

Division of Clinical Psychology Position Statement on the Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses Time for a Paradigm Shift

The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a 'disease' model.

Context

Classification is fundamental in medicine. To be effective, it requires a reliable and valid system for categorisation of clinical phenomena in order to aid communication, select interventions, indicate aetiology, predict outcomes, and provide a basis for research. Medical diagnosis is the process of matching an individual's pattern of symptoms and biological signs to a standard pattern in the classification, and ensuring that similar but alternative patterns are discounted in the matching – the process of differential diagnosis. The patterns themselves are commonly categorical; if it is one it cannot be the other, but several can co-occur (co-morbidity).

In psychiatry, diagnoses rely on the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) and the International Classification of Diseases: Classification of Mental and Behavioural Disorders (ICD-10). The regular revision of these two major classification systems is a clear recognition that they are, and remain, works in progress. The need for revision is a consequence not only of the need to accommodate evidence-based advances in thinking and practice, but also reflects more fundamental concerns about the development, personal impact and core assumptions of the systems themselves.

The development and use of these classification systems for psychological distress and behaviour has never been free of controversy. Many of the issues that arise in relation to psychiatric diagnosis stem from applying physical disease models and medical classification to the realms of thoughts, feelings and behaviours, as implied by terms such as 'symptoms' and 'mental illness' or 'psychiatric disease'. The Division of Clinical Psychology (DCP) has historically held mixed views about psychiatric classification and its implications in theory and practice, reflecting its position as representing clinical practitioners in a wide range of specialisms and as a scientific body. The DCP recognises that the current classification systems have underpinned much research and theory in the area and have shaped the structure and delivery of mental health services. Secondly, these systems provide seemingly 'tangible' entities for use in administrative, benefits, and insurance systems. Thirdly,

they are broadly accepted by most professional groups, many service users, the media and the general public.

At the same time it should be noted that functional psychiatric diagnoses such as schizophrenia, bipolar disorder, personality disorder, attention deficit hyperactivity disorder, conduct disorders and so on, due to their limited reliability and questionable validity, provide a flawed basis for evidence-based practice, research, intervention guidelines and the various administrative and non-clinical uses of diagnosis. This has been a matter of cross-professional concern for many years (e.g. Barker, 2011; BPS, 2000, 2011; Boyle, 2002; Bentall, 2004; Bracken *et al.*, 2012; Coppock & Hopton, 2000; Johnstone, 2008; Moncrieff, 2010). The current classification systems are less controversial for conditions with an identified biological aetiology such as in the fields of neuropsychology, the dementias, and moderate – severe learning disability.

Nevertheless, serious concerns have been raised about the increasing medicalisation of distress and behaviour in both adults and children (BPS, 2011; Conrad, 2007). The ‘functional’ diagnoses, for which there is substantial evidence for psychosocial factors in aetiology, and very limited support for a disease model, give rise to a wider range of views and positions and are the primary focus of this statement.

This position should not be read as a denial of the role of biology in mediating and enabling all forms of human experience, behaviour and distress (Cromby, Harper & Reavey, 2013), as is demonstrated, for example, in emerging epigenetic research (e.g. Read & Bentall, 2012; Szyf & Bick, 2013.) It recognises the complexity of the relationship between social, psychological and biological factors. In relation to the experiences that give rise to a functional psychiatric diagnosis, it calls for an approach that fully acknowledges the growing amount of evidence for psychosocial causal factors, but which does not assign an unevidenced role for biology as a primary cause, and that is transparent about the very limited support for the ‘disease’ model in such conditions. Such an approach would need to be multi-factorial, to contextualise distress and behaviour, and to acknowledge the complexity of the interactions involved, in keeping with the core principles of formulation in Clinical Psychology (DCP, 2011).

The Role of Clinical Psychologists

Irrespective of whether the psychiatric diagnosis refers to a condition with an established primary biological basis or not, there is clearly an identified role for psychological assessment, formulation and intervention in addressing psychosocial factors, taking into account the influences of biological contributions. The same pertains to applied psychology in health, where the role of psychologists is to identify, formulate and offer interventions relevant to the biopsychosocial factors that may predispose to physical illness and will materially influence its course, outcome and impact.

The Rationale for a Paradigm Shift

The statement outlines the rationale for this paradigm shift and makes recommendations for developing a new approach. The phrase ‘psychiatric diagnosis’

will be used as a short hand for the current classification scheme of the functional diagnoses.

