Diagnosis in the field of psychotherapy: A plea for an alternative to the DSM-5.x

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Purpose. This paper studies how diagnosis is currently conceptualized in the field of psychiatry, and examines whether this mode of diagnosis is relevant for psychotherapeutic intervention.

Method. Narrative literature review was used in this study.

Results. In the context of the DSM, diagnosis is equated with classification. Symptoms and complaints are approached in terms of a medical semiological model, and are seen as signs of underlying illness processes. In discussing this approach the author makes use of Gottlob Frege’s theory, in which three aspects of a sign are discerned: the reference/referent or Bedeutung, the sense or Sinn, and the representation/idea or Vorstellung. Based on this distinction, it is argued that in the transition from the DSM-III to the DSM-5 much effort has been taken to disambiguate the sense attributed to symptoms and complaints, while person-specific ideas and representations have been excluded. This exclusion of the Vorstellung is criticized, both from a psychiatric and a psychotherapeutic perspective. Subsequently it is argued that whereas the DSM-III and DSM-IV avoided strong statements on etiology, the DSM-5 makes clear choices. The DSM-5, and more recently the RDoC group within the NIMH, aims at developing systems of classification that start from the assumption that psychiatric disorders are brain disorders. It is argued that by doing so a referent is classified that is different from the object of intervention that psychotherapeutic theories are concerned with.

Conclusion. Such a view of diagnosis is not workable for psychotherapy. The exclusion of personal experiences associated with symptoms and complaints is problematic and the referent that recent psychiatric classification uses, that is, brain processes, is not compatible with the referent that psychotherapeutic theories use. Case formulation can be seen as an alternative to standard classification.

Practitioner Points

• A clear distinction between classification and diagnosis should be made.
• Psychotherapeutic diagnosis cannot exclude information on the embedding of problems in broader life contexts.
• Case formulation is a viable alternative to classification.

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As one examines handbooks on diverse forms of psychotherapy, one cannot but observe that making an accurate diagnosis is seen as crucial to the therapeutic process. Within descriptions of psychotherapy in the context of evidence-based health care, this is all the more obvious. In evidence-based mental health care, which is contested (Berrios, 2010; Westen, Novotny, & Thompson-Brenner, 2004), specific therapy protocols are designed and recommended for specific disorders. Psychiatric classification is thereby seen as a prerequisite for good psychological treatment.

However, this explicit concern about classifying mental disorders did not always occupy such a central role for psychotherapists and clinical theoreticians. For example, in his text ‘The Direction of Treatment and the Principles of its Power’, psychoanalyst Jacques Lacan (1958) discusses the goals and guidelines for clinical intervention in psychoanalysis, but does not build his arguments on diagnostic criteria. Similarly in his classic book ‘On Becoming a Person’ Carl Rogers (1961) extensively discusses the process of psychotherapy, but like many other psychotherapists he does not connect diagnostic considerations to his clinical method. The other way around, the discipline of descriptive psychopathology did not start with the aim of guiding psychological intervention. Most authors were guided by neurological theories and concerns, and aimed at grouping symptoms in terms of underlying medical syndromes (Berrios, 1996). Kraepelin (1907, p. 117) expressed this belief as follows: ‘Judging from our experience in internal medicine it is a fair assumption that similar disease processes will produce identical symptom pictures, identical pathological anatomy, and identical etiology’. The question as to how verbally based psychotherapies can be attuned to such medically oriented diagnoses was not a concern to most authors in the domain of descriptive psychopathology.

In this paper, I examine how authors in the field of (the philosophy of) psychiatry currently think about diagnosis. Etymologically, the word ‘diagnosis’ stems from the Greek verb ‘diagignoskein’, which means ‘to discern’ or ‘to distinguish’, as well as ‘to know thoroughly’ (Harper, 2011). Here I aim to examine what exactly it is that they want to discern, distinguish, or know thoroughly. My intermediate conclusion will be that in psychiatric diagnosis symptoms and dysfunctions are detected and treated like signs. Starting from Gottlob Frege’s philosophical theory of signs, I subsequently argue that considered from the perspective of psychotherapy one cannot be satisfied with such a semiological approach to diagnosis: it neglects that what is person-specific about a symptom or a mode of dysfunction, which is precisely what psychotherapy should focus on. Note that when using the concept ‘psychotherapy’ in this paper, I refer to Freud’s (1890, 1905) interpretation of the concept as the method(s) of treating symptoms or modes of dysfunction that start from words and speech.

