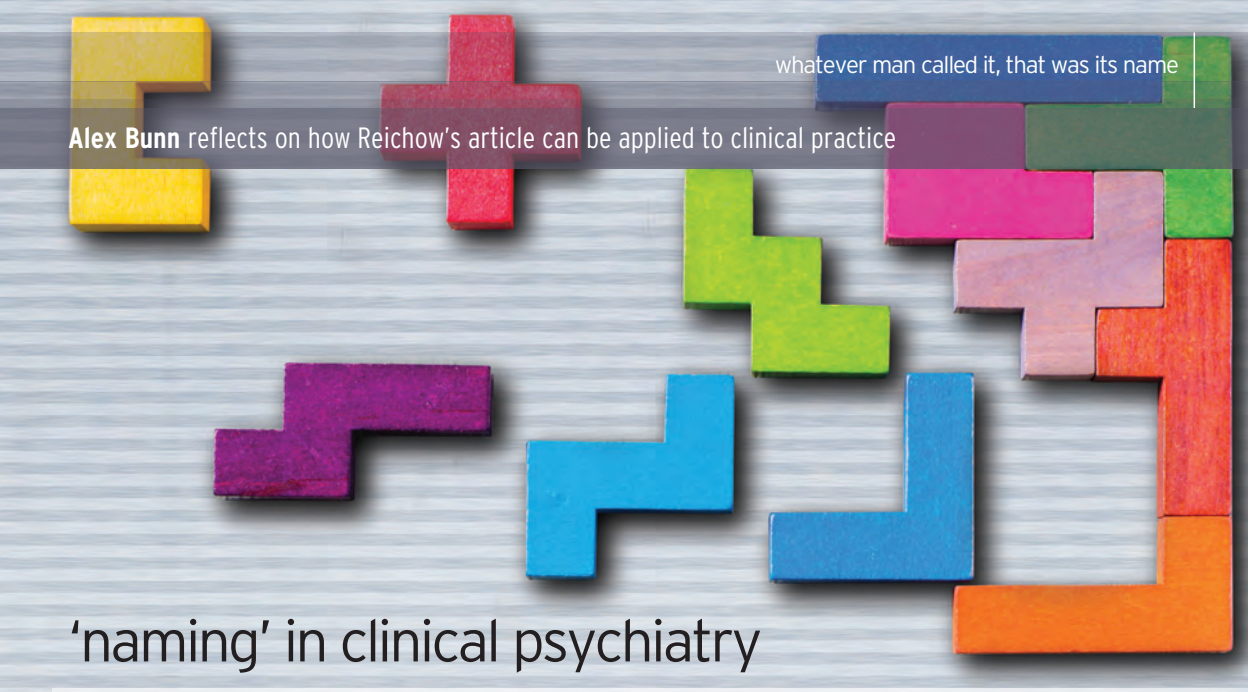
Alex Bunn reflects on how Reichow's article can be applied to clinical practice



'naming' in clinical psychiatry

So 'naming', creating definitions and classifications is a basic human activity mandated by God. How might medical language illuminate or distort our view of people?

how do you know?

There are two main schools of thought about knowledge. At one end, there is *positivism* which relies on hard sciences to 'read' a reality that exists independently of us. For instance, astronomers used telescopes to discover the laws of gravity. On the other end, there is *social constructivism* which states that truth is always socially constructed, and embedded in the local culture. We impose an order on the world, such as when men decided that a constellation resembled a lion, and called it Leo.

The naming of physical conditions is largely positivist. A diagnosis of TB likely represents an infection with a physical entity that can be visualised. The success of treatments like antibiotics gives biomedical classifications huge status. But in psychiatry, it is not so easy to 'read' the mental events and pathology of someone's inner world. So our definitions rely more on the imagination. We describe phenomena that cluster together, and decide whether they need attention because they cause distress or dysfunction. If so, we give them the label of a mental disorder.

Medicalising thoughts and behaviour has pros and cons. It can be very reassuring to know that your negative experiences are shared, and that certain treatments worked for others. For instance, a young woman was diagnosed with Autistic Spectrum Disorder and was immensely relieved. She was not just 'odd'; the diagnosis gave her access to professional help and specialist education. A diagnosis may also legitimately excuse someone from thoughts and behaviours beyond their immediate control. Somebody with schizophrenia is unlikely to intend paranoia or delusional thinking.

However, no naming is neutral, as it expresses a culture and a worldview. Historically, some labels have reflected prejudices, or been misused by political regimes. Sadly, many societies including Christian ones have used labels like 'witch' to persecute those on the margins of society. The diagnosis of 'drapetomania' was invented by an American physician to describe the inconvenient habit of a slave in disobeying their masters by running away.[1] The Soviet Union deemed unauthorised beliefs (political dissent and faith) a mental illness, 'political intoxication', in need of compulsory treatment.[2]

over-medicalisation, materialism and personal responsibility

More recently, the number of conditions in the DSM has swelled from 14 to 250, perhaps partially driven by the need for a diagnosis to access insurance funding in the US. Some cite false epidemics of ADHD, hypomania, and childhood bipolar disorder as a result. But has this mapping of every aberrant thought led to the over-medicalisation of human experience? DSM5 no longer excludes the diagnosis of depression following recent bereavement. Does this lead to the medicalisation of entirely appropriate grief? Is an elderly man with hoarding disorder best understood as sick or just self-protective? Mild cognitive impairment is a new entry, but where do we draw the line between naturally declining memory, and a pathological dementia?[3]

Another tendency of western medicine is to reduce humans to the merely material. For instance, when does sadness become depression? The serotonin hypothesis collapses melancholy to a chemical imbalance,[4] which may distract us from the higher level causes that need addressing, such as abuse suffered in childhood or heavy drinking used to forget it. The pharmaceutical industry[5] has an interest in maintaining a simplistic account, and doctors can be tempted to collude by prescribing rather than listening.

A final area of tension is our approach to certain behaviours that would previously have been viewed as sinful, needing repentance. Now they are more likely to be classed as disorders, needing treatment. A variety of acts, from terrorism to gambling and sexual harassment, have been reported this way.[6] I remember meeting a patient who had been convicted of grooming a minor online. He showed me letters he had written to his wife, asking why she hadn't spotted he was sick. He was convinced that his psychologist had told him 'the depression made me do it'. This is very unlikely, but illustrates how labels can suggest explanations for our actions.

questions for reflection

- When might a psychiatric diagnosis be de-stigmatising?
- When might a psychiatric diagnosis undermine personal responsibility?
- To what extent might some psychiatric categories be in tension with a biblical account of human behaviour?

The concept of a personality disorder (PD) aims to provide a scientific approach to antisocial or dysfunctional behaviour. ICD10 defines a PD as 'severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood.'[7] This classification recognises the impact of adverse childhood events on psychosocial development, and antisocial behaviour. But I have seen patients use the diagnosis of antisocial PD to justify violent behaviour or the need for addictive medications. Worse, I have heard doctors write such patients off as beyond redemption. It is worth reflecting deeply on the 'mad, bad or sad' debate.[8]

So let's be careful with the names we give people. ■

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