

RESEARCH

Overcoming Diagnostic Uncertainty: Clinicians, Patients and Institutional Work in Practice

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This article uses aspects from Institutional Ethnography to explore how both clinicians and young adults with mental health problems use different adaptation strategies to overcome the diagnostic uncertainty in psychiatry. The article illustrates the connection between the local production of diagnoses in Norwegian psychiatric outpatient clinics and the individual experience of being identified with multiple psychiatric diagnoses. The article explores how two clinicians from two psychiatric outpatient clinics produce diagnoses locally. It is shown how institutional texts coordinate the diagnostic work as 'ruling relations'. On the other side of the desk, the arbitrary element affects the young adults with mental health problems, who perform a large amount of identity work when dealing with the numerous diagnoses they are given. The young adults find the ease with which they are diagnosed, the number of diagnoses, and the way the diagnoses are used to be disturbing and confusing.

Keywords: Diagnostics; Mental health; Psychiatric outpatient clinic; Institutional Ethnography; Young adults

Introduction

Social research shows that diagnoses are powerful objectifications of individual illness experiences for different reasons (Brinkmann and Petersen 2015; Johannisson 2007; Kutchins and Kirk 1999). Diagnoses define who is pathological and who is not (Brinkmann 2016; Horwitz 2002). Diagnoses facilitate access to medical treatment and therapy (Conrad 2007; Ekeland 2011; Jutel and Nettleton 2011). Diagnoses are used by authorities as documentation of reduced work capacity, and thereby give legitimate access to social security (Järvinen and Mik-Meyer 2003; Rose 2013). Diagnoses offer a person experiencing mental health problems a scientific and standard description of the cause of their suffering (Brinkmann 2014; Hydén 2005; Mik-Meyer 2010; Mik-Meyer and Brehm Johansen 2009; Toft Rönberg 2017).

In addition, research has pointed to the fact that production of psychiatric diagnoses is an uncertain institutional process (Kutchins and Kirk 1999; Manning 2000; Rose and Abi-Rached 2013; Rosenhan 1973). Where somatic medicine largely depends on physical/biological tests when diagnosing pathological conditions, this element is absent when diagnosing mental disorders. The reason for this is the absence of testable biomarkers that can reveal mental disorders (Joyce 2011; Leo 2004; Singh and Rose 2009). To compensate for this, standardised diagnostic classifications and diagnostic questionnaires are used as an attempt to tame this inherent uncertainty and weak reliability (Burstow 2015; Ekeland 2011; Hautamäki 2018; Leo 2004).

The aim of this article is to explore how both clinicians and patients use different adaptation strategies to overcome the diagnostic uncertainty in psychiatry. The ambiguity in the diagnostic process has previously been explored in different institutional contexts. In an ethnographic study at a community mental health walk-in clinic, Brown (1987) found that the diagnostic work was full of conflict and contradiction. Brown argued that since diagnoses served different functions for different involved parties – such as the psychiatric system, health and welfare institutions, government agencies and private or governmental insurers – the diagnostic process leads to ambiguous situations and ambivalent clinician behavior (Brown 1987: 44). A more recent study demonstrates how clinicians deal with uncertainty regarding the ADHD diagnosis as it is described in the DSM IV diagnostic manual (Rafalovich 2005). This study uncovers how the clinicians negotiate and interpret the protocols for diagnosing in relation to different beliefs about the cause of the disorder and different pragmatic ways of treating children with ADHD-like behavior. The study concludes that the clinician displays a considerable ambivalence when diagnosing and treating ADHD in children (Ibid: 317).

