

**KITES and Wellington Research  
Diagnosis in Psychiatry Workshop  
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Kate Diesfeld, J.D., AUT University**

## **I Introduction**

- A. Can one system of diagnosis service the interests of all stakeholders? If not, what are the alternatives?
- B. My contribution draws upon research and former representation of service users before the Mental Health Review Tribunal in England.

## **II. New Zealand context:**

The criteria for involuntary assessment and treatment under New Zealand's legislation does not explicitly rely on named diagnoses. For example, the Acts does not refer to specific diagnoses such as schizophrenia. Rather, the criteria are based on a phenomenological approach (Bell and Brookbanks, 2007). For example, the Act requires a mental disorder which refers to abnormal state of mind with certain characteristics of a particular degree.

*Mental Health (Compulsory Assessment and Treatment) Act) 1992: Section 2*  
**Mental Disorder**, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—  
(a) poses a serious danger to the health or safety of that person or of others; or  
(b) seriously diminishes the capacity of that person to take care of himself or herself;—or involuntary treatment

Also, in New Zealand, there are occasions when a person has to identify as having a condition to secure protections (e.g. for protection against discrimination on the basis of disability. A qualifying condition is “psychiatric illness” under the Human Rights Act 1993 Section 21 (1)(h)(iii)). A diagnosis may be relevant to obtain the Act's protection from discrimination. However, there is also the potential for a psychiatric diagnosis to carry stigma and therefore future potential for discrimination. This raises the prospect that psychiatric diagnoses are a double-edged sword.

## **III. Research**

There is substantial critique regarding the Diagnostic and Statistical Manual V. An increase in the number of recognised psychiatric diagnoses may have substantial personal, social, political impacts. These include the

potential for the state to expand its coercive power over people who are deemed to have a psychiatric diagnosis.

For example, there has been extensive discussion at today's conference, and in the media and academic literature, regarding autism and autism spectrum conditions (Russell, 2012). According to research cited by Russell (2012:1), "The most recent estimate is that 1 in 88 US children have an autism spectrum disorder at age 8—the highest prevalence ever recorded" (Autism and Developmental Disabilities Monitoring Network, 2012). Russell also noted, "An article in *Pediatrics* concluded that 'the question of whether this historical increase can be fully accounted for by changes in diagnosis and classification remains open to debate' " (Russell, 2012: 1).

One example of a novel diagnosis that was recently conceptualised is hubris syndrome (Owen, 2007; Owen, 2008; MacSuibhne, 2009; Russell, 2011). It was articulated by Lord Owen, former Minister of Health and Foreign Secretary in the United Kingdom in the 1970s. He is interested in the interaction between politics and mental illness (Owen, 2008). Lord Owen observed that some foreign ministers' and presidents' behaviour was characterised by a reckless, hubristic belief in their own rightness. Interestingly, Russell (2011) observed that the word 'hubris' is derived from Greek and means both 'inviting disaster' and 'arrogance'.

Lord Owen developed the concept based on his observations of politicians such as British Prime Minister Tony Blair and US President George W. Bush. More recently, Russell (2011) analysed the behaviour of Anthony Eden, John F Kennedy, and Lyndon Johnson by applying the same concept. Lord Owen distinguished hubris syndrome from personality disorder; hubris syndrome involves an intoxication with power and absence of humility. Lord Owen aimed to establish "the causal link between holding power and aberrant behaviour that has the whiff of mental instability about it" (Owen, 2007, cited in Russell, 2011: 144). Lord Owen believes neurochemical and neuroscientific frameworks will clarify causes and prevent occurrences (Russell, 2011).

While the concept is fascinating, it may indicate a growing trend towards pathologising conduct that is viewed as socially unacceptable. Many people may be captured in the net of new psychiatric diagnoses with far reaching effects.

Another example of a newly conceptualised condition is solastalgia (MacSuibhne, 2009). The concept was created by an environmental philosopher and activist, Glenn Albrecht, "to give greater meaning and clarity to psychic distress caused by environmental change" (MacSuibhne, 2009: 1). Albrecht observed the psychic distress experienced by residents

near newly built power stations and open cut coal mining in New South Wales. He was concerned about the wider impact of unwelcome destruction of pastoral environments. The changes detrimentally impacted upon locals' sense of identity, place, and their physical and mental health. The concept expresses that while the sufferers are still located at "at home", they have a tremendous sense of longing for their lost environment, similar to homesickness. The word solastalgia is derived from solace (the well-being associated with a beloved location) and nostalgia (the longing for the former homeland).

