Superior
Health Council

DSM (5): THE USE AND STATUS OF DIAGNOSIS AND CLASSIFICATION OF MENTAL HEALTH PROBLEMS

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ADVISORY REPORT OF THE SUPERIOR HEALTH COUNCIL no. 9360

DSM (5): The use and status of diagnosis and classification of mental health problems

In this scientific advisory report, which offers guidance to public health policy-makers, the Superior Health Council of Belgium provides recommendations on use of classifications in mental health for professionals, policy makers and researchers.

This version was validated by the Board on
June - 2019[1]

SUMMARY

The SHC notes that the most commonly used tools for diagnosing mental health problems (the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or the *International Classification of Diseases and Related Health Problems* (ICD)) pose several problems and recommends that they be used with caution and that the DSM categories not be at the centre of care planning.

From an epistemological point of view, classifications are based on the assumption that mental disorders occur naturally, and that their designations reflect objective distinctions between different problems, which is not the case. The boundaries between people with a disease and those who are free from it are more dimensional than categorical.

At an organizational level, the SHC raises the question of the function of diagnostic classifications, which tend to legitimize a structure based on a biomedical model and protect psychiatry from the pressures of change, while mental health care is in a state of flux. On the other hand, this biomedical approach does not, as hoped, reduce stigma and discrimination of patients in mental health care.
In Belgium, the authorities give stakeholders and organisations a wide margin of freedom to use these systems, mainly used for registration purposes (MPD).

At a clinical level, classifications do not provide a picture of symptoms, management needs and prognosis because they lack validity, reliability and predictive power. On the other hand, they do not respond to new conceptions of health, defined by the ability to adapt, despite bio-psycho-social obstacles. However, it is more useful to understand the combination of factors causing and maintaining symptoms than to identify a category. A recovery-based approach (clinical, personal and social) better contextualizes symptoms and adapts interventions according to patients' values, affinities and goals, working closely with them.

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[1] The Council reserves the right to make minor typographical amendments to this document at any time. On the other hand, amendments that alter its content are automatically included in an erratum. In this case, a new version of the advisory report is issued.

The SHC therefore recommends the use of clinical case formulation as part of a "multi-layer" diagnostic process. This involves starting with a narrative description of the individual's symptoms, then recontextualizing them, classifying them on the basis of a limited number of general syndromes, and finally discussing these symptoms in terms of a continuum from crisis to recovery, to assess the need for care, the level of crisis and the recovery perspective (considered a contextual phenomenon).
This case formulation is a reasoned and still incomplete hypothesis, based on a continuous back and forth between data collection and the use of theoretical knowledge. The person and his relatives are a source of information about his or her mental state and context. The therapeutic relationship is at the heart of the treatment, which requires a reflective method of quality control.

Given the limitations of classification systems, and the latitude in their use granted by the different levels of power, the SHC therefore recommends that the use of the DSM or ICD be limited to broader categories of disorders, and that diagnoses remain working hypotheses. Disorders should not be considered as a static characteristic, but rather as interactive. Diagnostic labels should also be used with caution, while taking into account the importance for the person of recognizing their difficulties.
Psychological complaints must be dealt with regardless of their seriousness, in a non-medical way, with perspective and meaning at the centre. This requires low-threshold support structures.

Keywords and MeSH *descriptor terms*[2]

MeSH terms*	**Keywords**	**Sleutelwoorden**	**Mots clés**	**Schlüsselwörter**
Diagnostic and Statistical Manual of Mental Disorders	DSM	DSM	DSM	DSM
International Classification of Diseases	ICD	ICD	CIM	ICD
Classification	Classification	Classificatie	Classification	Klassifizierung
Mental Health	Mental Health	Geestelijke gezondheid	Santé mentale	psychische Gesundheit
Diagnosis	Diagnosis	Diagnose	Diagnostic	Diagnose
Case reports	Case study	Gevalstudies	Etude de cas	Fallstudie
	Multi layer approach	Meerlagige aanpak	Approche multicouches	mehrschichtiger Ansatz
	Epistemology	Epistemologie	Epistémologie	Epistemiologie
	Organizational Level	Organisatieniveau	Niveau organisationnel	Organisationsebene
	Clinical level	Klinisch niveau	Niveau clinique	klinische Ebene

MeSH (Medical Subject Headings) is the NLM (National Library of Medicine) controlled vocabulary thesaurus used for indexing articles for PubMed http://www.ncbi.nlm.nih.gov/mesh.

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[2] The Council wishes to clarify that the MeSH terms and keywords are used for referencing purposes as well as to provide an easy definition of the scope of the advisory report. For more information, see the section entitled "methodology".

CONTENTS

List of abbreviations used

ADHD	Attention deficit hyperactivity disorder
AViQ	*Agence pour une Vie de Qualité*
BeWo	*Initiatieven beschut wonen*
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Diseases and Related Health Problems
MHC	Mental Health Care
MPD	Minimum Psychiatric Data
ONE	*Office de la Naissance et de l'Enfance*
PVT	*Psychiatrische verzorgingstehuizen*

I INTRODUCTION AND ISSUE

Worldwide mental health problems are usually diagnosed in terms of the mental disorder categories such as described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) by the *American Psychiatric Association,* or in the *International Classification of Diseases and Related Health Problems* (ICD) by the *World Health Organisation*, which has a chapter on mental and behavioural disorders. A first edition of the DSM was published in 1952, and currently the fifth edition is in use (DSM-5), which was published in 2013. A first precursor of the ICD, in its turn, was presented in 1893[3], and currently the tenth edition is in use (ICD-10; published in 1999). A new edition was published in 2018 (ICD-11).

Both the DSM and the ICD are diagnostic classification systems, containing lists of disorders (e.g. ‘major depressive disorder’, ‘schizophrenia’…) that are grouped in overarching clusters (e.g. ‘depressive disorders’, ‘neurodevelopmental disorders’…). Each disorder is defined in terms of inclusion and exclusion criteria, with which a professional can decide from which disorder a person is suffering. This decision-making process is based on a list of *descriptive* features of each disorder: with an inventory of symptoms the diagnostician explores whether a given individual meets a sufficient number of the inclusion criteria as well as certain specifications that would exclude the diagnosis of a particular disorder.

Pivotal to DSM and ICD-based diagnosis are the checklists that are formulated for each disorder. These include key symptoms, specifications on the minimal duration of complaints, and indications of other conditions that might provoke similar symptoms. In total, the DSM-5 discerns 347 mental disorders; the ICD-10 discerns 321 disorders. For each DSM-5 and ICD-10 disorder, the same template of inclusion and exclusion criteria is used. Some disorders exclude one another; for example, a diagnosis of major depressive disorder excludes schizo-affective disorder, while other disorders might be combined, pointing to comorbidity, like major depressive disorder with comorbid general anxiety disorder.

Worldwide the DSM and the ICD are used as a basis for morbidity statistics; reimbursement systems; intervention decision support in health care, education and welfare contexts; design of research and trials; communication and teaching about mental health problems.

The objective of the SHC consists of clarifying and discussing the epistemological status of the DSM-5, as well as its role in the organization of mental health care and its use in clinical practice. Starting from observed limitations in the (use of) the DSM-5 the SHC aim at examining how classificatory diagnosis might be implemented in the broader process of clarifying mental health problems in individuals. Based on these discussions and evaluations the SHC aim at formulating recommendations on how the general public, clinicians, and policy makers can best deal with the diagnosis of mental health problems.

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[3] http://www.who.int/classifications/icd/en/HistoryOfICD.pdf

II ELABORATION AND ARGUMENTATION

1 Methodology

After analysing the request, the Board and the Chair of the working group identified the necessary fields of expertise. An ad hoc working group was then set up with the aim of bringing together experts from the broadest possible range of areas of expertise. For instance, all the experts from the SHC's standing working group "mental health" were invited to join this working group. The final composition of the working group includes backgrounds in psychiatry, lived-experience expertise, psychology, sociology and philosophy. Other experts also participated in part of the activities of the working group, but did not continue to the end, which accounts for the fact that its final composition may seem unbalanced in terms of linguistic background and theoretical orientations. However, the active participation of Jean-Louis Feys (professional sector) and Ariane Bazan (academic community) ensured that the French-speaking population was represented. Brenda Froyen represented the patients. The first meeting was held on 23 September 2016, and the last on 5 February 2019. The experts of this working group provided a general and an *ad hoc* declaration of interests and the Committee on Deontology assessed the potential risk of conflicts of interest.

This advisory report is based on a review of the scientific literature published in both scientific journals and reports from national and international organisations competent in this field (peer-reviewed), as well as on the opinion of the experts.

Once the advisory report was endorsed by the working group (and by the standing working group mental health), it was ultimately validated by the Board.

2 Epistemological status of mental disorders

As Cooper (2005) indicates, many users of classification systems like the DSM and ICD seem to assume that mental disorders are *natural kinds*. That is, they assume that there are kinds of mental disorders much in the same way as there are kinds of chemical substances or species of animals. The term 'natural kind' is a technical philosophical one that means many different things to different people, but the general idea can be easily explained if we look at the traditional example of a natural kind, namely water. All samples of water are basically the same kind of thing; they have the same microstructure that causes them to behave in the same way. By giving all this 'stuff' the same name, namely 'water', we get something right about the world itself. It does not depend on us and our classificatory preferences, financial incentives, social practices, or moral considerations that all samples of water are the same kind of thing. In that sense, water is a *natural* kind. It is epistemically very useful if a classification system succeeds in capturing natural kinds. We can predict how a sample will behave if we know that it is water, and we can explain why it behaves that way given what we know about the microstructure of water.