In a study from 2010, Whooley shows that psychiatrists in New York apply different strategies to work around the restraints that the DSM puts on their work (Whooley 2010). These 'workarounds' manifest in different work practices. Some psychiatrists use alternative taxonomies when producing diagnoses, e.g. by radically shrinking the range of diagnostic categories they use. Some psychiatrists fudge the diagnostic codes on forms to ensure that the patients will

get the cost of the treatment covered by the insurance companies or to ensure that the patients will gain admittance to a hospital. Some psychiatrists 'under-diagnose' or use so-called 'garbage can' diagnoses to spare the patient from unnecessary problems and stigma from the surrounding society. Whooley concludes by stating that the 'variation in how psychiatrists perceive and use the DSM exposes it as a failure in the attempt to unify the profession through standardisation' (Ibid: 466).

In this article, I will first explore how two clinicians from different psychiatric outpatient clinics in Norway react to the uncertainty in the diagnostic process. Second, the article explores how young adults diagnosed with numerous psychiatric diagnoses experience these identification processes and how they use the institutional categorizations in their identity work. I take my methodological point of departure in the standpoint of people situated in concrete institutional practices in which they produce or receive diagnoses related to mental health problems. To do this I utilize aspects from Institutional Ethnography (hereafter IE), developed by Dorothy E. Smith (1999, 2005). I also apply Richard Jenkins' understanding of identity construction (Jenkins 2008). In doing so I will underline the multidimensionality of psychiatry. Psychiatry is not a unified entity, but a socio-technical institutional complex (Pickersgill 2012, 2010), constituted by scientific knowledge, professional preferences and practice, patient receptiveness, societal demands and legislation (Manning 2000; Prior 1993).

Based on this understanding of the psychiatric institutional complex, this article contributes with new critical insight into how psychiatric diagnostics are exerted in local clinical practice and how diagnoses coordinate aspects of the everyday lives of the young adults being diagnosed.

Data and Method

The analyses in this article are parts of a larger institutional ethnography investigating the institutional encounters of young adults with mental health problems. Two other research articles based on the same data material have been published; (Olesen 2018a, b). The empirical data has been produced and collected over a period of approximately one and a half years, starting March 2015. The study has been subject to ethical review by NSD, the Norwegian Centre for Research Data. The data consists of four types of material: interview transcripts, field notes, institutional texts, and videos produced by participants. Twelve service users (seven women and five men) and 13 front-line professionals from different municipalities in northern Norway participated in the study. At the beginning of the study, the service users were between 16 and 33 years old, where the majority was between 19 and 28 years old. The young adults do not have a unilateral standpoint. However, common for all the young adults I have had contact with, is that they are outside the labour market and have contact with Norwegian Labour and Welfare Administration. Most of the young people have not completed an education at a level higher than secondary school and most of their everyday activities are somehow related to welfare services. All had one psychiatric diagnosis or more. Half of the young participants had between three and eight diagnoses. Additionally, virtually all the young people have been in contact with child and youth psychiatry at some point in their childhood and all have been in regular contact with different parts of the health and welfare system since they were between the ages of 16 and 21. Thus, all the young informants, despite their young age, have a relatively long experience with health and welfare services. All but one informant say that they have been at an Adult Psychiatric Outpatient clinic (VOP) where they have been diagnosed and have received one treatment or more. Eight of the young informants have been hospitalized in psychiatric departments. Normally they have been hospitalized from a few weeks to a few months at a time. One of the participants had been hospitalized for more than two consecutive years. Despite the young people's individual differences, I will, when writing about them as a group, refer to them as either 'young adults' or 'patients'.

In line with basic principles in Institutional Ethnography (Campbell and Gregor 2002), I mapped out the services the young service users attended in their everyday lives and recruited the professional participants from some of these services and institutions. This includes clinicians from VOP. VOP is typically the first and primary psychiatric service a person in need of mental health care is referred to, and where the first examination and evaluation is done.

Specific extracts from the data material will be given emphasis, in particular the account of a clinician from a psychiatric outpatient clinic and the accounts of four service users. The accounts from these informants are particularly detailed regarding how the diagnostic work is carried out and experienced. At the same time, the accounts presented in this article represent tendencies present throughout the data material.

