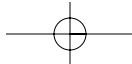
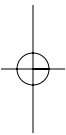
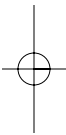


Bias in Psychiatric Diagnosis



Bias in Psychiatric Diagnosis

Edited by Paula J. Caplan
and Lisa Cosgrove

A project of the Association for Women in Psychology



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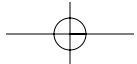
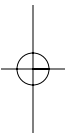
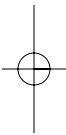
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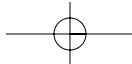
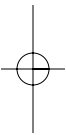
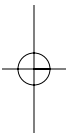
To the memory of Paul Gladstone, his radiance
—Paula J. Caplan

To Ellin Ellett Cosgrove, in memory of Robert Cosgrove,
who taught by example, and to Kelly, Brendan, and Abby
for making the world a better place
—Lisa Cosgrove



Only with radical social changes leading to a just society will there be a reduction in the incidence of emotional problems.

—Psychologist George Albee



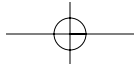
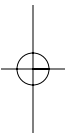
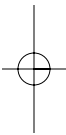
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Foreword

As the Coordinator of the Association for Women in Psychology (AWP), I am delighted to be involved with the development and distribution of this book as a project of AWP. Encouraging psychologists and other mental health workers to develop a critical perspective on diagnosis is an important mission and a form of advocacy for women. This charge has a long tradition within AWP.

The Association for Women in Psychology (AWP) is a scientific and educational feminist organization devoted to reevaluating and reformulating the role of psychology in women's lives. AWP challenges the assumptions of clinical and professional practices that limit the understanding and treatment of women (and men). Its role includes the critique of sexism and other forms of oppression and bias in professional and institutional practices and the education and sensitization of mental health professionals. Since 1969, AWP has provided opportunities for creative feminist contributions and the dissemination of feminist ideas through its conferences, workshops, and newsletter.

AWP was founded in 1969 when disenfranchised members of the American Psychological Association met with local feminist activists to discuss discrimination in the academic and professional worlds of psychology and to examine the contribution of psychology to women's oppression (Tiefer 1991). Since then, AWP members have been active in the both the critique of psychology and the development of feminist approaches to theory, research, teaching, and practice. Sexism in psychotherapy was among the original targets for change. In the 1970s, AWP attempted to define feminist therapy and its principles and to identify feminist therapists. In 1979, AWP endorsed the principles concerning the therapy and counseling of women written by a committee in the counseling division of the American Psychological Association. In the 1980s, AWP protested several new diagnostic categories (i.e., Self-defeating Personality Disorder, Premenstrual Dysphoric

Disorder, Sadistic Personality Disorder, and Paraphilic Coercive Disorder) proposed for the revision of the *Diagnostic and Statistical Manual of Mental Disorders-Third Edition* (American Psychiatric Association 1980). Joined by other women's groups and caucuses, AWP wrote letters and picketed the 1986 convention of the American Psychiatric Association. Following months of opposition, the disputed diagnostic categories were included in the *DSM* in a newly created appendix. Feminists have pointed out that masculine-biased assumptions about healthy behavior are codified within diagnostic labels (Kaplan 1983) and that diagnostic labels applied to both women and men reflect gender role stereotypes (Fodor and Rothblum 1984; Landrine 1989).

AWP supports *Bias in Psychiatric Diagnosis* as part of its action initiative to address contemporary issues in the (mis)diagnosis of women. In her *Brief History of the Association for Women in Psychology, 1969–1991*, Tiefer (1991) concludes that, in the early 1990s, AWP had a diminished activist role because it had not created a structure to find and fight new battles. Recently, AWP has attempted to recreate the activist role of the organization by developing Social Action Initiatives. The Social Action Initiatives are activist projects consistent with AWP's mission. Action Initiatives are adopted at the national level, and members are invited to work at the local level. Misdiagnosis of women has been adopted as one of the first three initiatives of AWP. As part of that initiative, AWP is supporting the efforts to address the problem of sexism in diagnosis already undertaken by longtime AWP member, Paula J. Caplan. In a second Social Action Initiative, AWP has supported the New View Campaign, a movement led by another longtime AWP member, Leonore Tiefer, to expose and critique the medicalization of women's sexuality and sexual problems. The New View Campaign and its efforts to challenge the drug-industry-supported diagnosis of Female Sexual Dysfunction are the subjects of Tiefer's chapter in *Bias in Psychiatric Diagnosis*. This book represents a continuation of AWP's proud history of analyzing sexist practice within psychology, by challenging diagnostic categories and labels that pathologize the gendered experiences of women.