To assume that the labels for mental disorder listed in the DSM or ICD are natural kind categories, is to believe that there are also natural distinctions between kinds of psychiatric problems, and that this is what these labels refer to. If that were the case, these labels could also be used in the same way as classification systems in other sciences; to naturally group individuals, make generalizations about them, and to predict and explain their properties. Many psychiatrists and philosophers of psychiatry have argued, however, that there are important differences between chemical kinds like water and psychiatric disorders. So much so, that we should be careful when using psychiatric classifications systems like the DSM and the ICD in the same way as the classification systems that are used in other sciences. To introduce these epistemological issues with classifying mental health problems, we list *seven concerns*, each of which has been discussed by asking whether mental disorders are 'natural kinds'.

(1) First of all, members of the same natural kind are supposed to have an important number of properties in common. In this sense, distinctions between kinds can be ‘natural’ rather than merely ‘arbitrary;’ when they are grounded in real similarities. All samples of water, for example, have many properties in common, making it very useful to know when some sample of stuff is water. In psychiatry this might mean that patients with the same diagnosis have the same symptoms, and have core characteristics in common at the level of biological, psychological and social functioning. Most categories of the DSM and the ICD appear to be weak at this level (Hyman, 2010; Frances, 2013, Vanheule, 2017; Van Os, 2010). Indeed, given the strong variation within each category there are not many broad generalizations or accurate predictions that can be made about people who are supposed to suffer from the same kind of disorder.

One reason for the level of variation between individuals who are diagnosed with the same disorder is that both the DSM and the ICD have followed a *polythetic* system for most disorders ever since they adopted a checklist-based approach (Nieman, 2016). A polythetic class is defined in terms of a broad set of criteria that are neither necessary nor sufficient for class membership. Each member of the category must possess a certain minimal number of defining characteristics, but none of the features has to be found in each member of the category. They both sketch broad profiles for most disorders, which allow for the diagnosis of a disorder in individuals based on somewhat – and sometimes completely - different characteristics. In the case of major depressive disorder, for example, the DSM-5 lists nine relevant clinical characteristics. Major depressive disorder can be diagnosed if at least five criteria are present, with the proviso that at least one of the symptoms includes either depressed mood or loss of interest or pleasure. Therefore, it is possible that one individual is diagnosed due to the presence of depressed mood, weight loss, insomnia, psychomotor agitation, and fatigue, while another is given the same diagnosis due to the presence of diminished interest in most daily activities, recurrent thoughts of death, diminished ability to concentrate, feelings of worthlessness, and hypersomnia (see: DSM-5, pp. 160–161): one disorder, two entirely different symptom profiles. Within the logic of polythetic diagnosis it is assumed that this variation is not a cause for concern due to “family resemblances” between different symptom profiles: all symptoms more or less point to the same underlying category (Berrios, 1999, 2012). The strength of polythetic diagnosis is that it covers variability: patients with different symptomatic profiles can be classified into one category, possibly tracing important underlying similarities. On the other hand, the weakness of polythetic diagnosis is that diversity is subsumed under a general nominator and risks being ignored. Polythetic classification has been seriously criticized by, e.g. Sutcliffe (1994) as logically incoherent.

This opens the question as to whether individual variation between cases should not be taken into account more strongly. To the extent that there is substantial variation within the group of individuals who are supposed to suffer from the same disorder, the use of a kind-based diagnosis for prediction and for treatment decisions is only limited compared to person-specific information.

(2) Secondly, distinctions between kinds of disorders can be ‘natural’ rather than ‘arbitrary’ when they are grounded in real differences. In chemistry it is useful to know that a substance is a metal because metals behave very differently from non-metals. Similarly, diagnosing individuals as suffering from a particular kind of mental disorder is epistemically fruitful if their problems differ substantially from the problems of people with a different disorder, and thus require a different treatment or have a different explanation. Again, however, the DSM and ICD categories seem less epistemically fruitful in this regard than kind categories in other sciences, since the specificity and exclusiveness of core characteristics and symptoms is largely lacking. Many diagnostic categories share important characteristics at the level of genetics and neurobiology, which is why a more flexible network approach of symptoms and causes is needed (Kendler, 2016).

Descriptively, this problem can also be observed at the level of the symptoms by means of which the disorders have been defined. For example, the symptom of restlessness is associated with several DSM-5 disorders that are not presumed to have family resemblance, like Attention Deficit and Hyperactivity Disorder; Generalized Anxiety disorder; Bipolar Disorder; Major Depressive Disorder; Post-Traumatic Stress Disorder; Caffeine Intoxication; Cannabis Withdrawal; Opioid Withdrawal; Stimulant Intoxication; Tobacco Withdrawal; Gambling Disorder; Medication-induced Acute Akathisia. Consequently it could be argued that in making clinical diagnostic characterizations of mental health problems, more attention should be paid to the context-based descriptive diagnosis (and treatment) of symptoms as such.

(3) Thirdly*,* diagnosing an individual as suffering from a particular kind of mental disorder is epistemically fruitful if this helps in explaining the problems or behaviour of that individual. In chemistry, for example, it is fruitful to know that a substance is water given our knowledge of the microstructure of water, if we aim to explain why it behaves in a particular way. This is another sense in which a kind category can be called 'natural' rather than 'arbitrary': if it refers to one specific cause or mechanism responsible for the other features associated with the kind. If, by contrast, there are many different possible causal factors associated with a kind, knowing that something or someone belongs to a kind might still provide us with some causal-explanatory information, but it will be less useful compared to when there is only one causal factor.

Arguably, this is the case for most of the DSM and ICD diagnostic categories: "In the 19th and early 20th centuries, the successful demonstration of a single infectious etiology for general paresis of the insane led to the idea that single, discrete causes might exist for other major psychiatric disorders. Over a century of increasingly sophisticated neurobiological research has failed to fulfill this vision" (Kendler et al., 2011, p. 1144); and "no genetic marker has yet been shown to be useful in prospectively identifying any specific psychiatric disorder" (Dubovsky, 2016, p. 130). As a result, these diagnostic categories can provide information about the often very many causal factors related to a certain type of problems, but are of limited use for specifying the actual causal factors at play for any given individual.

Importantly, a further complication with the DSM and ICD disorder categories is that these give rise to reification, and to what Steven Hyman (2010, p. 157), a former president of the US National Institute of Mental Health, calls "an unintended epistemic prison." While the diagnostic categories of the DSM are conventional groupings of symptoms, which is also indicated in the introductory chapter of the DSM-5, people tend to think of disorders as real entities. For example, reification is evident when people think of "attention deficit hyperactivity disorder (ADHD)" or "schizophrenia" as underlying diseases that give rise to characteristic symptoms, while in fact these labels are descriptive umbrella terms used to designate a collection of symptoms that make up particular syndromes. Reification produces the added problem of psychiatric disorders being understood as quasi-material conditions that *cause* symptoms, while in fact they only indicate that a (certain) minimal number of category-specific symptoms have been observed in an individual. Reifying mental disorders is very common, amongst some mental health professionals and especially among folk users of these categories (Hyman, 2010; Nieweg, 2005, Vanheule, 2017).

The three previous concerns about the extent to which the DSM and the ICD categories are 'natural kinds' were focused on their epistemic fruitfulness resulting from tracing real distinctions: real similarities, real differences and specific causes. But there are more epistemological issues that fall under the question whether psychiatric disorders are natural kinds, based on still other interpretations of 'natural'.

(4) Fourthly, the idea of natural kinds might also refer to the presumption that the properties distinguished by psychiatric categories have biological causes, as opposed to being determined by interpersonal, social or cultural events and factors. This presumption is not tenable for DSM and ICD diagnostic categories (Dar-Nimrod & Heine, 2011; Haslam, 2011). Indeed, in the case of psychiatric disorders contextual components play an important role in the causation of mental health problems. For example, in the case of schizophrenia and psychotic disorders it has been demonstrated that although heritability is often emphasized, "onset is associated with environmental factors such as early life adversity, growing up in an urban environment, minority group position and cannabis use, suggesting that exposure may have an impact on the developing 'social' brain during sensitive periods. Therefore heritability, as an index of genetic influence, may be of limited explanatory power unless viewed in the context of interaction with social effects" (Van Os et al., 2010, p. 203).

Moreover, a one-sided focus on biological causes is too narrow since it makes people expect that psychological and context-focused interventions are less relevant.

(5) Next, one might think that distinctions between kinds can only be 'natural' when they are categorical, since in that case no conventional decisions need to be taken about the cut-off point for having a particular disorder. Many chemical kinds have categorical boundaries in just this way. In case of the DSM and ICD diagnostic categories, however, there seem to be very few categorical boundaries between those who have a condition and those who do not (Narrow & Kuhl, 2011). Nonetheless, most of the diagnosed categories used in the DSM and the ICD are still conceived as categorical. An important epistemological concern is to what extent a classification system like the DSM would not do better to use dimensional criteria to reflect the actual dimensional nature of many psychiatric disorders, like is already done for some disorders in the DSM-5.

For example, in case of psychosis, Van Os (2016, p. 2) suggests to stop using the categorical schizophrenia construct, and instead start thinking of psychosis as a mixed continuum with "extreme heterogeneity, both between and within people, in psychopathology, treatment response, and outcome." The schizophrenia concept triggers diverse fixed essentialist believes in professionals, like the idea that schizophrenia is a chronic brain disorder with predominantly genetic risk factors. Evidence, by contrast, indicates that non-essential factors like the context one lives in or life history have a serious impact on the causation of schizophrenic pathology, implicating that it is a truly bio-psychosocial problem.

(6) Sixthly, the idea that psychiatric disorders are natural kinds sometimes refers to the presumption that *only* epistemic considerations based on knowledge about real similarities, differences and specific causes (see point 1-3) determine their diagnostic criteria. Instead, many people argue that social, financial, and ethical considerations co-determine the criteria of mental disorders (Frances, 2013). This is one more way in which psychiatric disorders would differ from seminal natural kinds like chemical substances. "The exact boundaries between, for example, healthy and unhealthy anxiety or healthy and unhealthy aggression are not written in nature; they are articulated by human beings living and working in particular places and times" (Parens & Johnston, 2011, p. 4). Given the central impact of moral values and social decision-making processes, great care needs to be taken with respect to whose opinions predominate in diagnostic judgment about what is acceptable and what is normal.

