The moral justification for classifying people into psychiatric diagnostic categories lies in its potential utility as a means to relieve human suffering. Yet, some claim that not only does the diagnostic process fail, it may perpetuate, or even create, the suffering it was intended to relieve.

In 1980, the American Psychiatric Association published the third edition of its Diagnostic and Statistical Manual (DSM-III). Since the 1982 Standards of Psychiatric Nursing/Mental Health Practice support the use of this standard psychiatric nomenclature along with nursing diagnoses as an indicator of accountability and quality practice among psychiatric nurses, it seems appropriate that the ethical issue of categorizing human beings into standardized psychiatric diagnosis be aired in the nursing literature.

The moral justification for classifying people into psychiatric diagnostic categories lies in its potential utility as a means to the goal of relieving human suffering. One argument asserts that not only do past and present psychiatric nosological systems fail at this effort, but that the diagnostic process and associated social phenomena perpetuate, if not actually create, the suffering they were allegedly intended to alleviate. On the other side of the diagnostic issue are those who view diagnosis as simply a potentially useful instrument. As with all instruments, however, it is vulnerable to misuse that can be destructive.

A prime example of misuse occurs when a psychiatric label is used to effect political or social discrimination rather than to guide treatment. The problem here is in application of psychiatric diagnosis not inherent in the instrument itself. Where the two arguments seem to possibly interface is in the belief that a reliable and valid diagnostic system, when applied with objectivity and sensitivity, could be of human value. The ideal is to achieve a utilitarian interface between the two horns of the dilemma.

Indictment

Two basic questions raised by those who view psychiatric diagnosis as an immoral practice are: 1) Just what is meant by the term, mental illness; and 2) Does such a condition exist? At the far end of the continuum are advocates of Szasz’s (1961) philosophy who contend that illness in the real sense is necessarily biologically demonstrable (their arguments were launched prior to the present era of biological theorists who now can demonstrate biochemical alterations associated with mental illness). According to Szasz, however, what are commonly called mental illnesses are actually problems in living, arbitrarily categorized according to the needs of society. In other words, diagnosis is used as a means of affecting control over individual idiosyncracies falling too far outside of the confines of social norms and interfering with...
homogeneity and homeostasis.

Less concerned with questions of etiology and more with the course of the phenomenon are the labeling theorists. Scheff (1966) believes that deviant behavior is of diverse origin and initially manifests itself in an unstructured, individually specific way. The transience or permanence of the deviant behavior is determined by societal feedback. Determinants of the kind of feedback are factors such as the frequency and visibility of the behavior and the tolerance of the culture.

Those more politically daring go so far as to say that position in the social hierarchy is the real determinant. They point to statistics such as the disproportionate number of certain socially undesirable subgroups involuntarily incarcerated in mental hospitals, i.e., the elderly, the indigent, and the politically dissident (Mechanic, 1980). If the manifest behavior is disruptive or salient enough to be focused upon, it is explicitly labeled and implicitly stabilized cognitively, through stigma and stereotype, and practically, by way of social ostracization, job discrimination, and involuntary commitment. When the individual integrates this feedback into his self-concept, he takes on the role of a mentally ill person, acting in accordance with socially contrived guidelines. The built-in “Catch 22” here is that non-acceptance of the feedback is deemed lack of insight, which is used as another symptom or evidence of mental illness (Scheff).

Labeling theorists believe that cross-cultural observations are supportive of this process. Anthropologists have noticed great similarities in the way mental illness manifests within a culture and great differences between cultures. “Pathoplasic” is a term coined to identify such cultural scriptors (Burdock, 1982). Examples are the oriental tendency towards somatization, or the Christian proclivity towards delusions of guilt.

The impact of the cultural frame of reference is taken even further by Mechanic, who believes that the same behavior might be treated with disdain in one culture, respect in another, and ignored in still another (i.e., witch versus witch, doctor versus eccentric). Psychiatric diagnostic systems are instruments through which this cultural relativism is made to look generic. Prior to DSM-III, these instruments were also defective. Critics cryptically point out that conversion from schizophrenia to manic depressive illness can be accomplished simply by crossing the Atlantic, referring to the American preference for thought disorders and the British for affective illnesses (Kendall, 1973).