The informants initially participated in a semi-structured interview (Holstein and Gubrium 1995; Järvinen and Mik-Meyer 2005; Smith 2005) with a duration varying from 45 minutes to 2 hours and 45 minutes. The interview situations were based on a schedule consisting of four overall themes covering (i) everyday institutional work, (ii) user involvement and experiences of being a service user, (iii) work and education, and (iv) the service relationship. I used the schedule as a guide in the interview situation, yet each interview evolved in its own direction. Based on the interview, the different participants contributed to different parts of the further study. Four informants participated in a film project, where they were given a simple camcorder and then filmed sequences from their everyday lives. Subsequently, and in accordance with aspects from 'photo-elicitation' (Harper 2002, 2012), the filmed material was used as a basis for an interview where the informants elaborated on the filmed sequences. An experience that often turned out to be

a central theme, in both the self-filmed material and in the interview situations, was the young adults' experiences of being diagnosed.

Due to this research design, some informants participated in one part of the project only, while others participated in several parts simultaneously. The level of participation was solely based on the informants' wishes and preferences. In addition, institutional text material from various services was collected throughout the fieldwork – the interview and screening guides referred to in this paper were collected from local psychiatric outpatient clinics.

All data material is anonymous; the names of persons, places and to some degree institutions that appear in the paper have been altered.

Institution, Text, Everyday Work and Identification

Institutions are, in an IE perspective, understood as a gathering of text-mediated relations coordinating specific functions in the modern welfare state (DeVault and McCoy 2006); 'texts' are not limited to written text, but replicable material that conveys a standardized or symbolic institutional discourse. Thus, a text can be a diagnosis written in a medical record, thereby identifying a patient with a specific mental disorder. This institutional action activates, as mentioned, a range of institutional processes both inside the psychiatric institutional complex and inside other institutional complexes in the welfare state.

The formalized texts are active and coordinate local understandings and actions; thereby the texts, conceptualized by Smith as 'ruling relations', connect the local institutional conditions with an overarching, trans-local institutional level (Smith 1999, 2005). A pivotal methodological element in a study that utilizes aspects from IE is that, even though the institutional texts are duplicated and distributed to several different locations in identical form, they are activated and read locally. While the ICD-10 manual organizes the categorization of psychiatric disorders, it will be operationalized in specific ways in different local institutional contexts. If institutional and governing texts are analyzed disconnected from their activation, the analyses will perhaps uncover e.g. generalizing and standardizing discursive tendencies or prevailing governance ideals, but not how texts in a local context are regulating everyday actions and practices.

IE is an in-between method of inquiry that departs from a locally situated standpoint of people and, from there, uncovers the connections between the local and the trans-local. Smith describes the approach thus:

For the ethnographer individual engagement with a text is locally observable and, at the same time, it is connecting the local into the translocality of the ruling relations. Discovering, then, how texts articulate our local doings to the translocally organized forms that coordinate our consciousnesses with those of others elsewhere and at other times is the objective (Smith 2006: 66).

The translocal institutional discourses define which concepts, categories and experiences count as significant and which are obscured (Smith 2005). Hence, the textual work performed in institutional complexes eliminates the individual perspectives by objectifying the partial experience of people.

From this perspective, the institutional is multifaceted since it is always possible to track the ruling relations in new directions. Thus, it is not possible to explore an institution as a whole, organizational unity – the ambition is, rather, to uncover a particular component within an institutional complex by showing how people as 'knowers' have embodied knowledge they act out when performing specific everyday work. It is through the everyday work of producing diagnoses that a clinician exposes knowledge about the institutional practice of categorizing people with psychiatric disorders – thereby exposing the ruling relations coordinating this institutional phenomenon. 'Work' should be understood broadly in an IE perspective; not just as paid labor, but as everything that a person does in his or her everyday life, both in relation to other people and to institutional complexities. A young adult receiving psychiatric diagnoses will perform wide-ranging identity-work relating to the institutional identification.