(7) A seventh and last way in which psychiatric disorders differ from traditional natural kinds like chemical substances, is that the classificatory practice itself has an impact on those who are classified. Whereas being labeled 'water' has no effect on the behavior of water, this independence proves not to be the case for mental health problems. The particular description of psychiatric disorders and the activity of labeling a patient as suffering from a disorder might influence the patient's actions and reflections.

This interaction leads to an epistemological worry, named by Hacking (2006, p. 23), that patients could become ‘moving targets’: “We think of these kinds of people [i.e. people with diagnoses] as definite classes defined by definite properties. As we get to know more about these properties, we will be able to control, help, change, or emulate them better. But it’s not quite like that. They are moving targets because our investigations interact with them, and change them. And since they are changed, they are not quite the same kind of people as before. The target has moved. I call this the ‘looping effect’”. That is, descriptions of mental problems that might have been accurate at one point can become inaccurate, for example because those who are labeled have changed in response to this description. Probably this is especially so in self-reflexive youngsters and adults, but less so in small children.

The broader concern, however, is that the description of psychiatric problems in a diagnostic manual is not causally innocuous. Knowledge of the descriptions associated with a psychiatric disorder has an effect on those who are diagnosed with them. Probably this concern also applies to dimensional diagnosis. A very different epistemological concern from the previous one is therefore to what extent knowledge of a diagnosis based on DSM or ICD categories engenders stigma (Haslam, 2011, Kvaale & Haslam, 2016), or, by contrast, can help individuals cope with or recover from their problems.

We have now discussed seven ways in which categories for psychiatric disorders as found in the DSM and the ICD differ from more traditional ‘natural kinds’, like chemical substances. We conclude that there are many epistemological concerns with classification in psychiatry, which are related to debates about their ‘natural kindness’.

3 Organisational aspects in connection with the use of diagnostic classification systems

3.1 Sociological perspectives

The use of psychiatric diagnoses is studied from both an organisational sociology perspective and from the perspective of research on stigma.

3.1.1 Organisational sociology perspectives

Sociological approaches to the relationship between diagnostic systems and the organisation of mental health care do not assume a rational organisational model to be self-evident. This rational model assumes that the objectives, structures and rules that guide the internal processes and practices in service organisations (such as mental health care (MHC) institutions) are the logical development of an underlying scientifically-based technical rationality. Thus, according to a rational organisational model of MHC, the hierarchical relationships among the various professional groups and the relationships between professionals and clients are logically derived from an underlying biomedical categorical disease model.

Research shows that this rational organisational model does not offer an accurate description of the actual operation of these institutions (Garrow & Hasenfeld, 2010; Scott, 2015). As a consequence, several organisational sociology perspectives have developed that no longer assume an inherent consistency between the organisational structure (e.g. the hierarchy of professional authority), the organisational culture (e.g. the dominant disease model), the organisational technology (e.g. the nature and content of the activities of professionals and the relation between the staff and the clients) and the environment in which these organisations operate (such as the institutional framework), but make the relationship between these aspects an empirical matter. With regard to the function of psychiatric diagnostic classifications in MHC, these perspectives focus on both the organisational causes and consequences of the dominance of this biomedical approach. Legitimacy is a core concept in each of these approaches. It is also contended that service organisations try to reduce uncertainty regarding the influx of resources, personnel and clients by defending the legitimacy of their organisational structure, their underlying organisational ideology and the results of their activities (Ruef & Scott, 1998). The use of categorical diagnostic classifications in MHC can be considered from the point of view of these processes of legitimisation and uncertainty reduction (Manning, 2000; Mirowsky & Ross, 1989).

From a sociological point of view, the use of diagnostic systems is regarded as a form of ritualised practice that says as much about the group that makes diagnoses as about the individual who gets the diagnosis. They serve to legitimise practices in society, and in this sense are in keeping with a power struggle among various participants.

These processes manifest themselves at the level of the service organisation, the level of the regional collaboration between service organisations, or the higher-lying institutional level. Consequently various organisational theories contribute to sociological thought about the role of diagnostics in the organisation of MHC: the contingency theory, the study of interorganisational relations and the (new) institutional approach (Garrow & Hasenfeld, 2010).

1) The contingency theory states that service organisations strive for an optimal coordination between the environment, the structure (such as the degree of differentiation and composition of the staff) and the technology (such as the clinical application of psychiatric knowledge) of their organisation. This optimal coordination increases their chances of survival. A core concept of the contingency approach is that one ideal organisational type does not exist, as a rational organisational model suggests, but that the nature of the environment determines what organisational type is optimal. The important aspects of the environment relate to the influx of financial resources and clients. This varies between stable and homogeneous and turbulent and heterogeneous. A stable and homogeneous influx of resources and clients leads service organisations to standardise, centralise and formalise their services and organisational structure. An unstable and heterogeneous influx leads to a differentiation of services and structure and more decentralised (such as interdisciplinary) decision-making (Garrow & Hasenfeld, 2010).

The relationship between the nature of the environment and the structure/technology of the organisation is characterised by a strong interaction. Once organisations are established, display a certain organisational structure and have internalised a technology, they attempt to maintain this. Thus psychiatric hospitals have a differentiated structure of departments focused on treatment of persons with mental health problems, and a technology or clinical practice based on a biomedical psychiatric disease model. The service organisations will then attempt to ensure themselves of a constant, and preferably homogeneous, influx of resources and clients by, among other things, increasing or defending the legitimacy of their organisational structure and technology.

Psychiatric diagnostic classification supports this process of legitimisation.

Moreover, service organisations in MHC are confronted with very complex problems in their clients, certainly in the case of serious mental health problems, and achieving reproducible results is a challenge. The emphasis therefore lies on a process-driven rather than a result-driven adjustment of practices. The focus is on procedures rather than outcomes, and psychiatric diagnostic classifications support these sometimes-ritualised procedures of classification and treatment. Therefore MHC participants strive to achieve reproducibility in a practice that is usually very difficult to reproduce.

The fact that MHC institutions continue to embrace the practice of psychiatric diagnostic classification despite its very minor prognostic value is an indication of its ritualised nature.

The contingency approach further contends that different components of service organisations, such as the treatment units and the administration/management, operate in different environments and therefore develop different organisational structures, such as a decentralised (interdisciplinary) professional organisation of the therapeutic departments and a hierarchic bureaucratic organisation of management (Scheid & Greenberg, 2007; Scott, 1985a).

The two other perspectives are complementary to this approach but consider the search for legitimisation and the search for a predictable flux of resources and clients from the perspective of the environment of service organisations. The study of interorganisational relations stresses how institutions are embedded in regional networks of mental health services and social services; the (new) institutional approach focuses primarily on the prevailing policy, the regulations or the institutional framework, mostly at the supra-regional level.

2) The attention given to the study of regional networks of interorganisational relations is the consequence of the deinstitutionalisation of MHC (Lorant et al., 2017; Nicaise et al., 2014), and the highly complex nature of the needs of their target group. Therefore MHC and its related sectors are characterised by a proliferation of services that are assumed to work together to meet these care and support needs (Provan & Milward, 1995). The evolution away from psychiatric hospitals toward regional networks of various service organisations has implications for the aforementioned processes of legitimisation and acquisition of resources. The former organisations have a professional-hierarchical and bureaucratic organisational structure dominated by psychiatry as a medical discipline. The regional networks of services are more or less integrated partnerships between service organisations. Here too institutions are in a hierarchic relationship. This is however more volatile, depending on the position of power of the institutions within the network of interorganisational relations. This position of power depends on the control that institutions have over the flux of clients and the control over financial and personnel resources. Their degree of affinity with influential professional groups and their biomedical disease models are also of the utmost importance. In MHC in Belgium, hospitals are, for all the reasons cited, at the top of the hierarchy. More recently we see the emergence of a recovery perspective as an alternative paradigm.

Service organisations in MHC use these power resources in an ongoing competition for control over (desirable, because treatable) clients and for the right to offer their services.

Service organisations in a more subordinate position in these regional networks try to collaborate with the more central service organisations. Thus hierarchic partnerships form that ensure that the psychiatric, categorical disease models and the biomedical paradigm exert an influence far beyond the walls of the psychiatric institutions. Psychiatric diagnostic classification systems legitimise and therefore support the regional power relations between the institutions and the professional groups. When psychiatry as a medical profession identifies with a strongly biomedical approach and with the institutions that convey this approach, dialogue with other approaches and collaboration with organisations that for example focus on the aforementioned recovery perspective are hindered.

3) the New Institutionalism also consistently devotes attention to the environment in which MHC institutions operate and how this determines their operation. It focuses on their relation to the government as the regulatory authority and on the impact of prevailing ideas in policy-making bodies on how care should be organised and changes in it.

MHC institutions have difficulty demonstrating the effectiveness of their interventions (Hasenfeld, 2009). Because knowledge about the causes and effective treatment of the problems of the clients is usually limited and contested, ambiguous and often contradictory perspectives and convictions of managers and professionals provide the justification for decisions about the treatment of clients in MHC (Hasenfeld, 1985, 2009; Kirk & Kutchins, 1992). Some institutions, like psychiatric hospitals, succeed in shielding their treatment models, ideologies and practices from these external, complex discussions about appropriate treatments and interventions. They consequently succeed in depicting their treatment technology as based on a rational, unambiguous body of scientific knowledge, such as the biomedical psychiatric approach. Most MHC institutions are however constantly confronted with changing ideas on what appropriate treatments/interventions and the corresponding organisational structures are, with government financing bodies, accreditation bodies, professional groups and other interest groups, and are faced with the challenge of constantly adapting to this changing institutional context and ensuring themselves of the essential influx of resources. They do this by avoiding a strict link between their current treatment practices and their ideas about appropriate treatment practices. For example, the use of diagnostic labels in MHC will only determine the nature of the actual interventions of therapists to a slight extent (Kirk & Kutchins, 1992). The institutional approach therefore points out the very loose internal organisation of service organisations in MHC (Scott, 1985a, 1985b). Their routine current treatment practices and the accompanying organisational structures have a dynamic that is more or less independent of the ideologies or 'rational myths' (Meyer & Rowan 1977), or shared belief systems about appropriate and desirable forms of treatment (D'Aunno et al., 1991) that act as the justification for their activities. The loose connection between the two ensures that institutions can continue to operate in an environment characterised by changing ideas with regard to proper and appropriate care.