**The Diagnostic and Statistical Manual of Mental Disorders**

Nowadays, diagnosis increasingly starts from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. All around the world, the DSM is used as a foundation in diverse domains such as psychiatry, health insurance, care management, pharmacy, and education (Pilgrim, 2007; Strand, 2011). The handbook is frequently criticized for its poor scientific basis (Bentall, 2004; Kutchins & Kirk, 1999); for its all-encompassing impact on our thinking on mental health and social behaviour (Watters, 2010; Whitaker, 2010); for its financial ties with pharmaceutical industry (Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006), and for its use as a
basis for disciplinary practices in contemporary society (Bailey, 2010; Hacking, 1998). Characteristically, DSM-based diagnosis aims at detecting mental disorders in individuals, thereby generating an inventory of such disorders: ‘DSM-IV is a categorical classification that divides mental disorders into types based on criterion sets with defining features’ (American Psychiatric Association, 1994, p. xxii). In total the most recent version of the DSM, the DSM-IV-TR (American Psychiatric Association, 2000), discerns 264 clinical disorders, 10 personality disorders as well as a number of ‘not otherwise specified’ categories. DSM-5\(^1\) (publication scheduled in 2013), the next edition will probably contain more than 300 diagnostic categories (American Psychiatric Association, 2011). For each disorder inclusion and exclusion criteria are defined, based on which one can decide from which disorder a person is suffering: problems are situated relative to a taxonomic list of possible disorders, and identified in terms of criteria that make up classes of disorders.

As evidenced in various texts, people developing the DSM-5 will follow a similar logic (American Psychiatric Association, 2011; Kupfer, First, & Regier, 2002; Kupfer & Regier, 2011; Rounsaville et al., 2002): ‘DSM-5 does not represent a radical departure from the past’ (Kupfer & Regier, 2011, p. 673). The main innovation in the classification of mental disorders that will possibly be included in the DSM-5 is that separate disorders will be grouped in terms of disorder spectra or clusters (Bernstein, 2011). Although the DSM-III and DSM-IV assumed that disorder categories are clearly distinct, which eventually led to an increase in the diagnosis of co-morbidity and difficulty classifying patients with vague symptoms, the DSM-5 will more strongly build on a dimensional assessment. The idea thereby is that dimensional assessment instruments will be used for grouping ‘syndromes within broad diagnostic categories’, and evaluating ‘supraordinate dimensions that cross current diagnostic boundaries’ (Regier et al., 2009, p. 649). For example, for the diagnosis of recurrent major depressive disorder this could imply that next to making a categorical decision as to whether or not the disorder is present, the severity of symptoms or global illness is rated on a Likert scale (American Psychiatric Association, 2011). In terms of broader diagnostic categories, it has been suggested that depressive disorders and anxiety disorders may make up an ‘internalizing cluster’ (Bernstein, 2011, p. 7). Irrespective of these changes, DSM-5 will continue to maintain a medical semiotic approach of symptoms and complaints, which I discuss in the next section.

**Psychiatric diagnosis qua medical semiotics: On the sense and representation of symptoms and complaints**

As a first step in my critique, I will now indicate that DSM diagnosis follows a neopositivist approach, and merely considers symptoms and complaints as signs of an underlying disorder. Neopositivism asserts that the only valid knowledge is of the world is gained via experimental research along the lines of natural sciences. Within this view, disorders are thought to be determined by laws of nature that are independent of time, individual

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\(^1\)Although in earlier texts, the upcoming version of DSM is announced as DSM-V (e.g., Kupfer et al., 2002; Regier, Narrow, Kuhl, & Kupfer, 2009) recent texts announce it as DSM-5 (e.g., Bernstein, 2011; Kupfer & Regier, 2011), meaning that the Roman numerals are replaced by Arabic numerals. Moreover, subsequent versions have already been announced as DSM-5.1 and DSM-5.2 (Kupfer & Regier, 2011, p. 673), whereby changes in the classification system are announced like upgrades in software packages.
and culture, which implies that symptoms and complaints are treated as if they were objective indicators of disease. Although from a neopositivist perspective one would expect that this leads to more accurate and reliable diagnosis, I point out that this is not the case, and that there are good reasons to believe that the DSM approach of symptoms and complaints is fallacious.

DSM diagnosis fits well within the tradition of medical semiotics whereby symptoms, complaints and behaviours are qualified as signs or objective indicators of an underlying syndrome-like disorder (Eco, 1976). The prospective patient is thereby seen as a sender of signs of illness, which the diagnostician qua receiver needs to decode. For this decoding process to be successful it is crucial that the receiver possesses the code whereby the sign can be interpreted. In psychiatric diagnosis, as performed within DSM, the handbook with its list of disorders and their criteria make up the code.