Richard Jenkins (like Smith) is inspired by Mead and Goffman, but where Smith focuses on the institutional everyday interactions, Jenkins focuses on how identity is constructed. Jenkins depicts how a person's identity is essentially social and constituted by an 'internal-external dialectic of identification', where "identities emerge out of the interaction between internal self-identification or group identification, on the one hand, and external categorization done by others, on the other" (Jenkins 2011: 3). Jenkins makes a distinction between what he calls the 'nominal' and the 'virtual' identification (Jenkins 2008: 99 ff); The 'nominal' describes the label the individual is identified with by others; in this context, it could be PTSD or bipolar disorder. The 'virtual' describes the individual understanding of the 'nominal' identification; the subjective self-presentation and understanding of the person diagnosed with PTSD or bi-polar disorder, and how this manifest itself in the individual's actions and conduct. In this article I will argue, that by looking at how institutional processes affect identification processes, it is possible to uncover how the local production of diagnoses are connected to the experience of receiving diagnosis.

In the following, I will show how clinicians and patients carry out practical institutional work by applying specific strategies to overcome or tame the diagnostic uncertainty. I thereby investigate how trans-local discourses of diagnoses, activated locally, affect both the person diagnosing and the person being diagnosed. Finally, I will compare the two perspectives on the phenomena.

Giving and receiving psychiatric diagnoses

The textual production of diagnoses

A clinician, Paul, from a psychiatric outpatient clinic (VOP) explains to me in an interview how he conducts the diagnosing process at the clinic. Paul is trained as a psychiatric clinician and performs diagnostic procedures in his every day work. His specific title and his specific functions at the outpatient clinic are concealed due to anonymity.

Paul describes how a standard procedure, which all therapists are obligated to go through when performing diagnostics, is performed:

I draw up for the patient what is going to happen now. That I am going to do a so-called anamnesis. It is your story and it is going to take one to two sessions, one session being 45 minutes. Afterwards I am going to do an interview called mini [M.I.N.I.], it is an interview covering the most common mental disorders. When the interview is done, if I get any hits on anything, I will continue with other examinations. You [the patient] will also get interview forms that are called BAI and BDI. These are your self-assessment of anxiety and depression. [...] Then I begin to draw up... when I have all the information, the assessment normally takes 4 to 6 hours, and then I will look for... is there a common thread here? Usually I say, like in the hospital, we must figure out if it is the arm or the foot that is broken before we can place the plaster. We try to get as much possible information, and then I give feedback, here is what I found. [...] I think that your problems are this and therefore you will get the diagnosis....

[Paul, clinician from a psychiatric outpatient clinic]

Paul explains further that the ideal process runs through three stages: i) diagnosing; ii) producing a treatment plan with a clear goal based on the diagnosis; and iii) completing the treatment plan, and thereby ending the treatment. I will focus on text work related to diagnosing and not go into details about the treatment plan or how the goal of the treatment plan is reached.

Paul clarifies that this standard diagnostic process involves, as a minimum, following four texts: a written anamnesis, the M.I.N.I. interview guide and the two self-assessment questionnaires, the BAI and the BDI. The M.I.N.I. is based on the DSM-IV and ICD-10 manuals. In the introduction to the M.I.N.I. interview guide (Sheehan and Lecrubier 2009), it is written that the guide is meant to reveal the major mental disorders described in the two above mentioned diagnostic manuals.

Paul explains that the clinicians use the M.I.N.I. as a quality control of their diagnostic practices. Even though he has more than 20 years of clinical experience, and he always has a fairly good idea about what kind of mental disorder a patient has, the M.I.N.I. interview helps him to ask all the questions he should. The interview functions as a checklist, Paul says; like an aircraft pilot goes through a checklist before take-off, Paul goes through the interview to ensure that he covers all possible symptoms. The interview screens for 21 mental disorders and abuses, e.g. 'Depressive episodes', 'Hyperkinetic disorders' (in the DSM-IV called 'Attention deficit hyperactivity disorder' [ADHD]), 'Bipolar affective disorder' and 'Alcohol and Substance abuse', and so on.