While the primary emphasis in our analysis is gender, the text also addresses the ways that race, social class, age, physical disability, and sexual orientation affect the classification of human beings into categories of psychiatric diagnosis. Other marginalized groups, such as poor and rural women, are also considered. Members of each of these groups suffer when we base our conceptions of normalcy on the behaviors and worldview of dominant social groups, and when the consequences of sexism, racism, homophobia, and "the struggle with poverty are misinterpreted as evidence of individual psychopathology" (Bullock, chapter 14 in this volume). As Caplan points out,

“these are just a sampling of the huge number of biases” that operate in human interactions, especially in interactions of individuals who differ in their access to power (Caplan and Cosgrove, introduction in this volume).

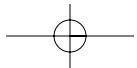
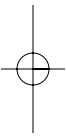
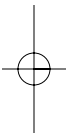
Feminists have historically examined the politics of gender, that is the experience of women (and men) as affected by the operation (and abuse) of power in interpersonal and institutional settings. Many of the authors in this book use the classic feminist analytic strategy of asking the basic political questions: Who says so? Who defines the problem? Who profits? Who pays? What is the price? Authors of other essays closely examine the methods and measures used to investigate and validate diagnostic categories. These classic feminist perspectives are offered here alongside contemporary postmodern perspectives on diagnosis as discourse and diagnostic categories as sociopolitical constructs. In addition to applying these analyses to various populations, settings, and diagnostic categories, the text teaches us to expose implicit assumptions in psychological practice and to examine critically the assignment of diagnostic labels. Our goal is to have every therapist and mental health worker who is trained in or employs diagnostic categories to be exposed to the feminist critique of diagnosis. While not satisfied with our impact on psychology and psychological practice to date, members of AWP are proud of our past and our continuing efforts to understand how inequality and oppression impacts women’s lives, and how to better advocate for women (and men) in distress. *Bias in Psychiatric Diagnosis* represents a continuation of our efforts.

Maureen McHugh

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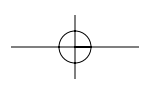
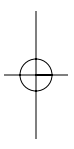
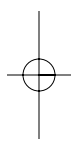
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Acknowledgments

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Is This Really Necessary?

Paula J. Caplan and Lisa Cosgrove

The judges of normality are present everywhere.

—Michel Foucault, *Discipline and Punishment*, 304

an official announcement [reads that] . . . nearly half of all Americans experience a psychiatric disorder. . . . does that mean no one is normal . . . ? Or [do] we live in such a crazy-making, sick, impersonal society that it does serious psychological damage to half of us? . . . should we be calling [people the] mentally ill, . . . or . . . society's wounded?

—Paula J. Caplan, *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*, 6

The word “name-calling” provokes negative associations, but the term “diagnostic labeling” has an aura of scientific precision, objectivity, and professionalism that lends it tremendous power. Language confers power (Miller and Swift 1977), and that power is “not distributed equitably across the social hierarchy” (Hare-Mustin and Marecek 1997, 106), a fact that has had tremendous impact on those who have sought mental health services. Diagnosis of physical problems has often been extremely useful,¹ and in principle, psychiatric diagnosis can be helpful, too (e.g., Emily J. Caplan, chapter 5 in this volume). Unfortunately, psychiatric labeling has been conceived of and applied in extremely biased ways and is surprisingly unwarranted by scientific research, and thus it can result in serious harm (P. Caplan 1995). As Hare-Mustin and Marecek note: “a diagnostic label . . . has a profound influence on what we think of people so labeled and how they think about themselves” (1997, 105). In addition, diagnostic labels often create problems with employers and the military and can potentially result in the loss of child custody, health insurance, and the right to make decisions about one’s legal affairs and medical care

(Emily J. Caplan, chapter 5). Furthermore, the topics deemed important for a client's therapy sessions can be heavily determined—sometimes for better but often for worse—by the diagnostic system and the label(s) given to that client. These dangers and others, combined with many forms of bias, help to determine *who* gets diagnosed and *with what labels*.