DSM severity assessment, whereby symptom/syndrome severity should be rated on a quantitative dimension, also fits within this medical semiotic model. Interestingly, APA president Carol A. Berstein (2011, p. 7) thinks of quantitative dimensions in psychopathology ‘in analogy with blood pressure or measures of blood lipids’. They are seen as parameters that should be measured with an instrument and then interpreted. What is assessed is the signal strength of a sign a sender is transmitting. Characteristically, the usefulness of such measurements depends on the availability of norms. For example, for blood pressure, a ratio of 140/90 mmHg for systolic blood pressure over diastolic pressure is typically considered as indicative of hypertension. Based on such norms, quantitative measurement of the signal strength conclusions are drawn as to whether a problem or dysfunction is present, absent, or marginally present.

To further characterize the way in which signs are treated within such a medical semiotic approach to symptoms, complaints, and behaviours, I suggest using Gottlob Frege’s (1892a, 1892b) distinction between three aspects of the sign: i.e. the reference/referent or Bedeutung of a sign, the sense or Sinn of a sign, and the representation/idea or Vorstellung of a sign. Frege discussed this distinction in an epistemological reflection on linguistic signs, and did not connect it to medical semiotics. Yet, I think his theory is relevant for further framing our discussion on the nature of diagnosis. In Frege’s work, the reference/referent concerns the object in the real world that the sign designates. It is the object as knowable via direct sense impression (Frege, 1892b). The sense, in its turn, concerns ‘the mode of presentation’ of a sign (Frege, 1892a, p. 153). It is the meaning commonly attributed to a sign: ‘The sense of a proper name is grasped by everybody who is sufficiently familiar with the language or totality of designations to which it belongs’ (Frege, 1892a, p. 153). The classic example Frege (1892a) uses to differentiate between Sinn and Bedeutung is the ancient distinction between the ‘morning star’ and the ‘evening star’. The morning star is the name given to the planet Venus when it appears east before sunrise, and the evening star is the name given to Venus when it appears west after sunset. In both cases the reference is the same, that is, the planet Venus qua celestial body, while the sense in people’s discourse differs dependent on being called morning star or evening star. Frege’s notion of the Vorstellung is the least well-known component he distinguishes in a sign. It concerns the representation that takes shape in the mind of an individual. He describes it as ‘an internal image, arising from memories of sense impressions which I have had and acts, both internal and external, which I have performed. Such an idea is often imbued with feeling; the clarity of its separate parts varies and oscillates . . . The idea is subjective: one man’s idea is not that of another’ (Frege, 1892a, p. 154). Although Sinn concerns the shared concept or common sense that a sign evokes, the Vorstellung concerns
an individual’s associative memory network, with subjective impressions and affective connotations.

Considered from the perspective of Frege’s distinction between reference/referent, sense, and representation/idea, it is quite obvious that this last dimension is excluded from the medical semiotic approach of the DSM: individual complaints are transposed in standard psychiatric language. This transposition effaces the Vorstellung side of a symptom or complaint, and focuses completely on the common sense interpretation on what a given type of symptom or complaint might indicate. Note that in his discussion of Vorstellung, Sinn, and Bedeutung, Frege (1892a) similarly puts the idiosyncratic representations/ideas that are connected to the sign aside, and particularly focuses on the relation between sense and reference. In his discussion of semiotics in relation to science, Eco (1976) suggests that such focus bears witness to a neopositivist approach to signs and science. The methodological consequence of such disambiguation is that the reliability of psychiatric classification should be enhanced, meaning that different raters should be more consistent in their judgement of given cases. Attaining more reliable classification by developing a straightforward descriptive language that is relatively free from theoretical terms was an objective that the developers of the DSM-III and DSM-IV considered of paramount importance (Decker, 2007; Strand, 2011; Verhaeghe, 2004). Against the background of critical studies on the unreliability of psychiatric diagnosis in the late 1960s and 1970s (Rosenhan, 1975; Sandifer, Hordern, & Green, 1970; Spitzer & Fliess, 1974; Temerlin, 1968), they aimed at standardized categorization and increased inter-rater reliability. Those in charge of the DSM-5 often praise this focus taken in the DSM-III and DSM-IV and present it as a scientific achievement (Bernstein, 2011; Kupfer et al., 2002; Kupfer & Regier, 2011; Stein et al., 2010). However, this is a position not everyone agrees with. Several authors, such Kutchins and Kirk (1997), demonstrated that the frequently mentioned ‘good reliability’ of the DSM-III and DSM-IV is largely exaggerated and actually not substantially better than reliabilities observed in the 1960s and 1970s. For example, in a study focusing on conduct disorder Kirk and Hsieh (2004) created a vignette with a short description of a youngster. The vignette was attuned to the diagnostic criteria of a conduct disorder, as defined in the DSM-IV. Starting from this short description, a sample of 1,334 psychiatrists, psychologists, and social workers who had broad experience in working with youngsters (20.7 years of age, on average) was asked to give a DSM diagnosis. Assessors differed substantially in their diagnosis: only 45.5% actually diagnosed conduct disorder, and in total 29 different DSM clinical disorders were suggested qua main diagnosis. This indicates that consistency in diagnosis is weak. Further examination of the data set demonstrated that information about the youngster’s ethnic background influenced the diagnosis significantly, and that depending on their professional specialty and their years of experience, diagnosticians gave significantly different diagnoses (Pottick et al., 2007).

