

The Uses of Diagnosis: A Commentary

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I have been asked to comment on Deborah Wright's account of her experience with her son because of my interest in the use of psychiatric diagnostic categories in family therapy (Beels 1977, 1988, 1989; Beels & McFarlane, 1982). I will develop two lines of thought that occurred to me after reading this very moving account of a family's struggle to define its problem. The first is about the uses of diagnostic accuracy; the second is about the role of diagnosis in the process of defining an illness experience. They both came to mind in thinking about a diagnosis that was offered to the family without the doctor ever seeing the patient, indeed, without any likelihood that the patient would ever collaborate with treatment.

I suspect that the number of consultations of this sort is larger than is reported: certainly, they are part of the group of services for which third-party payment is not available. My colleagues in the field of schizophrenia and the family tell me that they are often consulted by the parents of alienated young people on the edge of homelessness to whom psychiatric treatment or classification is unacceptable. The parents are desperate to do something about their sons and daughters, and their despair is in proportion to the fugitive's determination to be left alone with his or her own definition of the problem.

Agencies for the care of the homeless have many such cases in which the diagnostic picture is cloudy, and the persons are completely alienated and in a world of their own. One of their outreach strategies is to find and join with such alienated persons in whatever relationship they will accept, such as help in the search for food and shelter, then gradually to provide additional services over months and years—the last of which may be psychiatric diagnosis and medication. Often these psychiatric services are possible only after some change in nutrition and drug use reveals the person's better level of function and trust, which then makes it possible to begin a semblance of the conventional doctor-patient relationship. Workers in these teams have to ponder carefully how and when to involve the family in the process.

The story of Andrew presents a different problem, one quite familiar to therapists working with bipolar illness. The candidate patient is active, determined, angry, and regards himself as one of the few right people in a wrong world. Alliance of any kind is viewed with great irritability and wariness. The family is intensely involved and, for the purpose of diagnosis, its observations of signs are more to be relied on than what the patient says about symptoms. Mood swings, restlessness, pressured speech, periods of depression, periods of irritability and grandiosity, paranoid thinking, can all be found in the account, although in Andrew's case it is not clear that they are in the form of sustained phasic alternations.

What did a diagnosis mean in a situation like this? First, let us consider the uses of diagnosis, especially accuracy in diagnosis, in different circumstances. The strictest diagnoses are those used in treatment research: the Research Diagnostic Criteria. Here a scientific assertion is made that a certain treatment improved or did not improve a number of cases of the illness. Rigorous definition is important because clinicians who read the research report will use it as a guide in treatment, and the guide stands or falls depending on how clearly "caseness" is defined.

Less strict, but still as strict as would be compatible with knowledge and opportunity, is the diagnosis in clinical practice, which leads to the giving of a dangerous drug or the pronouncement of a serious prognosis. Here the guide is the medical motto: "Do no harm." The downside of the treatment or the prognosis must be heavily weighed against doing or saying nothing. In some situations, there is also an upside. An example is the practice of going through state hospital wards searching for manic-depressive patients who have been misdiagnosed as schizophrenic and consigned to ongoing treatment with phenothiazines and a chronic-ward routine. Many re-diagnosed manic-depressive patients improved greatly on a regimen of lithium, education, and support. Given the harmful alternative, it is a worthwhile thing to try.

Finally, before turning to my second topic, let us reflect on psychiatric diagnosis as part of a long historical process. Even though manic-depressive illness, or at least mania as a distinctive state, was known to Hippocrates, our thinking about it is still in the process of evolution. We should remember that the Diagnostic and Statistical Manual (DSM) in its successive editions is really a record of an epidemiological discussion going on in the psychiatric profession, and no part of it is to be read as the last word. It is a series of proposals to be tried out for their effectiveness. In that regard, it is especially interesting to contemplate an article (Blacker & Tsuang, 1992) from the Harvard School of Public Health by two thoughtful participants in this epidemiological discussion. Blacker and Tsuang take manic-depressive disease as an example of the psychiatric diagnosis par excellence. Few other conditions, they point out, have such a definite heredity and psychopharmacology, which are the two biological criteria for "real" disease as opposed to a cultural category or subjective illness experience. And yet, they say, look how fuzzy its edges are, how difficult it is to distinguish in particular cases from the conditions that lie on its borders: unipolar depression, schizoaffective disorder, schizophrenia, adult residua of attention-deficit disorder, borderline personality disorder, and toxic effects of chronic drug abuse, all of which fade into it in difficult cases. And difficult cases may be as numerous as classical ones—a situation that raises questions about the whole

enterprise of separating psychiatric diagnoses from one another by using inclusion and exclusion criteria. Perhaps, Blacker and Tsuang suggest, it would be better to have scales indicating the presence of symptoms—a collection of symptom scores. A person could have a little of this and more of that, and psychiatrists would assign scores instead of deciding whether a patient was in or out of a diagnostic box.