In the United States, distress is intensely psychologized,² including the proliferation of diagnoses and therapists, drugs marketed for every psychological state imaginable, cocktail party conversation in which laypeople analyze their own behavior and that of others, increasing use of mental health experts and social scientists as witnesses in court, and even New Age practices that involve psychological concepts. Thus, it is all the more alarming that, as Autumn Wiley shows (2001), authors of abnormal psychiatry textbooks almost or entirely ignore the extensive critiques of bias that have been published for years in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. It is not surprising, then, that undergraduate psychology majors “learn” about forms of alleged mental illness that have never been proven to exist and about diagnostic terms but do not learn about the biases involved in their creation and use. It is not that assigning a psychiatric diagnostic label is never helpful, but it is widely—and wrongly—believed that diagnostic labels are very helpful to therapists for choosing treatments and predicting treatment outcome. Unfortunately, in the realm of mental disorders, this is rarely true.³

The terms “mental illness,” “mental disorder,” “abnormality,” “normality,” and even “insanity” are constructs, terms that do not correspond to clearly identifiable, “real” objects. Constructs are defined by whoever does the defining, and the power to make a definition stick resides usually in groups that have the most social, political, and/or economic power. Beginning in the last twenty years of the twentieth century, the small number of primarily white, high-status, male psychiatrists who make the ultimate decisions about what goes into the therapists' diagnostic “Bible,” the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, have had more power than any group to decide who is and is not psychologically normal. But the *DSM* authors are not the only creators of diagnostic categories, for drug companies and book authors with “M.D.” or “Ph.D.” after their names have also been granted authority by the media and the wider public.

Biases in diagnosis of “mental disorder” take effect on shifting sands on shifting sands, because no one has ever been able to come up with a definition that they considered satisfactory, as the *DSM* authors have courageously acknowledged (Kirk and Kutchins 1992). The subjectivity is evident in the following italicized terms: mental disorder, they say, is a *clinically significant syndrome or pattern* that is *associated with distress or disability* or with *significantly increased risk of suffering, death, pain, disability, or an important*

loss of freedom and must be considered *a manifestation of a behavioral, psychological, or biological dysfunction* in the individual. The further proviso, that it must not be an *expectable and culturally sanctioned* response, presents particularly thorny problems in light of the richly *multicultural* world in which we live. The problems with this definition remind us poignantly that “mental disorder” is, after all, a construct.

The fact that psychiatric diagnosis is ubiquitous (in the mental health system and in noninstitutional contexts like social gatherings and the media) has tremendous impact on psychiatrists, social workers, pastoral counselors, guidance counselors, psychologists, family therapists, nurse practitioners, psychiatric nurses, and others. As many clinicians realize, demonstrably far more helpful than labeling in mental health settings is an intense focus on any or all of the following: therapists’ and others’ provision of listening ears, support, respect, familiarity with relevant research and with effective clinicians’ experiences, and a questioning approach to the literature and clinical narratives (P. Caplan 1995). Another helpful tool that is far too rarely used is *formulation*, the working out of the most likely explanations, insofar as one can tell, of the causes or perpetuating factors of the person’s problems (Block 2002).

When *DSM* began increasing in size because of its skyrocketing number of categories and subcategories, its authors claimed that their labels were “atheoretical,” not tied to any theory or treatment, and solidly based in empirical research (American Psychiatric Association 1980). Partly because of this atheoretical approach, the formulation that had been so important in psychoanalysis and many other “talk” therapies has become dwarfed and, in some cases, replaced by an emphasis on diagnosis. This change was impelled by the prominence of the *DSM*, the American Psychiatric Association’s aggressive marketing strategy for it, and the ready acceptance of its hundreds of categories and subcategories, by many therapists and researchers. The number of *DSM* labels has skyrocketed over the past fifty years. With each subsequent revision, new diagnostic categories have been added and others sometimes changed or deleted. In the seven years between the 1987 and 1994 editions, for example, the number of categories and subcategories increased from 297 to 374 (P. Caplan 1995). In addition to growing in size, this manual has become increasingly influential, due to the fact that third-party reimbursement now requires that patients receive a *DSM* diagnosis. Increased emphasis on diagnosis was impelled by insurance groups and health maintenance organizations (that want therapy to be brief and therefore want particular problems matched with particular drugs and quickly cured), by those media people who are too impressed by the psychiatric establishment to do real investigative journalism, and by laypeople who understandably want to believe that, as with a broken bone, diagnosis can lead to cure.