Organisations try to ensure themselves of an influx of resources. Therefore, ideology becomes detached from practice. Ideas evolve, but organisations often maintain their old way of operating. For example, the government promotes new ideas such as the recovery perspective and regional collaboration in MHC. Facilities in the sector take on these perspectives, while they maintain their routine practices. If the managements of the organisations in particular experience this institutional pressure to adapt to standards on how organisations should be structured and how they should work, this leads to a decoupling between operational units and management units of service organisations (Boxenbaum & Jonsson, 2017). A substantial decoupling arises between those who determine policy and those who take concrete action.
As already mentioned, not all institutions succeed in withstanding this institutional pressure to the same degree. Hospitals succeed in shielding their practices by, among other things, depicting their treatment technology as based on a rational, unambiguous body of scientific knowledge, such as the biomedical psychiatric approach, so that this is not contested.

The institutional approach stresses the distinction between rules on appropriate treatment that are technical in nature and institutionalised treatment procedures, when following the technical rules becomes an end in itself (Hasenfeld, 1985). These ritualised practices and treatment ideologies are then legitimised with reference to an underlying rational scientific model (Meyer & Rowan, 1977) that act as legitimation. The question is therefore what function psychiatric diagnostic classifications have in the present-day rapidly changing MHC (deinstitutionalisation).

3.1.2 Diagnostics and stigma

The use of psychiatric classifications is also addressed in sociological stigma literature. Stigma research had the use of psychiatric diagnostic classifications in its line of fire from the outset. This critical position hardened as a reaction to the biomedical turn in psychiatry, characterised by a growing orientation towards brain sciences from the nineteen seventies onwards (Pilgrim & Rogers, 2005). A critical movement of psychiatrists and sociologists then scrutinised the institutional basis of this growing dominance of the categorical disease model (Mayes & Horwitz, 2005; Pilgrim, 2007).

Research among the general population was also attentive to the spreading of negative stereotypes about, and a stigmatising attitude towards, people with mental disorders or people looking for professional help to deal with them. This research sees this stigma as an obstacle in the timely search for professional help (Clement et al., 2015), *inter alia* as a result of a lack of knowledge about the alleged causes of mental disorders (Gulliver et al.,2010). Moreover, stigmatisation is generally accompanied by discrimination, for example in the field of employment and housing, and this makes the recovery process more difficult (Wahl, 2012). The problem is therefore often sought outside the realm of mental healthcare.

Mental healthcare is likewise regarded as a victim of stigmatisation. Views among the general population about mental illness and the organisation of mental healthcare are highly instrumental on this point. Many people have a negative view of mental healthcare, fuelled, among other things, by media reporting. Erroneously, say the professional social workers themselves. But once again the problem of stigmatisation, in this case stigmatisation of the service (service stigma), is reduced to a problem of an illiterate or ill-informed civilian population.

In both cases little attention is paid to how mental healthcare itself, and more specifically the conventional biomedical, categorical approach itself, contributes to the problem. Research conducted among both the population at large and among users of mental healthcare shows that this is indeed the case.

In the first place the supposition that a population appropriating a biomedical standpoint on mental illness will abandon its prejudice towards people with mental problems and mental healthcare, appears not to square with the facts. This premise is behind many mental health promotion and anti-stigma campaigns, but various studies make it clear that people who adopt a biomedical standpoint and discourse as a rule stigmatise more (Corrigan & Watson, 2004). Moreover this assumption, that mental disorders first and foremost have a genetic origin or develop on the basis of disturbed brain tissue and therefore call for a pharmacological treatment, seems to have gained in importance over the last 15 years, at least in Germany (Angermeyer & Matschinger, 2005). But this does not appear to contribute to a reduction in a stereotypical and stigmatising attitude. On the contrary, studies clearly reveal that these assumptions and the adoption of the premises of tissue research encourage essentialist thinking, resulting in a heightened we/they focus (Pattyn et al., 2013).

What is more, this biomedical orientation also proves to hamper the acceptance among social workers of a prospect of recovery (Kram-Fernandez, 2018). The inclination to consider their clients' social and emotional environment from a diagnostic/categorical standpoint reinforces the experience of stigmatisation on the part of clients of mental institutions (Sercu & Bracke, 2017) – a stigma experience that impedes the clients' recovery (Verhaeghe & Bracke, 2012).

3.2 The use of psychiatric diagnostics in Belgium

3.2.1 Use in care

The exact way in which psychiatric classification systems are used in care is subject to change. The regulations that various authorities put forward on this are a guide to this use. This regulation evolves in time. Nevertheless, it is relevant to examine how much guidance is given by the government via a specific snapshot. This allows subsequent determination of the extent to which the ideas in this memorandum on clinical use of diagnostics can actually be implemented in practice.

Following is an assessment of the situation in January 2019

<u>Psychiatric hospital services</u>

Psychiatric hospital services in general and psychiatric hospitals are required to record the Minimum Psychiatric Data (MPD), including the diagnosis according to DSM-IV upon admission, upon change of service/community, and upon discharge.

In the A/T/K [*adult acute/chronic/children*] standards for psychiatric hospital services, nothing is specified about diagnostic aspects of the patients in care. For some patients who need aftercare, follow-up treatment is possible as an additional service in the RIZIV/INAMI (*National Institute for Health and Disability Insurance*) financing. In the application form, no mention is made of diagnostic codes. However, for patients with certain DSM-IV codes it is possible to request a one-time, 12-month extension.

Initiatives on sheltered accommodation, psychiatric care homes and MHC rehabilitation agreements

The initiatives on sheltered accommodation (*beschut wonen*, BeWo), psychiatric care homes (*psychiatrische verzorgingstehuizen*, PVT) and rehabilitation agreements that have arisen within the RIZIV/INAMI fall fully under regional authority as of 1 January 2019.

With regard to access to care, the Flemish decree of 6 July 2018 (takeover decree) states that a PVT or BeWo focuses on the “target group of adults and the elderly with a serious, long-term psychiatric problem (+ other criteria)”. No mention is made in this of a psychiatric classification. However, in the application forms for reimbursement, it is explicitly specified in the medical section for the health insurance fund (and for possible *à posteriori* checks by the Care Fund Commission (*zorgkassencommissie*)) that the coordinating physician of the BeWo and the coordinating and treating physician of the PVT must fill in DSM-5 codes on the application form. In the framework of compliance with the federal Minimum Psychiatric Data, the BeWo and PVT are asked to transmit data on the patients in care to the Agency for Care and Health annually. The same applies to the “multidimensional psychiatric diagnosis” upon admission and discharge. In practice these are the DMS-IV codes along the five axes. As of 1/1/2019, the MHC rehabilitation agreements also fall fully under regional authority. In Flanders, classificational diagnosis codes using DSM or ICD are requested in the medical section of the application for reimbursement. In the agreement for centres for outpatient rehabilitation of children, a classification according to ICD-10 is requested.

For the Walloon Region, a memorandum of understanding effective from 1 January 2019 was signed by the federal authorities and the federated entities in October 2016. Its aim was to make obligatory the implementation of a new version of the minimum psychiatric summary by means of transversal registration between hospitals, psychiatric care homes, sheltered housing initiatives, mental health services and rehabilitation agreements. To date, the implementation of this memorandum of understanding has not been the subject of any concrete operational implementation either at the federal level or within the Walloon entity. We do not know whether this new version of the minimum psychiatric summary will be implemented.

Youth assistance and care for the disabled

In Flanders, there is a distinction between directly accessible youth assistance and non-directly accessible youth assistance. If non-directly accessible help must be allocated, a DSM classification is necessary in the assessment process when an MHC problem or handicap is suspected. This is a part of the registration document. Often this diagnosis/assessment is made by an approved multidisciplinary team. The same also holds (within the framework of the M Decree) for referrals to special education, and in part for the application for extra support within regular education (within the new support model, previously inclusive education (*inclusief onderwijs*, ION) or integrated education (*geïntegreerd onderwijs*, GON)). Although the sector of student guidance centres (*centra voor leerlingenbegeleiding*, CLB) attaches great importance to an action-oriented approach, within the pro-diagnostic protocols of the sector there is repeated reference to the DSM-5. It is clear that none of these sectors limits itself to merely classificational diagnoses and that the importance of action-oriented diagnostics is strongly emphasised. Action-oriented diagnostics is focused on drawing up an individual functional profile with the attributes and vulnerabilities of both the child or the young person and his or her environment, offering explanations for problems that occur in daily life, and establishing subsequent indications for individualised support and treatment.

Also in Wallonia, there are many organisations and bodies that deal with youth assistance and care. If we limit ourselves to those that fall within the remit of the regional and community authority, we can differentiate between the services that fall under AViQ (Agency for Quality of Life), under Youth Assistance and the ONE (Office of Birth and Childhood), and under the PMS (Psycho-Medical-Social Centres) and specialised schools. For services provided under AViQ, a multi-diagnostic report is mandatory for admission, but no DSM or ICD diagnosis is required. No diagnosis is required for services provided by Youth Assistance and the ONE. To be placed in mental health care, no diagnosis is currently requested, but in the future a minimum psychiatric summary with diagnosis will be required. A multidisciplinary report is required to be eligible for admission to a specialised school, but a DSM diagnosis is not explicitly requested. Specialised education distinguishes among several types, and to distinguish these types a report is requested but a psychiatric or DSM diagnosis is not required. No diagnosis is necessary for care at a PMS Centre.