Moreover, the chair of the DSM-IV task force, Allen Frances, indicated that their system also provoked erroneous classification, which goes against the idea that the neopositivist approach of DSM diagnosis enhances unambiguous and correct decision making: ‘DSM-IV was an unwitting contributor to three false positive “epidemics.” Its publication coincided with high rates of attention deficit hyperactivity disorder, autistic disorder, and childhood bipolar disorders’ (Frances, 2010, p. c1168). Based on his appreciation of the currently available diagnostic criteria of the DSM-5 (American Psychiatric Association, 2011), Frances (2010, p. c1168) believes that the DSM-5 ‘could potentially set off at least eight new false positive epidemics of psychiatric disorder’. The disorders he mentions are binge eating, mixed anxiety depression, minor neurocognitive problem risk of psychosis,
temper dysregulation, ADHD, bipolar disorder, and major depressive disorder. Wakefield (2010) offers a similar critique and indicates that ever since DSM-III was developed, the problem of false positives remains unaddressed, as a result of which common mental distress is often diagnosed as a disorder.

In my opinion, the most fundamental choice made in DSM diagnosis consists of effacing the Vorstellung side of an individual’s problem completely. The assumption thereby is that by focusing on the sense psychiatrists commonly attribute to descriptive criteria of given disorders, an individual’s problem can be adequately grasped. The criticism of false positives and overestimated reliability put this assumption into perspective.

More fundamentally the elimination of the Vorstellung side has been put in question by Markova and Berrios (2009). In their view, the structures underlying mental symptoms and subjective complaints should be primarily seen as unstable, and as dissimilar to structures underlying objects such as tables or trees. In their view, the structure of a mental state such as ‘depressed mood’ is fuzzy because it depends on the individual judgment of the person experiencing the state. In their view mental symptoms are above all personal constructs: ‘They are constructs in the sense that subjects create sense or construct a meaning out of an inchoate preconceptual and preverbal experience. They are personal in that although social and cultural influences will help their articulation, the experiences themselves are unique to the individual and inaccessible to anyone else’ (Markova & Berrios, 2009, p. 344). Interestingly, this philosophical view is largely supported by psychometric literature on self-report questionnaires. Studies that examine the construct validity of questionnaires and test how well items represent theoretically presumed structures usually observe large amounts of residual variance. This indicates that of the mathematical variability in people’s answers on questionnaire items, only modest proportions can be explained by overarching models on the questionnaire’s factor structure. Take, for example, the Beck Depression Inventory-II (Beck, Steer, & Brown, 1996). This widely used questionnaire was developed in terms of the DSM-III criteria for depressive disorder, and in the development version of DSM-5, it is mentioned as a tool that could be used in psychiatric diagnosis of depressive disorder (American Psychiatric Association, 2011). The instrument is believed to be interesting for dimensional assessment of depressive symptoms because it measures a somatic-affective and a cognitive dimension of depression (Beck et al., 1996). Several studies, one of which I and my colleagues completed (Vanheule et al., 2008), have documented that this instrument has satisfying psychometric properties. However, what our data also make clear is that large amounts of variance remain unexplained by accepted factor models. For example, in a sample of 404 mental health patients, we observed that if one assumes that the Beck Depression Inventory-II measures a somatic-affective and a cognitive dimension of depression, on average 58% of the variance in the items remains unexplained. Variability between individuals interpretation of items is bigger than the common meaning they attribute to the items. Exclusively focusing on the Sinn side of depressive complaints, as articulated via this questionnaire, consequently implies that a substantial component of people’s experience is neglected. In my opinion such exclusion of the person-specific or Vorstellung side of mental symptoms or complaints is problematic.