In addition to these concerns, six other factors inspired this book:

- The burgeoning literature about bias in diagnosis is not reflected in most programs in which psychotherapists of any kind are trained (or in undergraduate psychology courses [Autumn Wiley 2001, chapter 4 in this volume]), although students in an increasing number of disciplines are being trained to become licensed therapists. Students in *all* therapy training programs need to think critically about diagnosis, the *DSM*, and the medical model on which much training is based.
- Increasingly, accrediting bodies for therapy training programs require the inclusion of materials about bias, and the literature about bias in diagnosis has been sparse.
- Harmful forms of bias are both morally wrong and therapeutically counterproductive, yet, even now, more than three decades after the publication of Phyllis Chesler's landmark book, *Women and Madness* (1972), trainees and faculty who attempt to point out instances of bias are often subjected to ostracism or mockery.
- The whole enterprise of psychiatric diagnosis is entirely unregulated, a fact to which the attention of students in training programs is rarely, if ever, drawn.
- Diagnosis of "mental illness" is more an art than a science, and many labels, even in the *DSM*, have not been shown by high-quality research to represent real entities (research by Pantony, reported by P. Caplan 1995). This contributes to the low agreement rate between clinician pairs about which *DSM* diagnosis to give a patient (Kirk and Kutchins 1992; P. Caplan 1995), and without this agreement (reliability), there *can be no validity*. As a result, any professional who applies to a patient a label that has not been validated and then bases treatment on that label is, in essence, submitting the patient to experimental treatment without their knowledge and consent. This has serious moral, ethical, and legal consequences.
- The possible negative fallout of diagnosis makes it important for therapists to realize that their patients will be at differential risk for those consequences, depending on their sex, age, racial classification, and so on.

Therapists who, uncritically following the medical model, believe that all emotional problems are caused by factors within the individual make what social psychologists call the fundamental attribution error (Ross 1977; Wiener and Marcus 1994), failing to consider the effects of social factors. Therapists working within the mental health system have developed alternatives to the medical model. For example, in 1987 Janet Stoppard led the Women and Mental Health Committee of the Canadian Mental Health Asso-

ciation (CMHA) in producing a report called *Women and mental health in Canada: Strategies for change* (Women and Mental Health Committee 1987). They dispensed with unvalidated systems of diagnostic labels, instead naming many of the known and proven causes of women's suffering, including poverty, violence, and lack of social and political power and resources. They proposed that money and energy be channeled into eradicating these causes, ending the report with point-by-point recommendations for action in therapists' training programs, various levels of government, and the CMHA itself. Unfortunately, the CMHA allowed the report to go out of print shortly after it was published, and neither the CMHA nor any other group or individual has reported having tracked whether any recommendations were followed. There is little evidence that they were, and there is little evidence in Canada or the United States that attempts to call attention to these major sources of emotional difficulty have permeated the mental health system. Clinicians and researchers could advocate for replacement of current diagnostic labels with descriptors like "the consequences of poverty," "the consequences of violence," "the effects of homelessness," "the damage done by interpersonal discrimination/demeaning treatment," and so on. The *DSM* authors provide one axis on which "psychosocial stressors" are to be listed, but the terms on Axes I and II are the focus of diagnosis and practice, and psychosocial stressors are often left out entirely.

Much current research is based on *DSM* categories, even when those categories have not been shown to represent real entities (P. Caplan 1995; Eli Lilly and Company Limited, 2003), and use of *DSM* categories can appear to some grant proposal reviewers to legitimize the proposed research. Furthermore, research reports in which *DSM* categories were used provide further apparent support for the legitimacy of the *DSM*, even if the study has no bearing on the validity or practical usefulness of a *DSM* category. However, as discussed in a number of chapters in this volume (e.g., Olio; Javed and Gerrard; P. Caplan, chapter 7 in this volume; Caplan and Profit, chapter 32 in this volume), non-*DSM* labels can have tremendous power and be used in biased ways. For instance, labeling people as "stressed" has become so nearly ubiquitous that it threatens to lose its meaning. Often, the word is used when accurate labels should be, for instance, "ashamed" or "terrified." Paula J. Caplan heard a psychologist describe a woman recently diagnosed with late-stage breast cancer as feeling "stressed" by the news. It is troubling enough when the label "stressed" masks the intensity or character of any emotion, and it is even more disturbing when it masks the effects of oppression and violence. A brilliant dramatization of labeling's masking effect is evident in Carolyn Gage's play, *Harriet Tubman Visits a Therapist*, in which runaway slave Tubman tells a therapist about the tragedy and horror of slavery, and the therapist responds

with the recommendation that Tubman perform stress-reduction exercises (Gage 1999). Sadly, this mimics what sometimes happens today with labeling the consequences of oppression.