Part of the concept's appeal is its articulation of an emerging and troubling phenomena, shared by many. It may well have political benefits to articulate the psychological, psychic and physical damage of damage to our environment. New concepts like solastalgia might helpfully illuminate the psychological damage created by the destruction of our homeland, in graphic medical terms. But there are also additional effects of expanding the categories of psychiatric diagnoses. As Professor Allen Francis observed, diagnostic classifications are potentially very problematic if they are lacking in scientific evidence; the proliferation of "mental illnesses" may expand the potential for unjustifiable invasion into liberty.<did he say that?>

MacSuibhne (2009) offers an additional critique of the notion of solastalgia. Albrecht, a non-clinician, did not take into account the process by which psychiatry defines and accepts phenomena as a "mental illness". MacSuibhne's article explores the foundational question: What qualifies as a mental illness? His framework may offer a constructive critique when new psychiatric diagnoses are proposed. Do the creators of new psychiatric categories abide by the psychiatric process of defining new conditions? Is society, and are clinicians, clear about what constitutes a mental illness? What are the wider personal, legal and political implications of promoting new psychiatric diagnoses?

Professor Mellsop has published widely on the effects of expansion of boundaries of psychiatry and "diagnostic creep" (e.g. Laird, B., Smith, B., Dutt, G., Mellsop, 2009; Mellsop and Diesfeld, 2011). He has worked with service users, their family/whanau and carers regarding their experiences of diagnosis. He reminds us that the DSM and ICD were designed as communication tools between clinicians, not as clinical tools (Laird, Smith et al, 2009). People who were labelled with psychotic illnesses expressed that it was very important *how* clinicians communicated diagnoses to service users how it was used for planning future care and supports.

Many debates regarding diagnostic classification represent the tension at the intersection of law and psychiatry. In his keynote lecture, Professor

Nigel Eastman reflected on similar issues at the November 2011 conference of Australian, New Zealand Psychiatry, Psychology and Law (Eastman, 2011). He observed that the law may be asking questions that psychiatry cannot answer. Likewise, science may provide answers that the law doesn't ask. The disciplines of law and psychiatry have distinctive philosophies, goals and foundational concepts. Sometimes they collide. Perhaps a common ground is to inquire what supports people want on their journey of recovery, instead of focusing on diagnostic labels.

#### **IV. Reflections upon best practice by clinicians**

Service users that I represented before the Mental Health Review Tribunal in England expressed the impact of specific diagnoses. Service users' observations mirrored the research by Professor Mellsop and his colleagues (2010). In some circumstances, service users have reported that a diagnosis may validate their experiences through acknowledgement that a person genuinely perceives certain phenomena. Also, a diagnosis may be a relief to parents who otherwise might believe that the service user's condition is attributable to "bad parenting".

According to service users, a psychiatric diagnosis impacts upon one's sense of self and identity. It also influences one's hopefulness for the future (Mellsop and Clapham Howard, 2012). For example, one service user that I represented expressed the hopelessness that descended when he was told that he had a diagnosis of schizophrenia. Another service user expressed the depressing effect of being told she had a borderline personality disorder. Both conditions are highly stigmatised and are viewed in the popular imagination as incurable, and perhaps untreatable.

I have also observed how this type of information could be sensitively communicated. In particular, two psychiatrists sensitively imparted their views on the service users' conditions. The psychiatrists explained to the service users that the diagnoses did not fully communicate the service users' specific distress.

Both psychiatrists placed the diagnoses in the context of the legal process of the Mental Health Review Tribunal. But they recognised the profound impact of such labels upon the service users. Instead of magnifying the diagnoses, the best psychiatrists promoted the services users' priorities and advocated for supports that the service users preferred. These approaches reflected the principles identified by Professor Mellsop and his colleagues (Laird et al, 2010). The emphasis was less on diagnosis and more on these types of questions: What are your life goals? How can we partner to overcome obstacles to those goals?

I have seen that some clinicians place a premium on maintaining the therapeutic relationship. They appreciate that *how* diagnoses are communicated has an enormous influence on how it is received. They clearly communicated that an enduring alliance with service users is the priority.

One psychiatrist explained what was known and not known about the condition and how his diagnosis was reached. He admitted the limitations and stigma of diagnoses as they currently exist. He understood that the medical terminology did not fully capture the person's lived experience. Most importantly, he expressed his belief in the service users' recovery process and inspired hope.

In conclusion, there is a potential for diagnostic classifications to be subject to "therapeutic creep". While some novel diagnoses may stir popular interest, a proliferation of new diagnoses may have significant outcomes for service users. Ideally, service users' perspectives will inform future critical scholarship and best practice, within New Zealand and abroad.

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