Similarly, Markova and Berrios (2009, p. 346) also argue that the clinical signs psychiatrists typically take into account when judging an individual’s state of mind cannot be considered as entities with a stable structure: ‘the constructs involved relate to the judgments made by clinicians and we have seen how these will depend on
manifold factors (e.g., experience, personal biases and mood) which, being neither fixed nor consistent, will serve to destabilize the structure itself. They quite strongly conclude that ‘for their formation and naming mental symptoms may depend less on (their necessary) brain inscription than on factors relating to the individual, the society, the culture, the particular state of disciplinary understanding and so on’ (Markova & Berrios, 2009, p. 348).

In addition to this general critique on the exclusive focus on the sense of symptoms and complaints in current psychiatry, it could be argued that from the perspective of psychotherapy, the assumption that problems of people requesting psychotherapeutic help can be adequately appraised while excluding the Vorstellung side of symptoms and complaints is more deeply problematic. First of all, the utility of the DSM is limited. For many people who apply for psychotherapeutic help, it is difficult to give a categorical DSM diagnosis before therapy gets started. Studies demonstrate that about 50% of the patients consulting for psychotherapy cannot be classified within the DSM system because their problems do not fit within one of the disorder categories or do not cross thresholds for any diagnostic category. (Goldfried, 2000; Westen et al., 2004). A second reason why building on DSM diagnoses is problematic in the context of psychotherapy is more fundamental, and concerns the exclusion of the Vorstellung side of complaints. The DSM excludes the lived experience of symptoms and complaints. It leaves an individual’s subjective interpretation of his own condition out of consideration, and neglects the contextual embedding of symptoms and complaints in memories, relationships, life narratives, existential events, as well as social and cultural situations. It also ignores variability in the experience of symptoms and complaints both in one individual and between individuals. Because of this, many psychotherapists explicitly argue for the opposite, and indicate that the Vorstellung side of symptoms and complaints is of utmost importance for psychological therapies, which brings them to prioritizing case-formulation (e.g., Johnstone & Dallos, 2006). For example, such focus on the case-specific meaning and significance of symptoms can be found in Freud’s theory. Throughout his work, Freud (e.g., Freud, 1918; Freud & Breuer, 1895) discussed patients’ symptoms and problems in terms of their associative memories and the life events that provoked surprise, conflict, or pain. Diagnostic labels are used secondarily in terms of exploring and explaining the precise nature of a patient’s problems. More radically, Lacan (1958, 1959; Vanheule, 2011) suggests that the symptoms an individual presents with should be studied in the context of specific lines of speech or particular signifiers a person uses. Full attention thereby goes to issues like the embedding of these signifiers in broader lines of speech and free associations or to the way in which existential issues are at stake, which are clearly different between individuals and variable over time. A similar plea for prioritizing the Vorstellung side of complaints in any diagnosis can also be found in theoreticians of a completely other psychotherapeutic orientations. For example, in their plea for using behavioural analysis, which they consider as an alternative to diagnostic classification, Kanfer and Saslow (1965, p. 533) stress the need of studying ‘the circumstances of the patient’s life pattern, relationships among his behaviours, and controlling stimuli in his social and his private experience’. Starting from learning theory they suggest that diagnosis should primarily focus on behaviour patterns, and on the personal experiences in which these patterns are embedded. Cognitive-behavioural therapists continue to endorse such a view, and add that not only behaviours, but cognition and moods also need to be included in such an approach (e.g., Grant et al., 2008; Tarrier, 2006). This focus on the Vorstellung side of symptoms and complaints in psychotherapy, goes against the neopositivist assumption that disorders
are independent of time, individual, and culture. As indicated the DSM system holds such assumption and believes that disorders are determined by natural laws. In the next section, I address how key figures in the development of DSM-5 think of these natural laws.

**Psychiatric diagnosis qua medical semiotics: On the reference of symptoms and complaints**

A further question we can ask is how the DSM deals with the reference or *Bedeutung* of symptoms and complaints. I will indicate that in contrast with earlier versions of the handbook, those in charge of DSM-5 radicalized the medical model that was followed since DSM-III, and advocate a strong belief in the neurobiological nature of mental disorders. Openness to psychological theories of mental functioning possibly disappears from the DSM-5.

According to Frege, it is quite crucial that any scientific discipline answers the question of which issue or object in the real world it is concerned with: ‘Of course in fiction words only have a sense, but in science and wherever we are concerned about truth, we are not prepared to rest content with sense, we also attach a *Bedeutung* to proper names and concept words’ (Frege, 1892a, p. 173).