By and large, research on human behavior tends to be conducted by individuals who interpret their results in ways that are consistent with prevalent forms of bias (Caplan and Caplan 1999). Racism, sexism, classism, ageism, mother-blaming, ableism, and other forms of bias are sustained both within and outside the social sciences and mental health fields (Burman 1998; Fine 1992; Wilkinson and Kitzinger 1995; Caplan, 2000). Further, drug companies fund much research that is used to advocate new diagnostic categories, because finding or creating a diagnostic label for a drug maximizes the likelihood of FDA approval and simplifies marketing. In the recent proliferation of television commercials for prescription drugs, many include a description of an ordinary phenomenon (such as shyness), the relabeling of it (shyness becomes “Social Anxiety Disorder”) in ways that alarm people because the message is that they are mentally ill, and finally the announcement that a brand-name drug is just what the “disordered” person needs. research on these and other drugs is frequently performed by their own in-house drug company researchers and sometimes by “independent” scientists. Drug companies do not pay these scientists’ salaries but the scientists are given drug corporations’ research money and often prohibited from publishing results that show the drugs to be ineffective or dangerous. Researchers and, indeed, at least one editor of a major medical journal are concerned about the association between funding source and study outcome (e.g., Angell 2000; Bodenheimer 2000; Davidson 1986; Friedberg, Saffran, Stinson, Nelson, and Bennett 1999; Korn 2000). Former *New England Journal of Medicine* editor, Dr. Marcia Angell, reports that finding a research psychiatrist to write an editorial on treatment of depression was difficult because “we found very few who did not have financial ties to drug companies that make antidepressants” (Angell 2000, 1516).

Therapists who choose or are required to diagnose their patients, are likely to read research reports in “scholarly” journals, the media, or both; and research-supported biases tend to affect the diagnoses they select for their patients. One example is the tendency to label abused women as “masochistic” based on poorly designed and misinterpreted research supposedly proving that aggression is biologically impelled and thus nonpathological in men (Caplan and Caplan 1999; Caplan 1993a; Fausto-Sterling 1992). But the existence of even greater bias against women is evident in this example, because of the powerful catch-22 situations in which they are placed: Women *victims* of violence are diagnosed as “masochistic,” but because aggression is coded as naturally masculine, women *perpetrators* of violence, even in self-defense,

are often labeled pathological for being “unwomanly,” “castrating,” or “psychopathic.” Similarly, women who stay with abusive partners are labeled “masochistic,” but women who leave are labeled “rejecting and cold” (P. Caplan 1993a; Stahly 2003; Fausto-Sterling 1992).

As human beings, mental health professionals who conduct psychological or psychiatric assessments and apply diagnostic labels can never be totally free from bias (Caplan and Wilson 1990; Fox 1997). However, many lawyers and judges operate as though assessors were infallible professionals whose work is objective science, and in this context therapists’ biases can lead to infringement of the legal rights—even constitutional protection—of members of marginalized groups. When making diagnoses and recommendations, a therapist can choose which theoretical or interpretive framework to use. To simplify only a little, there are two kinds of theories, one of which tends not to be supported by good research and (probably not coincidentally) to be racist, sexist, or otherwise negatively biased, and the other tends to be based on good research and not to be negatively biased. Serious legal principles are ignored when an assessor chooses to bring one of the former into play (P. Caplan 1993b). The courtroom is a stage on which some of the tragic consequences of diagnostic labeling are frequently played out through judicial edicts that basically constitute the rubber-stamping of a therapist’s diagnostic report. Consider this case: A woman and man divorce soon after their daughter is born. He has physically abused his wife. They agree that the mother will have care and custody of the child. When the daughter is a preschooler, she shows signs of having been sexually abused. The mother is alarmed but fears what her ex-husband will do if she contacts the relevant authorities. She calls her lawyer, who advises her to make a formal report of suspected abuse, which she does. Informed about this report, the judge remarks in a conference with the lawyers that if the Department of Child and Family Services fails to find that the child was abused, he will transfer custody to the father. The mother’s lawyer tells her what the judge says, and she is beside herself, feeling terrified and helpless. The next day, the mother has her first appointment with the psychologist whom the judge has ordered to conduct psychological assessments of both parents. The psychologist administers her a Minnesota Multiphasic Personality Inventory, and, although all her scores fall within the “normal” range, he writes in his report that her MMPI profile showed her to be extremely defensive and that her claim that the daughter might have been abused proved her to be an hysteric, a category almost always applied to women. In the “diagnosis” section of his report, on Axis II, he said that she had “Self-defeating Features.”