The key conceptual issues and concerns can be summarised as follows:

Core Issue 1: Concepts and models

- Interpretation presented as objective fact: Psychiatric diagnosis is often presented as an objective statement of fact, but is, in essence, a clinical judgement based on observation and interpretation of behaviour and self-report, and thus subject to variation and bias (e.g. Kirk & Kutchins, 1994).
- Limitations in validity and reliability: As a consequence of the above, numerous critiques testify to the resulting problems in reliability and validity, and the issues have surfaced once again in the process of developing DSM 5 (Bentall, 2004; Frances, 2012; Kirk & Kutchins, 1994).
- Restrictions in clinical utility and functions: The above limitations diminish the utility of functional diagnoses for purposes such as determining interventions, developing treatment guidelines, commissioning services, and carrying out research based on these categories.
- Biological emphasis: The dominance of a physical disease model minimises psychosocial causal factors in people's distress, experience and behaviour while over-emphasising biological interventions such as medication (Boyle, 2013; Cromby & Harper, 2013).
- Decontextualisation: Psychiatric diagnosis obscures the links between people's experiences, distress and behaviour and their social, cultural, familial and personal historical contexts.
- Ethnocentric bias: Psychiatric diagnosis is embedded in a Western worldview. As such, there is evidence that it is discriminatory to a diverse range of groups and neglectful of areas such as ethnicity, sexuality, gender, class, spirituality and culture (e.g. Bayer, 1987; Busfield, 1996; Fernando, 2010; Shaw & Proctor, 2005).

Core issue 2: Impact on service users

The needs of services users should be central to any system of classification. Service users express a wide range of views on psychiatric diagnosis, and the DCP recognises the importance of being respectful of their perspectives. Some service users report that diagnosis is useful in putting a name to their distress and assisting them in the understanding and management of their difficulties, whereas for others the experience is of negativity and harm. Some of the key concerns include:

- Discrimination: Research has demonstrated discrimination due to negative social attitudes towards those with a psychiatric diagnosis. This can create and compound social exclusion (Read, Haslam, Sayce & Davies, 2006).
- Stigmatisation and negative impact on identity: The language of disorder and deficit can negatively shape a person's outlook on life, and their identity and self-esteem (Barham & Hayward, 1995; Estroff, 1993; Honos-Webb & Leitner, 2001).

- Marginalising knowledge from lived experience: Service users often emphasise the primary significance of practical, material, interpersonal and social aspects of their experiences, which only constitute subsidiary or 'trigger' factors in the current system of classification (Beresford, 2013).
- Decision-making: Decisions about how to classify a person's behaviour and experience are often imposed as an objective fact, rather than shared in a transparent and open manner. For example service users' disagreement with their diagnosis can lead to being labelled as lacking insight, without acknowledgement of the limitations of the current system (Terkelsen, 2009).
- Disempowerment: The current classification systems position service users as necessarily dependent on expert advice and treatment, which may have the effect of discouraging them from making active choices about their recovery and the best means of achieving it. Many recovery narratives include a rejection of diagnoses (Bassman, 2007; Deegan, 1993; Longden, 2010; May, 2000)
- As noted above, diagnosis can lead to an over-reliance on medication, while underplaying the impact of its physical and psychological effects (Moncrieff, 2008).

Summary

The DCP believes there is a clear rationale and need for a paradigm shift in relation to functional psychiatric diagnoses. It argues for an approach that is multi-factorial, contextualises distress and behaviour, and acknowledges the complexity of the interactions involved in all human experience.

Action Points from the Position Statement

Action point 1

To share within the DCP and through pre-qualification training and continuing professional development, the issues raised by this statement. The aim is to achieve greater openness and transparency about the uses and limitations of the current system, and enhance service users' and carers' awareness and understanding of the issues.

Action point 2

To open up dialogue with partner organisations, service users and carers, voluntary agencies, and other professional bodies in order to find agreed ways forward. This will necessarily include safeguarding access to health and social care, benefits, work support, and legal and educational services that are currently diagnosis-based.

Action point 3

To support work, in conjunction with service users, on developing multi-factorial and contextual approaches which incorporate social, psychological and biological factors.

Action point 4

To ensure that a psychosocial perspective and psychological work are included in the electronic health record.

Action point 5

For the DCP to continue to promote the use of psychological formulation as one response to the concerns identified in this statement.

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