Rosenhan’s (1973) much publicized “insane” experiment tells of eight pseudopatients’ presentation at a psychiatric hospital with the sole complaint of “hearing voices.” Upon psychiatric evaluation all were diagnosed as schizophrenic, prescribed major tranquilizers, and hospitalized. One wonders why a system of such low reliability remained in use. The purported purpose, i.e., implementing assessment and directing treatment was not being accomplished with any accuracy.

Aside from this basic failing are the consequences of the system itself as outlined by labeling theorists. Rosenhan asserts that when there is a great deficit of knowledge in a particular area, the tendency is to invent some. In the psychiatric arena such a practice is ethically very dangerous. The autonomy of individuals caught in the system is compromised and they are treated with malevolence, possibly on totally false pretenses.

Defense

Despite the chronic debate over the existence of mental illness, not to mention disagreement over etiology and treatment, people continue to voluntarily seek the help of mental health professionals for problems involving some kind of manifest, subjective disturbance in well-being. Mental disorder, according to DSM-III, is defined as distress and/or dysfunction. This self-identified request for help clearly justifies and perhaps obligates response from members of the psychiatric community.

Psychiatry is a relatively young discipline. It is not unusual at this early formulative stage of a discipline to find ideological dissonance and political controversy over treatment approaches. Nor is it surprising that the degree of controversy would be inversely proportional to the amount of validated theory (Spitzer, Endicott, & Rubins, 1975). It is also characteristic of a young science to be more in the business of description than analysis and prediction. Basing psychiatric diagnoses on factors such as etiology and prognosis would be grandiose at this point, given the number of variables still unknown (Akiskel, 1978; Burdock, Sudlovsly, & Gershon, 1982).

Assuming the limitations dictated by the state of the art, it remains the belief of many that nosological systems are of ethical and practical value. Justifying this idea involves identifying the purpose of the mechanism and evaluat-
ing its application and efficacy. Cited raisons d'être include: facilitating development of the science itself by providing an operationalized, interdisciplinary vocabulary to stimulate research and enhance communication, defining the boundaries of the phenomena to be focused upon, and organizing complex and exhaustive information into a more concrete form by establishing indicative links (Campbell, 1981; Wilson & Williams, 1982).

**Discovery and Intervention**

From a more pragmatic and direct angle is a seemingly logical assertion that diagnosis is a fundamental part of the assessment process and assessment is a preliminary step toward etiological discovery and intervention (Strauss, 1975). Accurate assessment is not easily achieved in a field where the focused upon phenomena are for the most part intangible. The direction, however, has been toward increased accuracy and the criticisms, though not without some grounding in truth, certainly are exaggerated (Skodol & Spitzer, 1982).

That the mechanism of identification is actually the mechanism of creation in terms of mental illness is an idea with supposed cross-cultural backup, as outlined earlier. Evaluation of the same evidence from a different perspective, however, yields quite different conclusions. Kiev (1972) and Murphy (1976) take the position that although the specific content of manifest illness is culturally dictated, the underlying process is more universal than relative.

In evidence are put forth observations such as the incidence of disturbed thought processes and behavior in almost all cultures studied. Also offered as evidence is the fact that in most of these cultures these phenomena are salient enough to be given a specific name (Murphy). Despite vast differences in diagnostic lingos and ideas about etiology and treatment, there is proportionate equivalence in studied cultures of the prevalence of mental problems (Murphy).

Supporting data closer to home are found in Wing's (1982) analysis of the effects of deinstitutionalization in the U.S. He correlated increased rates of deinstitutionalization with increased rates of destitution and suicide. He also examined destitute and self-destructive people who had never entered the mental health system and found strikingly similar symptomatology to those institutionalized for years. This suggests something essential as opposed to contextually dictated in the disintegration process.

Attacks on the reliability of nosological systems have been exaggerated and sensationalized. Spitzer's (1976) analysis of the Rosenhan Experiment points out that what was actually proven is that people faking a symptom of a serious mental illness are likely to be treated on the basis of their complaint. He uses the analogy of the internist confronted with an individual manifesting hematemesis after drinking a quart of blood.