When Paul has completed the anamnesis, the M.I.N.I. interview and has received the scores from the BAI and BDI, he evaluates the results: "When the person scores on that and this diagnosis, I write a note, but in addition I will write a clinical assessment and then I compare it with the diagnosis book ICD-10". Symptoms have to match the criteria listed in the ICD-10 before a diagnosis can be given:

E.g. if you have a person who scores for F43.1, PTSD, I can then look up the diagnostics' guideline, for example: 'The disorder is usually not diagnosed if there is no evidence that it occurred within six months after an unusual traumatic event'. Hhhmm, this happened five years ago. Okay, we must ... then it probably cannot be PTSD, but there is an opening here. Many diagnoses overlap, so it becomes a question of perspective. What you are trained in, you will focus a bit more on that. We all have our interests, our ... so three typical diagnoses that are discussed very often are ADHD, Emotionally Unstable Personality Disorder and Bipolar disorder, and maybe you can mix Drug abuse into it as well. If we keep to those four, and you have an expert from each area, then they will diagnose according to their expertise.

Paul's description shows how the diagnosing process implies a circular reasoning. When using the M.I.N.I. interview, in addition to the BAI and BDI self-assessment schema, the patient's particular characteristics are translated into categories, or 'symptoms', through these textual representations. For example, when a patient fills out the BAI and BDI self-assessment schema, it is only possible to express the embodied subjective experiences based on the prefabricated questions and symptoms that the questionnaire presents. The same goes for the M.I.N.I. interview. As an example, in the section of the M.I.N.I. interview screening for 'Severe depressive episode', question A3b.

The patient is not asked why and in which context the sleep issues occur, but only whether the patient sleeps poorly, or sleeps a lot. Thereby the textual work that the therapist activates transforms the patient's particular characteristics into objective symptoms that again counterpart the diagnostic criteria listed in the ICD-10 (see **Figure 1.1**). This

narrows down the possible array of diagnoses that match with the manual. When a specific diagnosis is chosen out of a possible array of diagnoses that the symptoms match, symptoms are once again objectified to match this or that specific diagnosis. When the diagnosis is chosen it is written in the medical rapport of the patient and the clinician will have a basis for the following treatment based on the specific diagnosis or diagnoses – the circle is complete. The diagnostic work could be illustrated as in **Figure 1.2**.

Olaug Lian describes the logic of the circular reasoning in the diagnosing process thus: “The characteristics gives the illness, and the illness gives the characteristics. Premise and conclusion are the same, ergo we end up where we started” (Olaug 2014: 726. My translation). In other words, the particular characteristics of the person being diagnosed explain why she has a specific mental disorder (and diagnosis), and at the same time, the specific diagnosis explains her behavior, thoughts and way of being.

The circular reasoning and the consequences of diagnoses are a prime example of what Smith and Griffith call ‘Institutional Circuits’.

Do you have sleep issues almost every night (problems falling asleep, interrupted sleep, waking up early in the morning or sleeping excessively)

The last 2 weeks; ‘yes’/‘no’.

Previously episodes; ‘yes’/‘no’

(D. Sheehan & Lecrubier, 2009, p. 5)

Figure 1.1: Section from the M.I.N.I. interview guide, question A3b; ‘Severe depressive episode’.