At this level, a clear change can be observed in the transition between the DSM-III and DSM-IV on the one hand and DSM-5 on the other. A criticism several key figures in the development of the DSM-5 give is that earlier versions of the handbook were inadequate at that level: ‘diagnoses in the DSM-III, DSM-III-R, and DSM-IV are best understood as useful placeholders, based on careful description, but not on deeper understanding’ (Bernstein, 2011, p. 7). The DSM-5, by contrast is far more ambitious and aimed ‘to carve nature at its joints’ (Regier et al., 2009, p. 648). This claim, which uses a metaphor from Plato’s Phaedrus, makes clear that in its classification the DSM-5 assumes that mental disorders are natural kinds, meaning irreducible entities that are rooted in natural laws (Bird & Tobin, 2010; Keim Campbell, O’Rourke, & Slater, 2011). The laws that are thereby thought to be operative are neurobiological and are far removed from psychotherapeutic assumptions concerning the laws or processes that make up mental disorders.

Indeed, in different publications, key figures in the development of the DSM-5 voiced the idea that mental disorders should be thought of as neurobiological entities. According to Stein et al. (2010, p. 1760), the term ‘mental disorder’ is deceiving and could be replaced by ‘psychiatric disorder’ ‘insofar as it emphasizes that these conditions are not purely “mental” and that the line between “psychiatric disorder” and “other medical disorders” is not distinct’. In a collaborative article on the future of psychiatry, Kupfer – the chairperson of the DSM-5 taskforce – and colleagues even go a step further and use the term ‘complex brain disorder’ instead of ‘mental disorder’ (Reynolds, Lewis, Detre, Schatzberg, & Kupfer, 2009). In their view psychiatry is above all a ‘clinical neuroscience’, with the help of which ‘a deeper understanding of causal pathways to major neuropsychiatric illness is evolving, thus rendering artificial the boundary between psychiatry and neurology’ (Reynolds et al., 2009, p. 2). Similarly Insel (2010, p. 749) and colleagues, who are working on the so-called Research Domain Criteria (RDoC) project of the US National Institute of Mental Health (NIMH) state that ‘mental disorders can be addressed as disorders of brain circuits’.

Accordingly it has been argued that psychiatric classification should no longer be descriptive, but be more strongly attuned to advances in the field of biological psychiatry.
In the research agenda formulated for the DSM-5, this objective was formulated as follows: ‘It is our goal to translate basic and clinical neuroscience research relating brain structure, brain function, and behavior into a classification of psychiatric disorders based on etiology and pathophysiology’ (Charney et al., 2002, p. 70) and ‘It is our hope and expectation that through advances in animal models, genetics, neuroimaging, and postmortem investigations psychiatry will ultimately have a diagnostic system based on etiology and pathophysiology’ (Charney et al., 2002, p. 71). These quotes demonstrate that a basic theoretical assumption of the upcoming DSM-5 classification is that neurobiological disturbances cause mental disorders. A further belief that is expressed in the quotes is that neuroscience can and should inform decisions about the kind of disorders and the kind of classification criteria the system builds on. Therefore, it was suggested that neurobiological parameters should be included in the defining features of disorders: ‘The readiness of biological markers to serve as associated features, risk factors, or diagnostic criteria will be of major concern’ (Regier et al., 2009, p. 649).

However, in recent publications the tone has changed somewhat: ‘we anticipated that these emerging diagnostic and treatment advances would impact the diagnosis and classification of mental disorders faster than what has actually occurred’ (Kupfer & Regier, 2011, p. 672). The message is that biological evidence helped in distinguishing disorders and grouping disorders into spectra, but will not make up the criteria sets: ‘While not central to the criteria themselves, this information is nonetheless useful and informative for helping DSM provide a more precise picture of the clinical realities of psychiatric diagnosis’ (Kupfer & Regier, 2011, p. 672).

The hope now is that the RDoC project of the NIMH will enable the formulation of a nosological classification system that is predicated on a neuro-scientific basis, and that starting from this outcome the DSM will be further adapted: ‘we believe this initiative will be very informative for subsequent versions: DSM 5.1, DSM 5.2, and beyond’ (Kupfer & Regier, 2011, p. 673). The following four quotes make it clear that the assumptions and mission of the RDoC project are at any rate clear: ‘The NIMH is launching the Research Domain Criteria (RDoC) project to create a framework for research on pathophysiology, especially for genomics and neuroscience, which ultimately will inform future classification schemes’ (Insel et al., 2010, p. 748); ‘the RDoC framework assumes that data from genetics and clinical neuroscience will yield biosignatures that will augment clinical symptoms and signs for clinical management’ (Insel et al., 2010, p. 749); ‘RDoC are intended to ultimately provide a framework for classification based on empirical data from genetics and neuroscience’ (Insel et al., 2010, p. 749); and ‘NIMH views RDoC as the beginning of a transformative effort that needs to succeed over the next decade and beyond to implement neuroscience-based psychiatric classification’ (Insel et al., 2010, p. 750). What the quotes demonstrate is a strong belief in genetics and neuroscience. In terms of Frege’s theory, these ought to make clear the true reference or biosignature underlying psychiatric symptoms and complaints, such that in a next step, symptoms and complaints can be grouped more validly in disorder categories.

