry

Foucault attempts to reveal how the ideas and social structures that we now often take as necessary parts of human existence are in fact contingent. Foucault shows that it is ultimately the discourses (the way that they think, talk, write and perceive of a particular aspect of life) that a particular society accepts that determines what is accepted as true and false: 'Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true' (1980, p.131).

I follow Bracken and Thomas (2010) in suggesting that an awareness that the 'truth' of psychiatric diagnoses is relative to the discourse from which diagnoses originate allows us to see how we can develop a novel discourse that better serves patients. Such an approach allows us to share Szasz's belief that current psychiatric diagnoses are inappropriately amalgamated into the remit of contemporary medical discourse. Szasz is right to worry. The diagnoses of disorders in accordance with DSM-III are unreliable

(Williams et al. 1992). A patient's insight into their mental illness has been negatively correlated with emotional well-being (Hasson-Ohayon et al. 2006). There is growing evidence that therapeutic alliance may play a more significant role than specific interventions in recovery (Frank and Gunderson 1990).

However, Szasz's response is to reject the use of medical discourse for 'problems of living' completely, and suggest that mental illnesses are treated by nonmedical psychotherapists. But this is not the only choice. Foucault shows us that medical discourse is amenable to change. Therefore Bracken and Thomas (2010) suggest that we look to practice critical psychiatry, which seeks to develop a new 'medical discourse about mental suffering that is sensitive to the issue of meaning' (p.226). The development of such a discourse is one the central aims of the Critical Psychiatry Network.¹

Practicing critical psychiatry means (i) advocating the medical treatment of mental illness, *contra* Szasz, and (ii) looking to develop a more beneficial medical discourse in which to frame such illnesses. (i) Szasz claims that delusions and hallucinations are not symptoms of actual illness but rather 'created by patients and could be stopped by them' (2004, p.324). But almost any medical professional that has treated patients experiencing these symptoms would deny that they could be stopped through willpower alone. Critical psychiatry is therefore appealing as it maintains that medical treatment is required for mental illness. (ii) Critical psychiatry means awareness of the *ability to change* the way we view mental illness. Endorsing an entirely objective treatment of patients based upon pathological signs and symptoms alone is to ignore the en-cultured

¹ <http://www.criticalpsychiatry.co.uk/>

nature of human existence, and the contribution that an individual's values make to their experience of illness. Practitioners of critical psychiatry therefore look to develop a way of viewing mental illness that is sensitive to values and meaning.

Is diagnosis *valid* from the perspective of the critical psychiatrist? We must first establish what we mean by valid. By validity I mean roughly what Cronbach and Meehl (1955) called 'construct validity' - whether the constructs (in this case disease categories) purported by a theory appear to correspond to reality in some way. From the Foucaultian perspective, the validity of a disease category is the categories' correspondence to reality *as embedded in a particular discourse*. Since discourses are 'regimes of truth', the truthfulness of a category is relative to a particular discourse. Psychiatric diagnosis within a medical discourse is therefore valid provided the labels we give patients are true according to the evidence provided by medical research. For example, the validity of schizophrenia can be strengthened by revising our diagnostic categories in accordance with current research on the aetiology of schizophrenia, such as genetic variants that predispose individuals towards a particular end of the schizophrenia-bipolar disorder spectrum (Owen, Craddock, and Jablensky 2007), or the endophenotypes associated with schizophrenia (Allen et al. 2009). *We can therefore increase the validity of our diagnostic categories within medical discourse by listening to the increasing genetic and endophenotypic evidence.*

2. The Utility of Psychiatric Diagnosis

In this section I first summarise the view of Hesslow (1993), who argues that the concept of disease is clinically and theoretically irrelevant. It is clear that if we give up the concept of disease then we will have to give up the current diagnostic process, and so Hesslow's argument threatens the health of diagnosis. The crux of my response is that Hesslow's argument fails to establish the 'irrelevant' nature of our current concept of disease. His counter-examples merely locate the parts of current clinical practice that do not rely *exclusively* upon the concept of disease. His argument therefore relies upon the assumption that clinical decisions are made on the basis of single *disease-like* concept. His argument fails to address the possibility of extending current medical discourse; rather than 'replacing 'health' and 'disease' with other concepts, better suited to their purpose' (p.13), I suggest we keep our concept of disease, whilst extending our current discourse to include concepts that reference meaning and values.