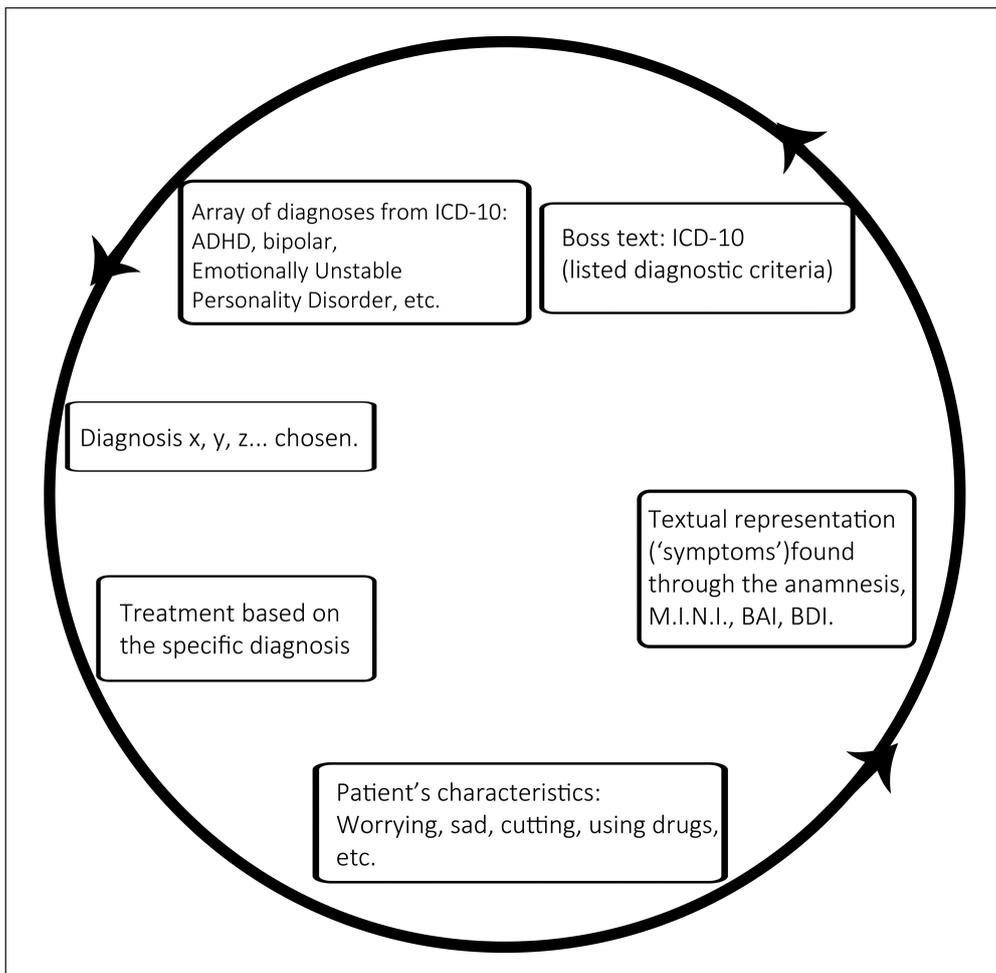


Figure 1.2: The institutional circuit of diagnoses.

Institutional circuits are recognizable and traceable sequences of institutional actions in which work is done to produce texts that select from actualities to build textual representation fitting an authoritative or ‘boss’ text (law, policy, managerial objectives, frames of discourse, etc.) in such a way that an institutional course of action can follow (Smith and Griffith 2014: 12).

When a diagnosis corresponds with the charted symptoms, and vice versa, a mandated treatment will follow; Paul explains: “If you have ADHD, you will get Ritalin or similar central nervous system stimulants. If you have bipolar, you can get mood stabilizers. If you are emotionally unstable, we work differently, without medicine.” The legitimization of a given treatment is based on the categories determined as valid in the authoritative ‘boss’ text, the ICD-10; hence, a clinician like Paul cannot circumvent or avoid the predefined classifications of the ICD.