This mother had sufficient resources to pay a good lawyer and two psychologists who could testify that (1) nothing in the court-appointed psychologist’s

notes or data suggested that she was defensive or hysterical, and (2) the assessor used *DSM* format and terminology to diagnose her, but the term “Self-defeating” is not in the current *DSM*. This example appears here because this scenario is tragically common.

The chapters in this book represent only a sampling of the huge number of kinds of bias in mental health diagnosis, including sexism, racism, ageism, homophobia/heterosexism, and classism. We include papers about some individual labels, as well as about problems that result from various manifestations of bias in diagnosis. We hope that awareness of some of these issues will sensitize both trainees and faculty to the sorts of things to look for in other instances, since critical thinking is developed in part by questioning the assumptions we are most likely to take for granted. Like K. Gergen (1994; 2001), we believe that productive and constructive critique engenders dialogue rather than impeding it. When we transcend dichotomous and other simplistic forms of thinking (e.g., science/politics; normal/abnormal), and when we dare to envision new ways of understanding the world, education becomes “the practice of freedom” (hooks 1994, 12), an aim that informs the spirit and content of this book.

Some of the chapters in this collection are about forms of bias—such as racism, ageism, sexism, heterosexism, classism—that affect large numbers of diagnostic categories. Some are addressed to such general topics as the “deep structure” (different levels) of bias in diagnosis or case studies of the history and politics of particular categories. Still others are about particular diagnostic categories. At the end of this chapter is a list of some of the useful journals and references for general readers or professionals who wish to read further. We hope clinical faculty will interweave their courses and case conferences with discussions of the ways biases interfere with clinical treatment, we hope students may form informal discussion groups about these matters, and we hope that general readers will discuss these matters with family, friends, and clinicians.

PIONEERS

It is important to review some of the classic work by those who have written about bias in “mental illness” diagnosis. Writing in 1923, when Sigmund Freud’s theories were becoming well known and in some quarters treated as gospel, psychiatrist and psychoanalyst Karen Horney had the courage to challenge two of the most central psychoanalytic diagnoses (Horney 1973). She questioned Freud’s notion of “penis envy” as a label for much of women’s and girls’ behavior and his claim that all females have not only “penis envy”

but also the wish to castrate the “favored male” (Horney 1973, 37). Criticized and ridiculed by Freud and his inner circle, Horney had suggested that females’ envy of or anger at males came not from wishing to have a penis but from understanding that males had more power and influence in many realms and fewer restrictions than did females. The “penis envy” and castration wish that Freud claimed as universal were examples, she said, of psychoanalysis’s own revelation “that much that we have regarded as constitutional merely represents a blockage of growth, a blockage which can be lifted” (Horney 1973, 13).

Another diagnostic term that psychoanalysts claimed to be fundamentally, immutably female was “masochistic.” Nevertheless, Horney pointed out that what was called masochism was actually women’s silent acceptance of the socially imposed conditions that made them unhappy (Horney 1939). In fact, she wrote that what was called masochism was in fact an effort to *avoid* suffering, to find safety and satisfaction by not making demands or being noticeable.

As the liberation movements began forty and fifty years ago, sociologist August B. Hollingshead and psychiatrist Fredrick C. Redlich had found in their classic work, *Social class and mental illness* (1958), a strong relationship between individuals’ socioeconomic class and the psychiatric diagnoses they were likely to receive.⁴ Hollingshead and Redlich pointed out the ways that the beliefs of staff members in different clinical settings led to different views of patients,⁵ but their findings were striking. They assigned participants to social class, using an index combining the person’s area of residence, occupation, and education. People in the “lowest” class, Class V, had the least education and lowest incomes and lived in the least expensive neighborhoods. They found:

- The “higher” the social class, the less likely an individual was to become a psychiatric patient of any kind; people in Classes IV and V combined were 2 1/2 times as likely as people in Classes I and II to enter psychiatric treatment, twice as likely to reenter treatment, and 5 times as likely to remain in continuous treatment.
- Diagnoses of “neuroses” were most likely to be given to members of higher than of lower social classes, and the reverse was true for “psychoses.”

