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THEORETICAL ARTICLE

No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished

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Abstract This article argues that psychiatric diagnoses are not valid or useful. The use of psychiatric diagnosis increases stigma, does not aid treatment decisions, is associated with worsening long-term prognosis for mental health problems, and imposes Western beliefs about mental distress on other cultures. This article reviews the evidence base focusing in particular on empirical findings in relation to the topics of: aetiology, validity, reliability, treatment and outcome, prognosis, colonialism, and cultural and public policy impact. This evidence points toward diagnostic based frameworks for understanding and intervening in mental health difficulties being unable to either improve our scientific knowledge or improve outcomes in clinical practice and suggests that we need to move away from reliance on diagnostic based approaches for organising research and service delivery. Alternative evidence-based models for organising effective mental health care are available. Therefore formal psychiatric diagnostic systems such as the mental health section of the International Classification of Diseases Tenth Edition (ICD-10) and Diagnostic Statistical Manual Fifth Edition (DSM 5) should be abolished.

PALABRAS CLAVE
Diagnóstico psiquiátrico;
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Estudio teórico

No más etiquetas psiquiátricas: por qué deberían suprimirse los sistemas formales de diagnóstico psiquiátrico

Resumen Este artículo plantea que los diagnósticos psiquiátricos no son válidos ni útiles. El uso del diagnóstico psiquiátrico aumenta el estigma, no ayuda a las decisiones sobre el tratamiento, se asocia con un empeoramiento en el pronóstico a largo plazo de los problemas de salud mental e impone creencias occidentales sobre la angustia mental en otras culturas. Se analiza la evidencia disponible acerca de hallazgos empíricos relacionados con la etiología, validez, fiabilidad, tratamiento y resultados, el pronóstico, el colonialismo y el impacto de la política cultural y pública. Esta evidencia apunta hacia diagnósticos basados en contextos

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de comprensión e intervención en los problemas de salud mental incapaces de mejorar el conocimiento científico o los resultados en la práctica clínica, sugiriéndose un alejamiento de la dependencia de los enfoques basados en diagnósticos para la organización de la investigación y la prestación de servicios. Están disponibles modelos alternativos basados en la evidencia para la organización efectiva de la atención en salud mental. Por lo tanto, los sistemas de diagnóstico psiquiátrico formales, como la décima edición de la Clasificación Internacional de Enfermedades (CIE-10) y la quinta edición del Manual Diagnóstico Estadístico (DSM 5) deben ser abolidos.

Modern Western psychiatry has secured many important advances in the care of people with mental distress (Obiols, 2012; Reed, Anaya & Evans, 2012). We have a variety of pharmacotherapies and psychotherapies that can help manage and understand distressing symptoms and find new ways to deal with them. The old asylums have been emptied and community care has developed a variety of services from early intervention to crisis management. The academic community, studying mental distress from a variety of angles, has grown in numbers and sophistication, with many journals and thousands of articles published each year. These are worthy achievements, and this progress has no doubt helped thousands of people across the world.

Despite these achievements, psychiatric theory and practice is at an impasse. Prevention has proved elusive, with mental health diagnoses becoming more not less common. The diagnoses listed in the major psychiatric diagnostic manuals have not yet been linked with any sort of physical test or other biological marker (apart from the dementias) and so, unlike the rest of medicine, psychiatric diagnoses do not have pathophysiological correlates and no independent data is available to the diagnostician to support their subjective assessment of diagnosis. Whilst reliability in making diagnoses has improved for some research purposes, this has not translated to clinical practice and the more important issue of validity remains poorly addressed. Tellingly, there is little evidence to show that using psychiatric diagnostic categories as a guide for treatment significantly impacts on outcomes.

This article highlights the extent to which empirical data is inconsistent with the diagnostic-based medical model remaining as the organising paradigm for practice. The important task of sketching out what services may look like once we discard systems such as ICD and DSM from routine clinical practice is not the primary purpose of this article and therefore will only be afforded a brief mention and not covered in any depth.

Aetiology

The failure of decades of basic science research to reveal any specific biological or psychological marker that identifies a psychiatric diagnosis is well recognised. Unlike the rest of medicine, which has developed diagnostic systems that build on an aetiological and pathophysiological framework, psychiatric diagnostic manuals such as DSM 5 (American Psychiatric Association, APA, 2013) and ICD-10 (World Health Organization, WHO, 1994) have failed to connect diagnostic categories with aetiological processes. Thus, there are no physical tests referred to in either manual that can be used to help establish a diagnosis. This lack of scientific progress connected to diagnostic groupings is a problem for research from a variety of perspectives, including biological research, where leading research groups are abandoning the use of current diagnostic constructs (Marneros & Akiskal, 2007; Owen, O'Donovan, Thapar, & Craddock, 2011). Despite the belief that psychiatric disorders have a clear genetic loading, molecular genetic research is failing to uncover any specific genetic profile for any disorder. Possible genetic abnormalities appears to account for only a small percentage of causal factors, and whatever genetic contribution has been found crosses diagnostic categories rather than having a distinct profile for each diagnostic category (Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013).

The one notable exception to the lack of aetiological organisation in diagnostic systems is 'post traumatic stress disorder' (PTSD), which implies that trauma leads to a particular and identifiable constellation of symptoms. However, there is a substantial body of evidence which finds that in the full spectrum of diagnoses in psychiatry, including psychosis, there is a greater likelihood of experiencing trauma and abuse (Bebbington et al., 2004; Escher, Romme, Buiks, Delespaul, & van Os, 2002; Goodman, Rosenberg, & Mueser, 1997; Greenfield, Strakowski, Tohen, Batson, & Kolbrener, 1994; Honig, Romme, Ensink, Pennings, & de Vries, 1998; Morrison, Frame, & Larkin, 2003; Mueser et al., 1998; Read, Agar, Argyle, & Aderhold, 2003; Varese et al., 2012).

Validity

If we were to apply the standards found in the rest of medicine, then the validity of a diagnostic construct depends on the extent to which it represents a naturally occurring category. If it can 'carve nature at its joints', then there should be some identifiable properties beyond symptoms or behaviours, in those who have the diagnosis that can distinguish them from those who don't. The failure of basic science research to reveal any specific biological marker for psychiatric diagnoses means that current psychiatric diagnostic systems do not share the same scientific security, of belonging to a technological model developed by research grounded in the natural sciences, as the rest of medicine. The attempted solution of continuing to spend the bulk of mental health research time and effort trying to correct this deficit by relentlessly searching for evidence of biological correlates continues to deliver nothing scientifically