3.2.2 Policy perspectives

To gain insight into the current policy vision on use of the DSM and related classification systems, the working group consulted with Mr Harmen Lecok, MHC advisor of federal minister De Block, Ministry of Social Affairs and Public Health.

From a policy perspective, the limitations in the use of psychiatric classification systems are acknowledged. The importance of a shift toward thinking in terms of support requirements, care needs and more transdiagnostic approaches that do not just stress particular diagnostic categories, but stress broader processes and dynamics that transcend specific disorders, is recognised. There is a desire to see this linked to a shift toward more recovery-oriented therapy, socialisation and reduction in residential beds.

3.2.3 Conclusion

The various authorities in Belgium do not strongly emphasise the use of psychiatric classification systems such as the DSM and the ICD in clinical diagnostic situations. The legal framework gives both individual caregivers and care organisations broad discretion in how they may make use of psychiatric classification systems. The government focuses mainly on use for registration purposes. The primary purpose of this seems to be that it is an opportunity to gain insight into types of psychiatric problems at the population level.

4 Clinical use of psychiatric diagnosis

4.1 Observations about contemporary psychiatric diagnosis

Contemporary clinical diagnostic practice is diverse, but to a large extent it is dominated by the DSM-IV (and in the near future DSM 5) and the ICD-10. These were initially developed for policy-making and epidemiological purposes, but especially from the 1980s onwards these manuals have been guiding clinical diagnostic practice to a large degree. When asked what diagnosis is, many people now think of selecting the correct classificatory category, like ‘schizophrenia’ or ‘major depressive disorder.’

In clinical practice such classificatory characterisation is often supplemented with results from standardardised psychological tests and case-specific notes, which also reflect the kind of setting in which the professional works, his/her professional training, and his/her theoretical background. This might give rise to individualized case formulation. The use of such case formulations is actually recommended by the DSM since the 1980s. In the DSM-5 (p. 19) this is formulated as follows: “The case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological, and biological factors that have contributed to developing a given mental disorder.” By taking such information into account, the clinician should develop a balanced idea of the problems or symptoms the individual is affected by, which should ultimately lead to a balanced clinical intervention: “The ultimate goal of a clinical case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual’s cultural and social context” (DSM-5, p. 19).

However, as Nancy Andreasen (2001, p. 674), a former editor of *American Journal of Psychiatry,* notes: “Many of us are besieged by injunctions to interview and diagnose patients as quickly as possible, and sometimes even to eliminate our ‘old-fashioned’ and ‘inefficient’ narrative records that summarize present illness and past history, replacing them with checklists of diagnostic criteria and symptom ratings.” All too often diagnosis tends to be reduced to pigeonholing complaints, whereby time-consuming activities, such as careful clinical case formulation do not fit the agenda of the diagnostician. Such reductionist use of psychiatric classification is not countered by the DSM and ICD manuals, which only concentrate on defining distinctive characteristics of multiple disorders.

Alternatively, it could be argued that this ‘reductionist’ use of psychiatric classification systems would be largely unproblematic, if research would learn that the validity, reliability, predictive power and pragmatic use value of common classification categories would be good. However, this is not the case.

Below we discuss 3 fundamental problems with the clinical use-value of classification-based diagnosis.

4.2 Problems with the reliability of psychiatric classification systems

A first problem concerns the problem of using these classification systems in reliable ways. Key to the development of DSM and ICD is that these aim at enhancing unambiguous diagnostic decision-making by formulating checklists of relevant characteristics for each disorder in the manual. Publications on diagnosis since the DSM-III often mention the heroic effort made by many in terms of improving its reliability in psychiatry. This is illustrated in the DSM-5 (p. 5), where it states that the “DSM has been the cornerstone of substantial progress in reliability.” Yet, research focusing on the DSM-5 field trials demonstrates that this is not the case (Vanheule et al., 2014).

In the DSM-5 field trials (Clarke et al., 2013; Regier et al., 2013), inter-rater reliability of 27 of the 347 DSM-5 diagnostic categories was tested. On a pairwise basis, 286 trained clinicians evaluated 1466 adult and 616 pediatric patients. This is the largest study that has yet been done on psychiatric inter-rater reliability. Reliability was evaluated by means of intraclass kappa coefficients, which reflect “the difference between the probabilities of getting a second positive diagnosis between those with a first positive and those with a first negative diagnosis” (Clarke et al., 2013, p. 47). Accurate kappa coefficients could be calculated for 15 disorders in adults and for eight disorders in children. Starting from the 2013 kappa thresholds, the DSM-5 field trial in adults observed very good reliability for three disorders (posttraumatic stress disorder: κ = .67, complex somatic disorder: κ = .61, major neurocognitive disorder: κ = .78); good reliability for seven disorders (including schizophrenia: κ = .46, alcohol use disorder: κ = .40 and borderline personality disorder: κ = .54); questionable reliability for four disorders (including major depressive disorder: κ = .28, generalized anxiety disorder: κ = .20, and antisocial personality disorder: κ = .21) and unacceptable reliability for one disorder (mixed anxiety-depressive disorder: κ = .00), which was eventually excluded from the DSM-5 manual. In the pediatric sample, very good reliability was observed for two diagnostic categories (autism spectrum disorders: κ = .69, ADHD: κ = .61); good reliability for two conditions (avoidant/restrictive food intake: κ = .48, oppositional defiant disorder: κ = .40); questionable reliability for two categories (disruptive mood dysregulation: κ = .25, major depressive disorder: κ = .28) and unacceptable reliability for one disorder (mixed anxiety-depressive disorder: κ = .05). Whereas this field trial was able to estimate reliabilities for *some* disorders, the majority of DSM-5 diagnostic categories were not tested at all: the DSM-5 counts 347 disorder categories, but kappa coefficients could only be calculated for 20 conditions (6%). Moreover, of those categories only 14 had a good or very good reliability, which means that only 4% of the DSM-5 categories have been shown to have sufficient reliability. Just because the field trials indicate that two out of three conditions had good kappa coefficients does not imply that the same is true for all other DSM-5 categories (94% of the manual). These might constitute reliable diagnostic categories, but for the moment have not been studied in sufficient detail.

Moreover, a comparison of the DSM-5 field trials versus pre-DSM-III studies (Spitzer & Fleiss, 1974) indicate that reliabilities anno 2013 are *not better* than those observed in 1974, and actually remain in the same range (Vanheule et al., 2014). While some disorders are now diagnosed more reliably (e.g. psychophysiological reaction/ complex somatic disorder), the reverse is true of other conditions (e.g. alcoholism/alcohol use disorder). Moreover, the diagnosis of mood/affective disorders remains a big concern.

One reason for this poor overall reliability is that often patients have symptoms that lack diagnostic specificity as they occur trans-categorically across different disorders, and/or patients end up with multiple diagnostic labels. Moreover, especially in people with persistent mental health problems, diagnoses often shift over time, while observed functioning does not change much.

4.3 Problems with the precision of psychiatric classification systems

A second problem concerns the diagnostic precision of DSM and ICD diagnostic categories. It is presumed that a diagnosis in psychiatry provides us with a precise idea about core symptoms, need for care, and prognosis, providing reliable and precise information about interventions and illness course. However, evidence indicates that such precision is lacking from DSM and ICD diagnostic categories.

The diagnostic categories in psychiatry are different from the diagnostic categories in, e.g. pulmonology or internal medicine, where a biological test can sometimes verify whether you have the disorder or not, or at least help in making clinical decisions. There is no such biological test available for the DSM diagnostic categories. This has led to the worrying consequence that people can receive a psychiatric diagnosis and medication, based on the subjective interpretation by the clinician of the vague criteria of an invalid, polythetic classification system. Some people may need medication, but currently medication prescription sometimes occurs because it is more convenient for the environment, substantiated by the DSM criteria that are multi-interpretable (Nieman, 2016).

Evidence indicates that too many people and especially children, are currently labeled with a DSM/ICD diagnosis. Probably personal characteristics and context variables strongly influence the labeling process. For example, a study of the University of British Columbia

(UBC) showed in the medical records of 937,943 Canadian children that the youngest children in the classroom are significantly more likely to be diagnosed with ADHD – and given medication – than their peers in the same grade (Morrow et al., 2012). Children born in December, close to the cut-off date for entry into school in British Columbia, were 39 per cent more likely to be diagnosed with ADHD than children born 11 months earlier. December-born children also were 48 per cent more likely to be treated with medication than their January born peers. The gap in ages among students in the same grade creates what researchers call a ‘relative age effect’, in which younger children within the same age cohort are at a disadvantage in academic and athletic activities. Younger students within a grade may be diagnosed with ADHD because they are less mature. Recently Kayal et al. (2017) replicated these results in a comprehensive study.

Problems of medicalization arise when psychiatric diagnostic categories are used to describe variation in mental health complaints in a general population (Horwitz 2002).

4.4 Problems with the validity of psychiatric classification systems

A third problem concerns the validity of the DSM disorder categories: for many disorder categories psychological and psychiatric basic research does not support the diagnostic criteria from the checklists, thus undermining the relevance of the disorder category. In order to be valid, a disorder category has to be reliable in the first place. Yet, even when the reliability of a disorder category is good, its validity can be problematic. For example, in an analysis of the criteria that make up PTSD, Rosen & Lilienfeld (2008) conclude “that virtually all core assumptions and hypothesized mechanisms lack compelling or consistent empirical support.” Most probably the objective to find a specific and coherent neurobiological structure underlying specific disorders is far too ambitious, except perhaps for neurocognitive disorders (Frances, 2013; Kagan, 2012; McNally, 2011; Van Os, 2016).