Hollingshead and Redlich attributed these class differences in diagnosis and treatment to social factors and wrote that “the measure of mental health or illness is not who is ‘normal’ or ‘abnormal’ but who is normal for what and for whom in each class” (360). They note, for instance, that “the external problems of lower class individuals, as well as threats to their economic, social,

and physical security, are much stronger than to members of the higher classes” and recommend “that psychiatrists need to understand the social system of the community if they are to diagnose accurately” (365 and 371).

Reporting a ten-year follow-up of the Hollingshead and Redlich study, Jerome K. Myers, Lee L. Bean, and Max P. Pepper note “the very process of diagnosis and treatment provides a social definition—that of mental patient” (1968, 13). They found a strong association between diagnosis and the treatment agency to which a patient goes, therefore the greater likelihood of people in Classes IV and V being diagnosed with severe mental illnesses could well explain the differences in ongoing hospitalization.

In *The politics of therapy*, Seymour L. Halleck (1971) addresses the social and environmental factors that give rise to problems, the expression of which often leads people to being psychiatrically diagnosed with labels that either carry implicit or explicit attributions of the problems to individual, intrapsychic factors. Halleck expressed concern that people might be simply diagnosed as “mentally ill” rather than listened to and understood to be exhibiting “behavior that is defined as symptomatic or unreasonable” by those around them in attempts to influence environments that are causing them harm (69). Halleck warned against therapists’ attempts to remove symptoms (so that people would no longer appear diagnosable) without giving careful thought to the role those “symptoms” played in the patients’ attempts to improve their environments. He noted the risk of rendering the person even more powerless “to cope with the forces of oppression” (70); otherwise, the therapist risked functioning only as “an agent of political control” (71). Halleck suggests that instead of diagnosing old people as depressed and treating the depression as though it were the source of their problems, “the psychiatrist should try to identify those factors . . . that help to make old age a nightmare . . . not only to care for the victims of a brutal process, but to prevent this process from becoming worse” (114). Halleck did not claim that all severe emotional problems were environmentally caused, but he made an impassioned plea with regard to the diagnosis and treatment of people whose primary struggles had such causes.

“Obviously if enough tranquilizing medication were dispensed, black protest could be eliminated” (74). He observes that the people who have been most concerned and militant about oppression tend to be prone to periods of anxiety and depression, even to “intense despair” (75). But, he asks, “what if while they were in jail Henry Thoreau, Eugene Debs, Martin Luther King, and Malcolm X had been given the opportunity to improve their mental outlook by taking a powerful antidepressant?” (75). Furthermore, in words that are powerful in their prescience, Halleck says that therapists ought to urge drug companies to “curb their merchandising fervor [which led to advertise-

ments that would often] depict patients who are overwhelmed with social problems; then they recommend dealing with these patients by simply tranquilizing or stimulating the patient” (77).

* * *

Please keep in mind that this book is specifically about *diagnosis*, because much has been written about the wide variety of problems and biases in *treatment*. Some implications for treatment (or lack of) are mentioned or will be obvious but are not explored here in detail. We hope that you will enjoy the range of voices and viewpoints that are represented in this book (e.g., academic, clinical, and explicitly political perspectives) as well as the broad range of the authors’ formal and experiential qualifications. We want to emphasize that no author in this book claims to have easy answers or all the answers for preventing harmful biases.

WHAT TO DO

Clinicians often ask what they can do to try to insulate patients from negative consequences of receiving a diagnosis. Clinical judgments are always involved in the process of diagnosis, whether in psychiatry or other fields. In some cases, the patient clearly meets the requisite number of criteria for one of the official diagnostic categories. However, there are cases in which questions arise about which is the most accurate diagnosis, and in those cases, clinicians might take particular care to consider the effects of their diagnoses on clients’ lives outside of treatment, as well as of the treatment implications of giving a patient one diagnosis rather than another.⁶ For instance, insurance companies often provide reimbursement for more therapy sessions for patients with certain diagnoses than with others. It is important to select a label that seems to accurately represent as many of the patient’s difficulties as possible and does not misrepresent any dangers or increase the potential risk to the patient or others. When there is any question about which diagnosis is most appropriate, the clinician can record which labels beside the chosen one were seriously considered and whether or not they were ruled out. Whatever diagnosis one gives a particular patient, it is important to be aware that diagnoses can be helpful but not infrequently have negative effects on patients’ rights to child custody, employment, health insurance, or the right to make decisions about their lives.