Considered historically, the development of such a classification system would be the icing on the cake of the so-called neo-kraepelinian movement in psychiatry that strongly influenced the development of the DSM-III. Fundamental to the development of the DSM-III was the work of the so-called Washington University Group, of which Eli Robins, Samuel Guze, and George Winokur were the leaders (Decker, 2007; Strand, 2011). In the 1960s and early 1970s, these US psychiatrists believed that modern psychiatry should adopt Emil Kraepelin’s descriptive approach, and argued that only empirical research
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with a strong focus on biology held any promise for psychiatry. They condemned psychoanalysis, and more broadly aimed at refuting psychological approaches of mental suffering. Kraepelin was attractive to them because of his classificatory focus and his assumption of biological causes underlying mental disease. Like a Linnaean botanist he studied cases, and more particularly the form with which these presented over time (Compton & Guze, 1995). By describing presenting symptoms, onset of symptoms, course, outcome, prevalence, predisposing factors, familial illness history, and risk factors, he aimed at detecting disease-specific biological abnormalities: ‘The principal requisite in the knowledge of mental diseases is an accurate definition of the separate disease process. In the solution of this problem one must have, on the one hand, knowledge of the physical changes in the cerebral cortex, and on the other of the mental symptoms associated with them’ (Kraepelin, 1907, p. 115).

In several works, authors from the Washington University Group praised this approach. They remained silent on Kraepelin’s speculations concerning specific biological disturbances in particular diseases – for example, Kraepelin thought that dementia praecox was caused by disease processes in the brain and paranoia by genetic degeneracy (Decker, 2007) – but used Kraepelin for promoting three main ideas. The first is that psychiatric discourse should be attuned to medical thinking. This implies that ‘concepts, strategies, and jargon of general medicine are applied to psychiatric disorders: diagnosis, differential diagnosis, etiology, pathogenesis, treatment, natural history, epidemiology, complications, and so on’ (Guze, 1992, p. 4). The second idea is that diagnosis in psychiatry comes down to classifying symptoms, complaints, and behaviours based on pre-established criteria (Feighner et al., 1972; Welner, Liss, & Robins, 1974). This brought them to make the now famous statement that ‘classification is diagnosis’ (Robins & Guze, 1970, p. 983, emphasis added). Crucial to this idea, is that they thus adopted a medical semiological stance. The underlying assumption, which can also be found in Kraepelin, is that disorders/diseases are entities in the real world and not subjective psychological states. The third idea they thus promote is that any further examination of mental disorders should start from ‘the primary organ of psychiatric illness’ (Compton & Guze, 1995, p. 200), that is, the brain. Indeed, in their view mental disorders are above all rooted in disorder-specific biological factors, which make up the real substance of which symptoms, complaints and behaviours are only the observable form. Hence Compton and Guze’s (1995, p. 200) statement: ‘the medical model is without a priori theory, but does consider brain mechanisms to be a priority’.

While Szasz (1961) harshly criticized such a medicalizing approach, and argued that mental suffering could not be thought of as a medical condition, these ideas were highly influential in the taskforce that elaborated the DSM-III and determined the way in which they shaped their diagnostic approach (Decker, 2007; Strand, 2011). In line with the Washington University Group the DSM-III taskforce adopted a medical discourse for reflecting on mental disorders, and removed DSM-I and DSM-II terms such as ‘neurosis’ or ‘psychological reaction’ from their diagnostic system. Likewise, they adopted a medical semiological stance and equated diagnosis with classifying disorders based on pre-established criteria. With respect to the third issue, that is, the link between observable disorder profiles and corresponding biological factors, Robert Spitzer, who chaired the DSM-III taskforce, avoided strong statements (Decker, 2007). The idea he advocated was that ‘the approach taken in DSM-III is atheoretical with regard to etiology or pathophysiological process’ (American Psychiatric Association, 1980, p. 7). Actually this is a most remarkable claim. Literally it says that mental disorders are made up by pathophysiological processes, yet, that at the level of specific neuropsychiatric models
and theories, the DSM-III takes no firm position. By creating ‘a framework for research on pathophysiology, especially for genomics and neuroscience, which ultimately will inform future classification schemes’ (Insel et al., 2010, p. 748), a framework that is promoted by the DSM-5 chair (Kupfer & Regier, 2011), RDoC seems to want to fill this gap, with the aim of finally attuning psychiatric classification to brain processes. Such classification system would be the crown glory of the project Kraepelin started, yet, for the time being it is a project leading psychiatrists believe in, and hope for, but that remains unachieved.