Looking at the case of Andrew from this standpoint, one could say that, although he may not rate the full scale on manic-depressive symptoms, he scores low on other dimensions of pathology, except possibly chronic drug use. There he has only consistently used marijuana; and the way he describes that usage ("my medication") seems in a way to confirm the experience of some manic or hypomanic patients—that they need something to keep themselves under control. And if we were allowed to use scales for ingenuity and accomplishment, rather than pathology, Andrew would, like many other sufferers from manic-depressive illness, score very high on those. The stories of outstandingly productive people who have had such symptoms are collected in the recent book by K.R. Jamison (1993).

The idea of doing away with categorical diagnosis comes from epidemiologists, and one can imagine how it would contribute to the progress of that science. It is interesting to think about what would happen to the practice of psychiatric therapy without diagnostic boxes in which to put patients.

This brings us to the second subject that the story of Andrew and his family brings to mind: the function of diagnosis as part of the social process of treatment. The anthropologist and psychiatrist Arthur Kleinman (1988) has written an elegant book on this subject. He notes that a diagnosis is a socially negotiated meaning, to which there are many contributors besides the patient's subjective experience. These other parties cause the patient to modify and reinterpret that experience. Examples of these other influences are: the cultural categories that define morally acceptable suffering, the family's and the larger group's ways of responding to those categories, and meanings that the healing profession offers as a guide to treatment. A successfully negotiated and agreed-upon diagnosis, coming out of this process, externalizes the problem, defines what means will be used to attack it, and so re-moralizes not only the patient but the others. It promotes the formation of a support group, formal or informal. A diagnosis is not only a box—it can also be a battle plan.

All these processes of agreement and assent are an essential part of psychiatric treatment in all cultures. But, in our medical culture, these processes have acquired the derisive name "placebo response," the nonspecific factors that lead to healing. Since we believe that healing should be the result of the operation of scientifically objectifiable elements, like drug chemistry or "correct" interpretations, we have relegated the placebo response to the lowly status of a contaminant in research designed to reveal "really" effective treatments. Kleinman suggests that, since the placebo response contributes such a large share of the therapeutic effect, we should instead be studying what brings about the largest possible placebo response in a particular social situation. This is one of the reasons we should be interested in folk healing practices. If we can understand the nature of the re-moralization that makes for effective treatment, we can add that to our unique cultural contribution—the scientific knowledge of biological psychiatry—to achieve a real synergy of effect. I think this combination is one of the things David Moltz (1993) is talking about in his recommendations for the family treatment of manic-depressive disorder in his article in this journal issue.

The story of Andrew and his family provides an especially interesting example of the process of negotiating a meaning for an illness experience, since not only was the patient not part of the treatment, but the absence of a diagnostic and treatment consensus was the essence of the original demoralization of the family. Andrew's idea was that he was having so much trouble in the world because the world was both sick and heartlessly cruel. He saw his parents as the leading exponents and representatives of that sick world. His parents, on the other hand, were victims of family systems theory. They felt that something in his growing up—for which they were responsible—was to blame, and now that he was moving farther and farther away from them, there was less and less hope of correcting whatever it was. His behavior was supposed to have a function in the family, and the family could not change itself so as to relieve him of such a responsibility. He rejected all offers of contact.

The diagnosis of manic-depressive disease did two things. It took the blame off the parents so that they could act. And even though Andrew rejected the diagnosis at first, it changed some things for him: his parents were no longer debating with him—they were turning to him with the question: "How can we help?" From there on, the path was a steady series of offers of love and concrete help from the parents, which built the alliance in much the same way as the offers of food and shelter build alliances between the agencies and the homeless.

Readers of *Family Process* will also recognize that the consultation offered to Andrew's family derives directly from the practice of psychoeducation (Anderson, Reiss, & Hogarty, 1986; Falloon, Boyd, McGill, *et al.*, 1982). The guidelines of that approach—joining with the family, avoiding blame, externalizing the problem of the illness, and entertaining many experimental ways of approaching that problem—appear in this case to have helped in the reorientation of the family's efforts. Their great patience with each other and the love that comes through in this account were the indispensable ingredients.

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