Clinicians who feel in a given case that it is consistent with their clinical assessment and judgment to do so can write on the patient’s chart next to the diagnosis such statements as, “The fact that this patient has received this

diagnosis does not in and of itself indicate that the patient lacks such capacities as the ability to be a good parent, caretaker of others or employee or to make decisions about their medical and psychological care, their legal affairs, or other important aspects of their lives.” Some therapists offer to give their clients letters in which they make statements about the diagnosis that are relevant to the particular person’s life situation and needs. For example, a therapist who had diagnosed a woman as having Chronic Adjustment Disorder gave her a letter in which he stated that her disorder was a result of severe, ongoing crises in her life and that it was likely, if the crises abated, that she would be employable and that she would not necessarily always have the disorder and be mentally ill if her life circumstances improved.

It is wise for clinicians to make sure that their words and actions are consistent with the ethical standards of their respective professions and to check with attorneys about how best to choose to protect both the patient and the clinician.

Clinicians should also fully inform patients: (1) that they have to give them a diagnosis, (2) the reason that they have to do this (most often because required by their place of work and/or required for reimbursement by insurance companies and because diagnoses are used in treatment planning), (3) that there are potentially negative consequences of receiving a diagnosis and what these can be, and (4) what the clinician is doing—or will do in the future, if relevant—to try to protect the patient as much as possible from those consequences.

Finally, it is important to initiate and engage in ongoing discussions with colleagues and consultants about the various potential and actual positive and negative consequences of diagnosis, and it is important to educate the public about these matters, to make the realm of diagnosis more transparent to all.

Journals:

APA Division 44—Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues—Newsletter: *SPSLGI Newsletter*; *Cultural Diversity and Ethnic Minority Psychology*; *Feminism and Psychology*; *International Journal of Critical Psychology*; *Journal of Feminist Family Therapy*; *Journal of Social Issues*; *Psychology of Women Quarterly*; *Radical Psychology*; *Theory & Psychology*; *Women and Therapy*; Special issue, *Independent Thinking Review*, on “Critical Thinking About Psychology.” (1995). Volume 1, Number 4.

Websites:

Critical Psychology Homepage <http://www.uws.edu.au/criticalpsychology/crit-psych-net.htm>

Psychologists for Social Responsibility <http://www.psysr.org/>

Psychology of Women Resource List listserv@uriacc.uri.edu
Radical Psychology Network <http://www.radpsynet.org/>

NOTES

1. However, the history of medicine includes many examples of serious errors in diagnosis; for instance, tuberculosis was believed to be psychogenic until the tubercle bacillus was discovered.

2. Goode (2002) reported an increase in the number of people who are in psychotherapy and noted that the increase was greatest for older adults and the unemployed, a pattern that appears to reflect, at least in part, the social factors that lead people to seek therapy.

3. See Harris, Hilton, and Rice (1993, 26–285) who found minimal relationships among the way a patient was diagnosed, the patient's problems, and the kinds of drugs that were prescribed. Psychotropic drugs were the primary form of treatment.

4. Dohrenwend and Dohrenwend (1969, 174) also reported this pattern and wrote that "Social environmental pressures in normal civil life, even in the lowest social class, produce symptoms that persist only as long as the situational pressure continues or in the absence of secondary gain," explaining that at least some symptoms were environmentally caused. In a related vein, Berton H. Kaplan, in collaboration with Alexander H. Leighton, Jane M. Murphy, and Nicholas Freyberg (1971, 24) observed that some people were diagnosed as mentally ill because of "interference with striving" caused by conditions among the lower classes.

5. They further noted that their therapists had difficulty in distinguishing among subcategories of "schizophrenia;" their decision to compress them all into one group foreshadowed the ongoing difficulties of the authors of the *DSM*. That is, although justifying the enormous, rapid increase in their manual's subcategories by asserting that they improve the accuracy of diagnosis, they in fact found that the only way to obtain anything close to a positive correlation between the diagnoses assigned a patient by two different professionals was largely to ignore the subcategories and use the overarching categories (Kirk and Kutchins 1992; P. Caplan 1995).

6. This is not a suggestion to distort, cover up, or otherwise misrepresent the patients' symptoms or problems. In fact, for many reasons, only one of which is that harm can come from diagnosis, it would be particularly troubling if negative consequences resulted from a diagnosis that was a misrepresentation.

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