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PSYCHOSIS: WHAT IT IS AND WHAT IT IS NOT
Psychiatric diagnosis an an ethical problem

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SUMMARY

The different causes of misdiagnosis in psychiatry are reviewed, and the ethical implications of such misdiagnoses are discussed.

Key words: *psychosis – ethics - misdiagnosis*

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Any discipline that would dare to address, in the aggregate, the politically oppressed, the socially marginal, the sexually deviant, the worried well, the intimately abused, the morally dubious, the unpredictably irrational, and the emotionally labile must be controversial.

Sadler JZ. The values and psychiatric diagnosis. Oxford, 2005

Psychiatric diagnosis should, as in all other diagnoses in medicine enable communication, explain pathology, and enables prognosis, treament, and prevention. However, psychiatric diagnoses are much more value-laden than all other medical diagnoses.

We can gain a general idea of the relevance of values in the areas with which physical medicine and psychiatry are respectively concerned.

- **Physical medicine** is concerned with areas of human experience and behaviour over which our values are more or less *uniform*.
- **Psychiatry** is concerned with areas of human experience and behaviour – emotion, desire, belief, volition, etc.- over which our values are highly *variable*.

What do I mean by *values?* And how will I distinguish values from other assumptions that lurk behind our knowledge and actions vis-a-vis psychiatric diagnosis? The term "values" is often used to shore up all sorts of political agendas, social reform intentions and voter turnout. Values in this sense has to do with a very narrow sense of the concept I wish to use – a narrow sense having to do with particular social practices and beliefs. A more specific, philosophical definition of values is needed for my use.

The Webster's New Unabridged Dictionary describes three (of thirteen overall) definitions that are relevant to my purposes today:

Some definitions:

6. That quality of a thing according to which it is thought of as being more or less desirable, useful, estimable, important, etc.; worth or the degree of worth.

7. that which is desirable or worthy of esteem for its own sake; thing or quality having intrinsic worth.

13. (pl) in sociology, acts, customs, institutions, etc. regarded in a particular, especially favorable, way by people, ethnic group, etc.

These definitions are instructive because they suggest that values have several important functions: 1. that they describe a quality of something (are thus a description), and 2. that they have something to do with what people do; more specifically, they function to influence, guide, or regulate people's choices or actions. 3. moreover, values can be part of an assumed (sub)culture, shaping traditions, appreciation of the beautiful, assessment of the guilty, personal responses to crisis, ascertainment of the truth, and other kinds of social – cultural interaction. Values can vary on a continuum (thought of as more or less...), that is, we can have a lot of a value such as joy or, more usually, too little of it.

The ethical problem of psychiatric diagnosis stems from its capacity for misuse – that is, the knowing misapplication of diagnostc categories to persons to whom they do not apply, a misapplica-

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tion that may place those individuals at risk for the harmful effects of psychiatric diagnosis. These effects include not only the loss of personal freedom, and not only the subjection to noxious psychiatric environments and treatments, but also the possibility of life-long labelling, as well as a variety of legal and social disadvantages ranging from declarations of non-responsibility in family and financial affairs to, under the most extreme circumstances, under Nazi rule, the deprivation of life.

In general, misdiagnoses may be said to originate in two ways. The first way is purposeful: the psychiatrist applies a standard psychiatric diagnosis to a person for whom he or she knows it to be inappropriate in order to achieve some end that is not, by common definition, medical. That end may vary from instance to instance. For example, the psychiatrist may be under direct and obvious pressure from a family to hospitalize a troublesome member of that family, or from political authorities to hospitalize a troublesome dissident. On the other hand, the psychiatrist may also issue a purposeful misdiagnosis at the person's own request. For example, a diagnosis resulting in hospitalization may be a protection against a worse fate, such as jail in the case of a criminal offender, the military draft in the case of a war-resister, or the birth of an unwanted child in the case of a woman seeking an abortion in a place where the procedure is available only to those who can show medical need. In both types of cases of purposeful misdiagnosis, harm may be said to result. In the first type the harm is obviously to the person. In the second, it is to the integrity of the profession. One's concern should certainly be for the first type of harm; but the second, largely overlooked as a sort of victimless crime, also requires attention.

However, it is the other kind – misdiagnoses that result not from the wilful misapplication of psychiatric categories, but from the primarily non-purposeful causes – that deserve the greatest scrutiny. They deserve it because most misdiagnoses belong in this category. And they deserve it because purposeful misdiagnoses are in general clear and usually understood as unethical, while those that are non-purposeful are much more subtle and insidious, much more a part of the fabric of the field itself, and much more difficult to identify and stop.

Non-purposeful misdiagnoses, it should be stressed, are different from real *mistakes* in diagnosis. Mistakes in diagnosis result from a process in which, for want of adequate information about the patient or the illness, or lack of proper training, the psychiatrist issues a diagnosis to a person whose clinical state should be categorized differently. Non-purposeful misediagnoses, by contrast, result from a process in which a psychiatrist has both adequate information about the patient and the illness and proper training, but issues an incorrect diagnosis because of factors extrinsic to the patient – and does so without being aware, or fully aware, that he or she is doing so. Sometimes, such awareness is fully absent: the misdiagnosis is non-purposeful in the fullest sense. Sometimes, however, awareness would be present were it not for the efforts of the psychiatrist, through the use of various techniques of denial and self-delusion, to escape the moral self-condemnation that would result from such awareness. At this most extreme end of the spectrum of non-purposefulness, the veneer of non-awareness may be so thin as to allow awareness, and therefore purposefulness, to emerge in such a manner as to make it difficult to distingush from the purposefulness present in clear-cut cases of conscious, fully purposeful, misdiagnosis.