Chances are the assumption would be internal bleeding and treatment according to the usual standard. He also notes that "schizophrenia in remission," the final diagnosis of the eight pseudopatients, is highly atypical and connotes diagnostic confusion on the part of the evaluators.

That this is evidence of a bias toward active treatment in uncertain situations is conceded, but not global diagnostic incompetence. Sensationalized criticism has served to devalue diagnostic systems to the point that further refinement has been stifled, if not pushed backward (Spitzer, 1976). In light of the fact that in all contexts there seem to be people who need help getting along in life, critics who irresponsibly attack systems of ethical intent because of misapplication, seem themselves unethical.

**Toward Utility**

The low reliability of past diagnostic systems is well established and inherently limits validity. Sources of, and solutions to this problem are succinctly outlined by Spitzer et al (1975) and are as follows:

1) **Subject Variance.** Addresses the fact that a person's problems may change over time, from one condition to another, or from different phases of the same. Incorporating this variance into the diagnostic process might decrease the incidence of the "once a schizophrenic, always a schizophrenic" thinking thereby decreasing the risk of labeling effect.

2) **Information Variance.** The clinical picture may be very different depending on the data source, i.e., patient versus family versus history. A more structured clinical interview dictating consideration of all information sources would broaden the perspective and minimize the chances of exploitation by history or a maleficient informant.

3) **Observation and Criterion Variance.** Referring to the
selective attendance of clinicians according to their etiologic orientation. Descriptive emphasis affords common ground among approaches and specific inclusion and exclusion criteria for specific diagnostic categories help decrease the risk of biased interpretation of information.

The solutions were considered in the development of Multiaxial DSM-III. In addition, there was an attempt to incorporate the interplay of the individual and society by considering variables such as stressors and level of past adaptive function on discrete axes. This effort toward a more ideal instrument necessitates capitalizing on a maximum amount of existing knowledge and translating it into a utilitarian form. The translation should foster communication about the phenomena between all vested persons, i.e., interdisciplinary team and patients (Strauss, 1975).

The aim of interdisciplinary communication has presented a conflict for a discipline struggling to identify its treatment territory, like psychiatric nursing. Theorists have emphasized a need to establish systems of assessment that differ from those of other disciplines in order to establish uniqueness of perspective (Roy, 1975). This aim at times seems to be at odds with our overriding goals and might, in fact, foster fragmentation of communication within the psychiatric disciplines. Wilson et al (1982) suggest that rather than an esoteric separatist focus, the psychiatric nursing perspective could be used to refine axes 4 and 5 of DSM-III since people's wholism, strengths, and interaction with their environments are vital parts of the nursing domain.

Incorporating current knowledge into diagnostic systems is becoming increasingly crucial with the recent progress in psychobiological research. Biological markers may provide external validity that previous and current systems lack and/or may actually redefine categories (Akiskal, 1975). Biological correlates proposed include level of urinary MHPG, which seems to vary with affective states; platelet MHO activity, perhaps a genetic marker for schizophrenia; and sleep patterns correlated with phases of affective disorders.

One of the cardinal tenants of ethics is that no black and white exists in life, only grey. Psychiatric diagnostic systems are neither perfect, nor useless. Labeling theorists are not all right, nor are they all wrong. Perhaps the answer will come from incorporating knowledge from all points of view with the guiding principle being the beneficence of the identified patient as opposed to any social or political goals or the vested interests of individual disciplines.

References

DIAGNOSTIC LABELING
KEY POINTS

Diagnostic Labeling: The Rotten Apple Stigma.

1. Publication of the DSM-III, the evolution of the nursing diagnosis movement, and health policy changes based on prospective payment and DRG raise not only administrative and clinical issues but ethical ones as well.

2. An ethical dilemma surrounds diagnoses of psychiatric disorders: one position asserts that classification of human beings is unrelated, of questionable validity, and inconsistent with nursing's goals of humanitaniism and individualized care; another asserts that generating and testing nosological systems is both ethically just and clinically pragmatic.

3. Resolution of ethical dilemmas around diagnostic classification systems will depend not only on the refinement of the approach for categorizing psychiatric disorders but also from interdisciplinary communication of knowledge and findings among professionals who keep as their guiding principle the benefit to the patient.