2.1 Hesslow's Argument

Hesslow establishes that the utility of a concept can be either theoretical, practical, or both. In the case of disease, he argues that it is neither theoretically nor practically useful. I focus my critique upon his analysis of the concept's *practical* utility. He first contends that there are four commonly identified practical uses of the disease concept: grounds for medical treatment, medical insurance, disease as a grounds for special rights, and mental illness as grounds for irresponsibility. In each case, he argues that disease is actually not a useful concept; the decisions made by practioners of medicine and law are not based upon the health/disease distinction but other considerations. The examination of one of these practical uses is sufficient for the argument advanced here,

since Hesslow's approach in all four cases is structurally identical. Let us turn to his examination of disease as grounds for medical treatment.

Hesslow establishes that disease is neither necessary nor sufficient for medical treatment. It is not sufficient because benign tumours such as birthmarks are diseases but do not always legitimize treatment. It is not necessary because there are healthy conditions that we do treat, such as cosmetic surgery and sex change operations. He argues that the decision to treat or not treat in these counterexamples are because our decisions are not based upon the concept of disease but rather 'the fact that some medical intervention may be beneficial and that it is within the physician's power to help the patient' (p.7). If this is the case, he argues, we should give up the concept of disease and replace it with new concepts that reflect the *actual* basis for our clinical decisions.

2.2 A Foucaultian Response

From the explication above, two things about Hesslow's argument should be clear: (i) the examples Hesslow considers are peripheral and not prototypical of clinical decision-making and (ii) he is seeking concepts that are either necessary or sufficient grounds for medical treatment. I will now explain why both these aspects of Hesslow's argument are problematic.

- (i) The fact that there exist some instances in which the health/disease distinction *alone* is not enough to guide clinical decision-making does not tell us anything about the basis for more central, typical clinical decisions. For example, the treatment plan that a

doctor assigns a patient admitted with a myocardial infarction may be driven exclusively by the health/disease distinction.

- (ii) *There is no reason to think that a single concept must provide either a necessary or a sufficient condition for many instances of clinical decision-making.* Let us consider an example that Hesslow himself uses (p.8). In the case of extensive cancer treatment, doctors often decide that the potential benefits of treatment are outweighed by the suffering that undergoing treatment may cause. Hesslow sees this example as adding weight against the utility of the disease concept; I see this example as evidence of the multifactorial nature of clinical decisions. The fact that treatment benefits are *outweighed* by other factors such as potential suffering, or a patient's 'ultimate goals in life' shows that in examples such as this, necessary or sufficient conditions cannot be found.

What does Hesslow get right? His examples show us that clinical decision-making cannot be reduced to a single binary, health/disease distinction. His example of cancer treatment demonstrates how clinicians must weight up multiple factors: not just disease status, but also the values and goals of the patient ('her ultimate goals in life'). Hesslow's response to the imperfections of the health/disease distinction is to reject the distinction, in a similar fashion to Szasz's rejection of mental illness based upon the imperfections of the bodily/mental illness distinction. *The appropriate response, however, is the same as in the case of Szasz.* Rather than reject the use of the concepts in the binary distinction, we should instead move towards a *more useful discourse.* *The discourse required in both cases is the same.* As Hesslow's cancer example demonstrates, what clinical practice requires is a discourse that includes disease *alongside* other concepts that reference the patient's value and goals. Hesslow's

recommendation of a movement towards a discourse that does not include disease is simply a *non sequitur*. Disease and diagnosis are useful clinically but can be improved by movement towards a more useful discourse.

3. Conclusion

In both §1 and §2, we examined the works of authors who threaten the health of diagnosis. §1 considered Szasz's attack on mental illness and its diagnosis, which hinges upon a false dichotomy between bodily and mental illness. §2 examined Hesslow's attempt to eliminate the concept of disease because it fails to provide a necessary or sufficient condition for treatment. Both authors' arguments share a dogmatic reliance upon binary distinctions. Szasz's mistake is to think that such a distinction can in fact be drawn; Hesslow's error is in thinking a single binary distinction must provide necessary or sufficient grounds for medical treatment. The solution in both cases is identical: valid and useful diagnosis is to be found in establishing a medical discourse that is sensitive to the values and goals of patients. Let us share the vision of the Icarus Project, a support network set up by and for sufferers of mental illness, who dream of 'a language that is so vast and rich that it expresses the infinite diversity of human experiences'.²

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² <http://theicarusproject.net/mission-vision-principles/>

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