One of the sources of non-purposeful psychiatric misdiagnoses, and probably the most significant, is the attractiveness of the diagnostic process as a means of solving or avoiding complex human problems. With remarkable ease diagnosis can turn the fright of chaos into the comfort of the known; the burden of doubt into the pleasure of certainty; the shame of hurting others into the pride of helping them; the dilemma of moral judgement into the clarity of medical diagnosis.

Diagnosis as explanation, mitigation, and exculpation

Behaviour that is odd, objectionable, troublesome, or illegal, can be through the mediation of diagnosis, suddenly explained, and explained away.

To be sure, such behaviour may indeed be the product of diagnosable mental illness. But the capacity of a diagnosis to perform this function makes its use a temptation even in cases in which such illness does not exist or, at best, is only marginally present. The arena in which this diagnostic temptation has been most evident has been the law. For years psychiatrists have been asked to testify as witnesses in cases of persons accused of various crimes. Naturally, defendants

and defence counsels have often sought findings of "not guilty by reason of insanity", even when they have suspected or known insanity not to have played a role, because of either belief that, at least in cases of such serious crimes as murder or rape, confinement in a hospital may be shorter than the sentence that would be likely to be imposed should the defendant be found guilty and not insane. Still, some persons do commit crimes because they are insane: the law recognizes that insanity compromises free will, and classifies someone without free will as legally not resposible for his or her actions. The role of a psychiatrist in such a case is to recognize mental illness.

The trouble is that attempts have been made to expand that role into realms in which psychiatrists do not have expertise. The pressure for that expansion has been the wish to explain diagnostically – and explain away legally – criminal behaviours that do not involve classical psychotic states. Instead of insanity the clinical questions have involved issues about which psychiatry has almost no validated knowledge: questions primarily of coercion, persuasion, and influence.

It seems that the beauty of diagnosis will continue to be appreciated in the legal arena, and psychiatrists will testimony in support of psychological defences of all kinds – defences, for example, that attribute criminal actions to the defendant's early childhood rearing or to the pressures of his or her adolescent peers. While such influences undoubtedly exist, almost nothing is known about how they affect the capacity for individual judgement and the existence of free will.

Diagnosis as reassurance

A second beauty of diagnosis is its power to reassure. When acts are committed whose implications are disturbing – acts that suggest vulnerabilities in ourselves, our institutions, or our communal beliefs – diagnoses often come to mind, both in the layman and psychiatrist, which shift the frame of the behaviour from the threatening personal or social arena to a safer medical one. Doing this, many concerns are eased: when one's actions were not the result of inherent vulnerabilities of the society, or institution, and were not the result of a person's morale, but, on the contrary, the result of his or her mental illness, everybody is reassured, particularly the person, who will become "good", as the proper treatment "cleans" him.

Diagnosis as self-confirming hypothesis

Perhaps the most remarkable property of diagnosis, and sometimes the most enraging for the diagnosed patient, is its capacity for inevitable self-confirmation. That property is used in everyday life by persons who call others "crazy" or "weird": once they do so, everything that the receivers of such lay diagnoses do can be attributed to, and dismissed as a result of, those or similar psycho-pathologizing epithets. In fact, everything they do subsequently can become a proof that the original diagnosis was correct.

Diagnosis as discreditation and punishment

One particularly destructive function of diagnosis evident in everyday life is its capacity to discredit by attributing a person's views, politics, actions, or conclusions to a mind gone sick: diagnosis as a weapon.

We saw this everywhere in the past and we still see it nowadays: in the former Soviet union, in the Middle East; it has become a common language and a common weapon among politicians. But the most flagrant setting for the raw use of psychiatry to discredit – and, indeed, to intimidate and to punish – has been the former Soviet unipom. And it is here that the category of non-purposeful misdiagnoses that was defined earlier, begins to merge with, and seems at times indistinguishable from, the category of purposeful misdiagnoses.

Diagnosis as the reflection of social trends

One use of diagnosis that has been particularly problematic has involved the diagnosis of "recovered" or "repressed" memory. Some health practitioners attributed certain symptoms they believed persons had, or certain of their behaviours, to experiences that they were assumed to have had during their childhoods but could not remember because memories of those experiences had been "repressed". These experiences were generally assumed to have involved sexual abuse, aften said to have been carried out by a parent. On occasion, as a result of these diagnoses, parents or others, such as persons in charge of schools, would be subjected to criminal charges and punishments.

To some extent the growth of the tendency to expect – and to "recover – repressed memories was a product of trends in the general culture, especially in US, related to focus on victimization and concerns particularly regarding women. Such victimization, as well as childhood abuse,

obviously occurs. But when the search for such abuse becomes part of the diagnostic enterprise, and especially when psychiatric "symptoms" said to be the products of such abuse are identified that are ambigous and could be the result of numerous factors, what can follow is considerable harm to everybody involved.

Conclusion

As perception can be distorted in the process of the disease, it can also be distorted by other reasons of which we are mostly unaware. However, psychiatrists should at times at least reexamine, and, if necessary, redefine their diagnostic tools, particularly in the light of the values that lie deep under the surface of our acts and behaviour but still have the power not only to influence but to guide our cognition, emotion, and behaviour.

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