A final issue is related to the superior measurement properties of dimensional indicators of mental ill health. Overall dimensional measures are more sensitive to change, such as over time, or between conditions (Mirowsky & Ross 2002). As a result, the use of categorical measures hinders the accurate assessment the recovery process and the impact of situational factors. A weak association between, for instance, level of education attainment and a diagnosis of depression is often interpreted as evidence that major depression is less sensitive to social conditions, but that could not be farther from the truth. The categorical measure is just a bad indicator, because of the use of cut-off points. The same holds for the evaluation of the effects of intervention and treatment. As meta-analyses of, for instance, Fournier et al (2010) show, diagnostic categories are used to initiate treatment amongst homogeneous groups of clients, but dimensional measures are preferred to model change in severity of symptoms.

4.5 Changing conceptualizations of mental health and mental health problems.

Characteristic of both the DSM and the ICD approach of diagnosis is that these strongly bear witness to a decontextualized approach of mental health problems that focuses on dysfunction only. In the DSM-5 (p. 20) the following definition of mental disorder can be found: “A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.” This definition indicates that above all, mental disorders are conceptualized as typical sets of symptoms and clinically observable signs that make up a syndrome. The main problem is that scientists actually don’t know how ‘functional’ mental activity would be organized, and as a result all evaluations of dysfunction rest on value-laden assessments. According to Jerome Wakefield, it sanctions behaviours in terms of how unusual they are in the general population. Along this way the manual “replaces the dysfunction requirement with the requirement that the condition cannot be a statistically expectable response to the environment” (Wakefield, 1992, p. 233). Dysfunction cannot be adequately defined; therefore the DSM takes an a priori focus on behavioural traits, thus sanctioning extreme modes of behaviour and experience. Interestingly, Wakefield (2010) also stresses the value-laden dimension of diagnosis: symptoms are embedded in contexts, and have a moral meaning that coheres with the context and the individual. Along this way, he warns us against a normative approach to dysfunction that only starts from opinions of others and statistical information about human functioning, thus making a plea for us to take into account the diagnosed person’s perspective in diagnostic evaluations. The DSM, by contrast, does not specify the necessity to build on the subjective experience of the individual who is diagnosed. As a result, deviance from the statistical mean, and opinions of others concerning the unacceptability of someone’s behaviour, tends to be central to the evaluation of dysfunction.

A further problem with the DSM definition is that it does not specify how disabilities should be conceptualized. The concept “disability” is complex, and has a long history (Mallet & Runswick-Cole, 2014). The World Health Organization currently defines it as “an umbrella term for impairments, activity limitations, and participation restrictions. Disability refers to the negative aspects of the interaction between individuals with a health condition (such as cerebral palsy, Down syndrome, depression) and personal and environmental factors (such as negative attitudes, inaccessible transportation and public buildings, and limited social supports)” (WHO, 2011b, p. 7). What is important about this definition is that disability is not only an individual problem, but a contextual and interactional phenomenon: “disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others” (WHO, 2011a, p. 4). In line with this definition, many mental health problems imply significant disability, which, for example, can be observed in a reduced capacity to participate in mainstream jobs and schools. Often, people with symptoms are hampered by prejudice because of unusual aspects in their modes of functioning. Prejudice and rejection obstruct social interaction. The WHO definition implies that disability is an outcome of the *interaction* between an individual and a context, which both have peculiarities. Indeed, disability is not simply a personal trait that can be attributed to an individual, but is just as much an expression of how the context around an individual is organized, and how contextual mechanisms of exclusion hamper the individual.

Thus considered, the WHO-disability diagnosis goes hand in hand with empowerment-oriented thinking. Given the fact that social environments are shaped by social values this viewpoint implies that, in part, disability is caused by the context. Disability holds up a mirror to the context, and points to expectations and elements of prejudice, through which an individual is judged, just as it reflects idiosyncrasies in an individual’s functioning. By leaving disability undefined, and not embracing such an interactional perspective, the DSM, by contrast, might well entail an individualizing focus, in which disability is seen as an outcome of personal dysfunction.

Moreover, it is unclear whose perspective is taken as a reference in the DSM assessment of disability. Clearly, the WHO definition implies that the position of the individual who experiences disability stands to the fore. Conversely, DSM-oriented diagnosis might well imply that opinions of others prevail, while already early in life people are important informants about their own mental condition (Egger, 2009).

Meanwhile, societal ideas about health and healthcare are changing. In 1948, the World Health Organization started defining health as synonymous to an individual situation of being free from symptoms: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (www.who.int/about/mission/en). Clinically, such a definition coheres with a diagnostic focus on detecting symptoms of specific disorders, and a treatment approach that aims at deleting symptoms. Nowadays, new approaches on health are emerging. In 2011 Huber and colleagues launched a new definition of health: “Health as the ability to adapt and to self manage, in the face of social, physical and emotional challenges”. Within this view, health is not only composed of bio-psychosocial components, but also has an existential dimension: mental health problems challenge people’s self-experience as well as their social and societal position, which is often seriously hampered.

4.6 Recovery: a new paradigm in psychiatry

An important concept that coheres with this new approach of health is *recovery*. Initially, the concept of recovery emerged from the service user movements in the 1970s, challenging traditional biomedical approaches to mental illness. Key to this movement is the shift from services based on traditional clinical outcomes (absence or reduction of symptoms) to recovery “as defined by the service user’s view of what is needed or desirable in the care s/he is encountering to help him/her resume a meaningful life and valued roles” (Pincus et al., 2016). The recovery movement criticizes the dominant narrow emphasis on diagnosis and guidelines, which starts from a limited definition of health. Currently, recovery is mainly studied among adults. Discussion and studies of how it applies to other age groups are still scarce (Ozonoff, 2013).

In contemporary literature (e.g. Slade & Longden, 2015; Lloyd, 2008) three kinds of recovery are often discerned: (1) clinical recovery; (2) personal recovery; and (3) social recovery.

The concept of *clinical recovery* has emerged from professional-led research and practice, and is often defined as “full symptom remission, full or part-time work or education, independent living without supervision by informal carers, and having friends with whom activities can be shared, all sustained for a period of two years” (Slade & Longden, 2015, p. 3). It is conceptualised as a psychological change that has to occur within an individual with a mental health condition, for which evidence-based recovery-promoting rehabilitation interventions might be designed (e.g. Morin and Franck, 2017). A major risk of such approach is that while promoting personal change, it tends to blame the individual if positive outcomes fail to occur (Stuart et al., 2017).

The concept of *personal recovery* evolved from the mental health service user and survivor movement, and is usually defined as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993, p. 12). This definition starts from a first-person perspective, in which personal experience is pivotal. Leamy and al. (2011) developed an empirically-based conceptual framework of personal recovery organised around five key areas: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (CHIME). In a recent systematic review Stuart and al. (2017) endorsed this framework, but also expanded it by acknowledging people’s difficulties and struggles to recover. This gave rise to the CHIME-D model that involves six factors crucial to personal recovery (Stuart et al., 2017, p. 299):

1. Connectedness: Peer support and support groups; relationships; support from others; being part of the community)
2. Hope and optimism about the future (Belief in possibility of recovery; motivation to change; hope-inspiring relationships; positive thinking and valuing success; having dreams and aspirations)
3. Identity (Rebuilding/redefining positive sense of identity; Overcoming stigma)
4. Meaning in life (Meaning of mental illness experiences; Spirituality; Quality of life; Meaningful life and social roles; Rebuilding life)

5. Empowerment (Personal responsibility; Control over life; Focusing upon strengths)
6. Difficulties (Ambivalence and contradiction; disempowerment; financial concerns; loss and negative life changes; stumbling, struggling and suffering; substance use comorbid with mental illness)

The concept of *social recovery* is sometimes used as a synonym of personal recovery, but more specifically refers to the community-related dimension of recovery, with goals to restore social skills and social inclusion in diverse social networks (family, friends, supportive professional school/work, leisure…) (Lloyd, et al., 2008; Mezzina, 2006a). During the course of their mental illness, many people suffering from mental health problems internalise societal notions of severe mental illness as they take on a patient's role and identity, becoming more lonely and isolated from common social networks (Mezzina, et al., 2006b). Social recovery consists of realizing social inclusion, such that one regains power and status in ordinary social life, and is involved in social networks that don't exclusively consist of people suffering from mental health condition and health care professional. Such recovery is obtained if one regains active citizenship, that is: "the practice of exercising one's social rights" (Mezzina, 2006a), and can fulfil role domains that are both of interest to the person with a severe mental illness, but are also valued by the wider community (Lloyd, et al., 2008). Chester et al. (2016, p. 271) define social recovery as "being able to live with minimal social disruption and being financially independent with stable accommodation".

Traditional accounts of mental health only pay attention to clinical recovery. The recovery movement urges to take a wider scope, and to also include personal and social recovery. The definition of a meaningful life is personal and depends on what people really aspire to and what is important to them (Shrank & Slade, 2007)
In this broad approach of recovery, self-narratives play an important role. When suffering from mental health problems people need a contextualised account about themselves that pays attention to strengths and vulnerabilities, and help them giving a chance to create meaning around their experiences and articulate the CHIME-D components in the context of an individual's life.

Moreover, while the traditional biomedical approach of mental health problems makes a strict distinction between diagnosis and treatment, such is not the case from the perspective of recovery. Traditionally, mental health care is organised as follows: first an intake takes place, often resulting in a DSM or ICD classificatory diagnosis. Frequently, in a next stage, an intervention takes place, preferably focusing on evidence-based treatment guidelines. The recovery-based model starts from a different perspective: it focuses on the challenge of managing symptoms and suffering; contextualizing symptoms and suffering in an empowering way; questioning and changing life contexts and ways of living such that meaning, identity and connectedness can be found; and questioning and changing social contexts such that these support social recovery. With respect to intervention and support this opens the question focusing on how we can help supporting the recovery from such mental crises. Recovery requires professionals to have a supportive role at all levels. In this process, partnership and shared decision-making are important: professionals should get in touch with patients' values, affinities and goals, and adapt interventions onto this. From a recovery perspective traditional treatment approaches and evidence-based protocols make up only one intervention strategy within a broader relational process.