A question one could ask is whether this attempt to attune the classification of psychiatric disorders to brain processes will ever be successful. Surely, this attempt reflects a neopositivist approach of psychiatry qua discipline, whereby an ultimate disambiguation of the sense attributed to signs is sought by clarifying the link with the underlying object in the real world (see Eco, 1976). Critics such as Markova and Berrios (2009) do not believe that this project holds much promise. In their view, mental symptoms and behaviours are made up by idiographic components that resist generalization across cases: ‘as constructs with poorly defined boundaries whose determination is dependent on interpretation, mental symptoms are of a different order of data compared with for example rates of blood flow, concentrations of neurotransmitters or changes in contrast density’ (Markova & Berrios, 2009, p. 348). Furthermore, starting from systems theory several authors suggested that biological variables too, could better be seen as unstable entities. Critics such as Noble (2008) and Oyama (2000) suggest that biological variables are as much influenced by environmental factors, as they are influencing other domains of human functioning.

Considered from the perspective of psychotherapy, the project of classifying disorders in terms of brain processes is again more deeply problematic. Although in the DSM-III and DSM-IV it was still suggested that some disorders might have a psychological origin or might be the result of an interaction between biological, social, and psychological factors (American Psychiatric Association, 1980, p. 7), such openness to psychological theories of mental functioning seem to be absent from the DSM-5. The referents mentioned in texts by key figures for the development of the DSM-5, and by the RDoC group are only neurobiological, which evidently gives rise to reflection on neuroscientific models of intervention, rather than to modes of intervention in which speech is the major tool for change.

**Conclusion**

In this paper, I examined how diagnosis is currently conceptualized in the field of psychiatry and explored whether this mode of diagnosis is relevant for psychotherapeutic intervention. With reference to the etymological meaning of the term 'diagnosis', which means ‘to discern’ as well as ‘to know thoroughly’, I mapped how diagnoses are made. I argued that in the context of the DSM, diagnosis is equated with classification, and that the option of approaching symptoms and complaints in terms of an individualizing medical semiological model reflects a theoretical choice. Symptoms and complaints are thereby seen as signs of underlying illness processes. With the aid of Frege I subsequently discerned three aspects of a sign: the reference/referent or Bedeutung of a sign, the sense or Sinn of a sign, and the representation/idea or Vorstellung of a sign. Starting from this distinction I argued that in the movement between the DSM-III and DSM-5 much effort went to disambiguating the sense attributed to symptoms and complaints, while person-specific ideas and representations were excluded. Both from a psychiatric and psychotherapeutic perspective, this exclusion of the Vorstellung
side was criticized. Subsequently I documented that whereas the DSM-III and DSM-IV avoided strong statements on etiology, but still indicated that the cause of mental disorders was to be sought in pathophysiology, the DSM-5 makes clear choices. The DSM-5 and the more recently started RDoC group within the NIMH in the United States clearly aim at developing psychiatric classification systems that start from the idea that psychiatric disorders are brain disorders. The assumption of these new classification systems is that mental disorders are caused by neurobiological factors, which should be diagnosed as precisely as possible. Such view bears witness of a neopositivist approach of diagnosis, whereby it is assumed that ultimately, it will be possible to link neurobiological referents to manifest mental symptoms and complaints. The belief thereby is that if such disambiguation is achieved diagnosis will at last be truly scientific.

In my view, such idea of diagnosis is not workable for psychotherapy. The referent recent psychiatric classification starts from - brain processes - is not attuned to the referent psychotherapeutic theories start from. This viewpoint does not imply that I am against the DSM per se - I am happy to leave neurological examinations to specialists in that field. What I do find problematic, is that the DSM is further used as the golden standard for tailoring all kinds of interventions in mental health care. In my opinion current developments in psychiatric diagnosis urge us to reflect on alternatives, that is, on modes of diagnosis that fit the discipline of psychotherapy. Psychotherapists and psychologists have too much neglected the issue of prioritizing discipline-specific referents and should plea for a mode of diagnosis that in its goal of knowing problems thoroughly takes into account people's idiographic experience. 'Thinking in cases', as Forrester (1996) called, it should be advocated more strongly, and as an alternative to classification, formulation should be investigated and be discussed in greater depth.

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