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Belgian Superior Health Council advises against the use of the DSM categories

Worldwide, the DSM is, much like the ICD, a frequently used classificatory diagnostic instrument. However, questions have been raised about its pragmatic and scientific status.[1–3] Therefore, in 2016, the Belgian Governmental Superior Health Council set up an expert group comprised of academics and practitioners in psychiatry, clinical psychology, sociology, and philosophy as well as a service user to evaluate relevant literature and evidence.[4]

Epistemologically, the expert group concluded that mental disorder categories should not be treated as natural kind categories but as constructs that have a causal impact on those who are classified. Sociologically, the group observed that diagnostic classifications tend to legitimise organisational structures and protect psychiatry from pressures to change. Moreover, the literature suggests that a biomedical approach does not, as hoped, reduce stigma and discrimination. Clinically, the group concluded that common diagnostic categories lack validity, reliability, and predictive power. Additionally, these do not tally with new conceptions of health, defined by the ability to adapt despite biopsychosocial obstacles.[5]

The Council observed that multilayered clinical case formulation provides a useful alternative. Thus, symptoms, complaints, and suffering can best be contextualised in terms of biographical information, existential challenges, contextual-interactional functioning, mental processes, and biological considerations. Classification can still occur but on the basis of a small number of general syndromes (eg, psychotic syndrome or depression syndrome), which stimulates personal diagnostic formulation. These should be discussed in terms of a continuum from crisis to recovery to assess the need for care and support.

The report ends with recommendations that encourage contextualised patient-centred psychiatry. These recommendations include the advice to refrain from using the DSM categories for organising and reimbursing interventions and for organising prevention and promoting mental health literacy.

The report has five key recommendations aimed at clinicians, policy makers, and the general public: (1) default non-problematising and non-medicalising approaches to mental complaints or crises because they might express existential and social problems; (2) careful listening to subjective experiences; (3) providing help and support for mental complaints or crises without a formal diagnosis as a precondition; (4) taking the perspective of people with mental complaints or crises and the way in which they give meaning as central to diagnosis and treatment; and (6) when formulating a case, paying close attention to the person-specific way in which, among other things, mental, existential (giving and losing meaning), biological, social, and cultural factors take shape.

To our knowledge, this is the first time a public body has drawn such an explicit conclusion about how psychiatric diagnosis might best be used in clinical and public health practice.

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