Considered from the perspective of recovery, people with mental health problems make up a diverse group. After an initial crisis some recover entirely at all levels of recovery. Other people chronically keep wrestling with their mental health condition, and to diverse degrees they keep experiencing constraints at the level of clinical, personal and/or social recovery, which might imply a need for continued support. While many persons actually recover, others don't or only very poorly so make a step towards recovery. Some mental health conditions (like the degree of long standing psychosis or the degree of severe addiction) and personal characteristics (like intelligence or age) might make up a difficulty or barrier for recovery, for which it is crucial that it does not lead to blame and exclusion. Overall it should be assumed that there is a continuum between (complete) recovery and sustained need for support. People suffering from mental health problems, whether moderate or severe in nature, whether episodically or long standing, don't make up a different kind of people than those who are currently free of such problems. Psychopathology should be assessed on dimensions of psychosis, anxiety, depression, autism, hyperactivity etc., and treated in an integrated manner. The need for support should be assessed carefully, and, possibly accompanied with a judicious use of psychopharmacology, psychosocial support and psychotherapy should be tried first. Recent developments, like so-called Headspace centres can play an important role in helping young people in the early stages of mental illness to reduce the chance of severe mental illness. Headspace centres are low stigma settings (www.headspace.org.au) where not only young people (12–25 years) with severe psychiatric problems seek help but also young people with early and mild to moderate problems are encouraged to seek assessment and care. It is not necessary to be referred or receive a DSM/ICD diagnosis before or even after help is provided. In headspace centres young people and/or their parents and friends can seek help for problems ranging from general health, education, to drug use, anxiety and other (emerging) psychiatric symptoms. This enables stepped-care psychiatric interventions for help-seeking youth, and reduces the level of under-treatment as well as the risk of premature and over-treatment with medication provided by health care professionals who are not yet familiar with the clinical staging concepts (McGorry et al., 2011, 2014; Nieman & McGorry 2015).

Interestingly, the recovery approach implies that diagnosis should move beyond the mapping of symptoms with the aim of controlling these through interventions. Symptom management is important, but personal recovery and societal recovery are equally crucial. Therefore, diagnosis should not be limited to a clinical assessment of symptoms and syndromes, but should just as well reflect an individual's stage of recovery, as well as reflect one's need for care and support in the process of personal recovery.

4.7 The alternative: multi-layered diagnosis

The topic of psychiatry is extreme subjective experience that cannot be mapped one-to-one to a biological substrate in the brain. Subjective experience is influenced by biological, environmental, social, mental and existential factors. All human beings are vulnerable to (Calmeyn 2014), what is labelled as, psychiatric symptoms because: *'each of us craves perdurance, groundedness, community and pattern and yet we must all face inevitable death, groundless, isolation and meaninglessness'* (Yalom 1980). Thus, suffering is inherent to living but modern western societies do not seem to acknowledge this fact. A consequence is that many people with mild complaints of depression and anxiety are labelled with a psychiatric diagnosis and treated whereas those with severe psychiatric symptoms are left untreated because of mental healthcare waiting lists, often with detrimental consequences.

In psychiatry, an individual-focused approach may be important instead of trying to fit individuals in diagnostic categories. The blend of biological, environmental, social and existential causal and maintaining factors in psychiatric symptoms has probably as many variations as there are people. Therefore, each person deserves an idiographic, personalized approach in which his/her blend of causal and maintaining factors is investigated. Some factors could be influenced, but others not. This approach may lead to a more enduring recovery than trying to fit individuals in broad diagnostic DSM categories that have not much value for understanding the problems of the individual patients or for possible solutions for these problems (Nieman, 2016).

As an alternative to the dominant disorder-oriented approach of diagnosis with the DSM or the ICD we propose that in clinical situations a contextualising approach should be followed, in which the symptom(s), complaint(s) and/or experience of suffering a person is bothered by is taken as the point of departure. As a first step in the diagnostic process these symptom(s), complaint(s) and/or experience of suffering should be characterised descriptively, such that in a next step these can be situated relative to three aspects of broader functioning.

First, symptom(s), complaint(s) and/or experience of suffering should be discussed in terms of different domains concerning a specific area of human functioning, and that cannot be reduced to one another. Such personalised characterisations should situate and discuss someone's functioning in terms of his or her lifespan and biopsychosocial context.

The following five domains are best taken into account:

A. Biographical factors; course of life; pathobiography and treatment history.

B. Existential factors and issues in life. We need to consider that the concerns rooted in human existence (death, meaninglessness, isolation) inevitably lead to some degree of anxiety and depression, and might also make up the dynamic basis of other symptoms. Yet, the struggle with issues of human existence is not per definition pathological.

C. Contextual-interactional functioning (family, relationships, work, school, leisure). Dependent on differences between specific individuals and between different moments in life psychosocial contexts can both serve as a destabilizing and crisis-provoking factor or as a resilience-creating force. How they function in relation to an individual's mental health problems should be studied in detail, thus paying attention to the opportunities and threats these imply for the process of recovery.

D. Mental processes, psychological dynamics, behaviour patterns, systemic processes. Usually, the functioning of people with mental health problems is organised in patterned ways, which can be characterized by making use of psychological theories. Clinicians can best make use of such frameworks in characterising the functioning of people with mental health problems. Currently relevant frameworks include developmental and lifespan psychological frameworks; cognitive-behavioral models; psychoanalytic and psychodynamic theories; experiential and client-centred approaches; and systemic approaches.

E. Biological factors and psychopharmacological models.

Second, symptom(s), complaint(s) and/or experience of suffering should be discussed in terms of descriptive knowledge about psychiatric syndromes. For this purpose, the complex list of disorders discerned in the DSM is not required, since it has the disadvantage of directing the focus towards hypothesized fixed conditions an individual suffers from. A better way for this type of diagnosis probably is to give a broad classificatory characterisation of people's mental health conditions in the form of a limited number of broad syndromes (psychotic syndrome, anxiety syndrome, addiction syndrome, depression syndrome, etc), which in their own turn might constitute dimensions.

In this context, categorization and the illness threshold need to be re-examined. The categorical classification system should be replaced by a service system (not-necessarily within psychiatry) that takes into account the observation that general human concerns and problems may need psychosocial support while psychiatric diagnosis is not needed. The dimensional nature of psychiatric symptoms should be taken into account as well (Hickie et al., 2013; McGorry 2006; 2013; McGorry et al., 2007; 2014; Nieman, 2016; Scott, 2011; Scott et al. 2006).

Third, symptom(s), complaint(s) and/or experience of suffering should be discussed in terms of the continuum ranging from crisis to recovery. Recovery is best discussed in its clinical, personal and social dimensions. Recovery should not only be discussed as an individual process, but also in terms of the contextual and interactional processes that either support or hinder recovery.

4.8 Diagnosis by means of clinical case formulations

Practically, such multi-layered approach of diagnosis implies the use of *clinical case formulations* (Vanheule, 2017; Van Os, 2018). A clinical case construction is a narrative description in which symptoms and mental health complaints are framed within the context of a person's broader functioning, such that the impact of symptom and context, the logic of functioning, as well as strengths and aspects of resilience are mapped. Case formulations can be constructed on the basis of concrete material from clinical meetings, observation data and information from psychological testing. The diagnostician discusses this material with the aim of making clear *how* problems are organised (Bruch & Bond, 1998).

On the basis of an overview study of definitions that authors with various theoretical backgrounds use, in this regard, Sturmey states (2009, p. 8) that a case formulation usually has the following four characteristics:

1) It discusses the core aspects of a case; i.e., it does not just list endless details about the patient and the content of sessions.
2) A case formulation integrates the information about a case in the context of a coherent idea about the nature of the problems with which the patient is struggling.
3) Case formulations are always tentative and reflect what the clinician knows until then. In other words, additional information may always ensure that one can revise her opinion about a case.
4) A case formulation aims at giving direction to interventions.

These characteristics indicate that a case formulation is a *reasoned assumption*. The diagnostician starts by listening and observing – if relevant supplemented with test results – and brings the gathered information into dialog with theoretical ideas and research data on psychopathological mechanisms and structures. In making case formulations clinicians should make use of clinical theories (developmental and lifespan psychological frameworks; cognitive-behavioral models; psychoanalytic and psychodynamic theories; experiential and client-centred approaches; and systemic approaches) and insights drawn from research, and be explicit about what they observe, and what they extrapolate. In this interplay between clinical material and theoretical knowledge the diagnostician, making use of abductive reasoning, constructs a logical-plausible hypothesis about how an individual's problems are organised (Vertue & Haig, 2008).

The work on a case formulation consists of a continuous dialectic between the collection of clinical data and a theoretically informed reading of the collected material. Along this path the diagnostician constructs a knowledgeable and relevant interpretation of the individual's (dis)functioning, without assuming that they can ever provide an exactly correct explanation. Case formulations articulate a plausible construction, but the explanation is never complete. The knowledge that we build along this path is uncertain and not to be simply generalised to other cases or over time.

A case construction is usually built up on the basis of material that is collected in a limited time period. They are not longitudinal observations that reflect the actual path through which a symptom has evolved, but information that at most expresses logical relations between specific aspects of someone's functioning. That is why it is also usually not justified to draw causal conclusions in a case construction. What can be achieved at best is a clarification of the internal structure in someone's functioning. In a case formulation, a diagnostician discusses observed materials with the aim of expressing *how* problems are organised. Theory is necessary for building such a case construction, which implies that different theories most probably result in different kinds of explanation. At the same time, clinical case constructions should be more than just psychological snapshots, and integrate information about the problem in a time frame that characterizes its genesis as well as evolution across time. Given the tentative nature of a case formulation is it possible that two diagnosticians interpret the functioning of a patient in different ways, particularly when they use different theoretical frameworks. In addition, both constructions can be pertinent and articulate a plausible framework around the problems someone is wrestling with. In order to determine what formulation is the best, one needs to take a pragmatic position: The value of a case formulation depends on the extent to which it enables the clinician to respond adequately (Vanheule, 2017).

Clinical case formulation should be seen as a matter of co-creation, in which the one suffering from mental health problems is actively involved in analysing and formulating his/her problems. Some mental health conditions (like in acute psychosis) and personal characteristics (like intelligence or age) might make up a difficulty or barrier for active participation, but then again people should be approached as active informants about their own mental condition and context they live in. It should be investigated in a collaborative way what the individual blend is of social (e.g. isolation), environmental (e.g. stimulus overload in large cities), biological (e.g. stress) and existential (e.g. meaninglessness) factors and whether these factors can be influenced. Meaning can often been (re)found in self-actualization. The therapeutic relationship with a healthcare professional, trained peer or expert by experience that is characterized by genuineness, empathy and positive regard (Yalom, 2017) should be at the core of the treatment.

Through its strong focus on a casuistic study of the logic in a patient's functioning, diagnosis by means of case formulation is by itself vulnerable to becoming too strongly influenced by the style of a diagnostician, and by errors of thinking or preconceptions in his or her functioning. That is why diagnosis by means of case formulation should entail a reflexive method for quality monitoring that helps diagnosticians to optimise the validity and reliability of their decision-making. *Reflexivity* is pivotal to good quality assurance, and indicates the need for an overall critical attitude. Applied to the praxis of clinical case construction, reflexivity implies that in preparing case formulations diagnosticians should bring into account the influence of their own perspective. *Reliability* relates to the importance of systematic work and to excluding possible sources of distortion. Obtaining good reliability requires that attention is paid to the logical consistency of the clinical decision-making process and to potential sources of bias. *Validity* concerns the efforts to guarantee that findings are correct. To come to sound decisions, the clinician must carefully test and check whether conclusions are well founded in interview materials, observation data and available test results. Case constructions can only be valuable if they build on sufficient data and on accurate source materials (Dawson & Moghaddam, 2016; Vanheule, 2017).

III CONCLUSION AND RECOMMENDATIONS

DSM is a classification instrument first published over 40 years ago. The most recent version is DSM-5. The instrument presents a number of fundamental problems in terms of epistemology, validity and reliability. We estimate that the quality of the instrument in its current set-up and form cannot be substantially improved. This inherent problem is often not recognised in institutional and clinical use.

As the various Belgian authorities offer clear discretion in the use of psychiatric classification systems, it is realistic to implement the recommendations below.

- We recommend dealing carefully with classification instruments such as DSM and ICD and showing caution when making diagnoses. Given the somewhat limited scientific evidence for discerning sharply defined psychological disorders, we believe it is best when classifying to work primarily with the main categories.

- It is best to consider those disorders as broad spectra within which varied symptoms can occur and where floating transitions to a state of personal and social well-being take place. In addition, it is best to view those disorders as syndromes (i.e. groups of symptoms/complaints that often occur together) that disrupt day-to-day functioning, rather than as expressions of "underlying" diseases.

- When people use or are given diagnostic labels, then they often soon begin making "essentialising" statements. The disorder is then seen as a static characteristic of a person that causes problems. Just think of statements such as: 'He is boisterous because he has ADHD'; 'She doesn't work because she's depressed'. This is a problem because the categories in DSM and ICD are simply descriptions of behaviour which typify the "surface" of the way an individual functions. We recommend making no essentialising statements, either in consultation between professionals or in communication with care users.

- We advise laypeople, professionals, policy makers and researchers to use diagnostic labels with caution. People with a diagnosis are sometimes viewed too narrowly from the perspective of that diagnosis. Aspects of their perception are all too quickly pathologised. This is stigmatising. We advise acting with greater circumspection on this point.

- Labelling on the basis of categorial diagnoses leads to split thinking, whereby "they" are different from "us". This creates remoteness, so that people with psychological issues are seen as different, rather than as fellow human beings. This gives rise to unwarranted treatment such as nannying, inappropriate and brazen interactions and stigmatisation.

- We advise laypeople, professionals, policy makers and researchers to take clear account of and to highlight the questing/uncertain nature of diagnoses. We recommend not seeing classifying statements as "certainties" or as static characteristics but rather as working hypotheses which have to be constantly questioned during clinical work and which can change.

- Many people who are given a diagnosis see this as official recognition of their problem. With the diagnosis, the professional puts a name to the difficulty that an individual and/or those around him are struggling with. Recognition is important and must be central when formulating cases (see below).

- We recommend considering psychiatric disorders as interactive. They testify to the struggle between person and context, and to difficulties experienced in life. On the one hand, they bear witness to the individuality of a person's mental state . On the other hand, they reflect the challenges that an individual faces in his daily environment (such as relationships, social circumstances and cultural mores). Moreover, psychological complaints and disorders often reflect a struggle with typical human existential uncertainties. These components form an interwoven, systemic whole. We recommend naming that explicitly. So it is imprudent to apply uniform cause-and-effect reasoning to categories of disorders from the DSM and the ICD. For example, one-sided "*tissue thinking*" (where the assumption is that the cause lies purely in the brain or in the genes) has no scientific basis.

- We recommend adopting a step-by-step approach to the use of diagnostics:

    - Everyone experiences psychological complaints, which show normal variations in gravity and intensity. Those complaints are all too often viewed from a psychopathological standpoint and considered to constitute problems. De-contextualising those complaints and essentialising their causes and characteristics contributes towards their medicalisation. Social standards, too, based on ideal images of mental health, encourage this problematisation. Professionals and policy makers must endeavour to adopt a non-problematizing and non-medicalising approach to psychological complaints because they may be the expression of existential problems.

    - We advise above all listening carefully to people with psychological complaints, regardless of how serious these are, taking into account the experiences and living environment of the individual and his/her significant others, such as family and other professionals. Subjective experience must be central, without automatically reducing it this via professional contexts to all sorts of explanations (biomedical / sociological / psychological). The less coming of age the person, the more significant others should be involved in the diagnostic process.

    - We advise enabling the provision of help and support for psychological complaints without a formal diagnosis as a precondition for professional help. Some psychological complaints are best dealt with by means of psycho-social support and low threshold counselling.

    - Professionals should need to enter clearly into dialogue with people who have psychological complaints and their significant others, take their experiences and their quest more seriously and share their own experiences if this is appropriate. The perspective of people with psychological complaints and the way in which they give meaning to it should be central to diagnosis and treatment.

    - In cases of persistent psychological complaints, it is best to carefully mapping the context and the need for care, paying attention to mental, existential (giving and losing meaning), organic, psychological, social and cultural factors. This can best be done in a *case formulation,* which through a narrative typifies the way an individual functions contextually, assessing the need for support/care, the crisis level and the prospects for a cure. Only within this process do we find it advisable to make statements about disorders (based on broad disorder categories that form syndrome spectra).

    - When *formulating a case,* we recommend paying close attention to the person-specific way in which, among other things, mental, existential (giving and losing meaning), organic, psychological, social and cultural factors take shape. Psychological difficulties cannot simply be reduced to standard categories. Subsequently, treatments should also be person-specific.

- At the organisational level, we recommend that DSM categories not be the focus in setting up care. We also recommend that prevention of psychological complaints and promotion of mental health literacy not be organised from an essentialising and medicalising perspective.

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V COMPOSITION OF THE WORKING GROUP

The composition of the Committee and that of the Board as well as the list of experts appointed by Royal Decree are available on the following website: About us.

All experts joined the working group ***in a private capacity***. Their general declarations of interests as well as those of the members of the Committee and the Board can be viewed on the SHC website (site: conflicts of interest).

The following experts were involved in drawing up and endorsing this advisory report. The working group was chaired by **CALMEYN Marc**; the scientific secretary **GERARD Sylvie**.

ADRIAENS Pieter R.	Philosophy	KUL
BAZAN Ariane	Psychology	ULB
BRACKE Piet	Sociology	UGent
CALMEYN Marc	Psychiatry, psychotherapy	PZ Onze-Lieve-Vrouw
DEVISCH Ignaas	Ethics	UGent
FEYS Jean-Louis	Psychiatry	CP St-Bernard
FROYEN Brenda	Experiential expertise	
LEMEIRE Olivier	Philosophy	KUL
NIEMAN Dorien	Psychology	University of Amsterdam
ROEYERS Herbert	Psychology	UGent
VANHEULE Stijn	Psychology	UGent

The following experts were heard but did not take part in endorsing the advisory report:

VAN OS Jim	Psychiatry	UMC Utrecht

The following firms/associations/etc. were heard:

VANDERBERGEN Jan	Medical Direction	Christian mutualities

The following administrations and/or ministerial cabinets were heard:

LECOK Harmen	Advisor	Ministry of Social Affairs and Public Health

The standing working group Mental health has endorsed the advisory report. The standing working group was chaired by **Jacques De Mol**; the scientific secretary was **Sylvie Gerard**.

BIER Jean-Christophe	Neurology	ULB
DE LEPELEIRE Jan	General practitioner	KULeuven
LAMY Dominique	General practitioner	
MAGEROTTE Ghislain	Orthopedagogy	UMons
VAN HOOF Elk	Clinical psychology	VUB
VAN WEST Dirk	Child psychiatry	ZNA
VERSCHRAEGEN Jurn	Social nursing	Expertisecentrum Dementie Vlaanderen

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