An interesting aspect in Paul’s account is how much the individual interests of the therapist actually determine which diagnosis the patient will get. Because of the way in which Paul reads the ICD-10 criteria listed for ADHD, Emotionally Unstable Personality Disorder, Bipolar disorder and Substance abuse, all of these diagnoses can be attached to the same symptoms found in the same person. This comorbidity is complex and comprehensive since the extent of overlapping diagnoses is widespread and systematic. Another clinician, Heidi, from a different outpatient clinic (located in a different region than Paul) explains how the interpretation of symptoms change over time:

Here in this region, personality disorder was not really used for many years, because we [clinicians] did not have that perspective. But then it was combined with ADHD. [...] [B]efore it was a rare diagnosis, now there is a sharp increase in ADHD. The symptom expression of ADHD is similar to trauma or developing disorders. It depends on the eye of the beholder [...] E.g. if one should take sexual abuse seriously [...] there is a very large under-diagnosing of posttraumatic stress disorder, and dissociative disorder. Patients have anxiety, social phobia, generalized anxiety, severe depression. They tend to harm themselves and they have underlying personality disorder, borderline, drug problems... The patient will have all of this, but it is not certain that a clinician will see that the overall problem might be PTSD, or dissociative [disorder]. Then the patient will get all of these diagnoses.
[Heidi, clinician from a psychiatric outpatient clinic]

Heidi’s account is very similar to that of Paul, but at the same time highlights how different types of diagnoses are preferred differently by different clinicians, at different outpatient clinics and at different times. Personality disorder used to be unpopular in this particular region; now personality disorder is popular together with ADHD, but Heidi believes that trauma diagnoses are used too infrequently. At the same time, Heidi links personality disorder, ADHD, posttraumatic stress disorder, dissociative disorder, anxiety, depression, self-harm and drug abuse together, and emphasizes that they potentially overlap each other. The two accounts from the clinicians present a picture of the diagnostic process as containing a systematic overlapping of categorizations. A similar argument is put forward by Ian Hacking who, from a logical point of view, argues that the systematic overlap of diagnoses is due to the amount of categorizations and sub-categorizations in the diagnostic manuals, and that the categorization logic of the manual is based on the botanical, Linnaean model (Hacking 2013: 5). Hacking states that the systematic overlap of diagnoses shows that ‘mental illnesses’ by nature are irregular and fit poorly with the regular logic of classification in the manual.

Hacking’s point is that it is a fundamental logical flaw to classify mental illnesses as if these phenomena were comparable with uniform entities such as plants and animals or somatic diseases, for that matter.

Paul is aware of the inconsistency in the ICD-10, as the above extracts show. According to Paul (and Heidi), in practical clinical work, which diagnoses a clinician will choose is therefore often arbitrary – based on expertise, experience and professional interest.

Work-knowledge and ‘non-work’

The accounts from the clinicians quoted above emphasize how they apply specific strategies when dealing with the diagnostic uncertainty. Since the textual work cannot pin down a precise and exclusive diagnosis, the clinician determining the diagnosis needs to make a choice that is not based on the inherent objective logic of the ICD, but relies on the clinician’s professional – yet subjective – interests and expertise. The way Paul handles this uncertain element is by acting pragmatically – the reality he meets in the clinic does not fit completely with the standardization of the ICD; when the same collection of symptoms can be diagnosed with different disorders, Paul uses the tools he knows best: “My personal interest is personality disorder, its diagnostics. I have worked a lot with that.” Later in the interview, Paul elaborates on his expertise in personality disorder: “If you have an unstable personality disorder, you definitely have anxiety, depression and some experiences of trauma. Maybe you have a drug issue as well. You have all these things,” Paul explains. In his understanding, the unstable personality disorder can, to a large degree, explain the other possible lower level diagnoses and Paul believes that by treating the unstable personality disorder, the anxiety, depression, trauma and drug-use symptoms will diminish. Heidi uses a similar argument, but she believes that often a PTSD or trauma type diagnosis can explain symptoms of personality disorder, anxiety, depression and drug use. She explains in the interview that her arena of interest is trauma disorders. Thus, the clinician’s specialized area of interest works to a

large degree as a guiding principal when they produce diagnoses, but this part of their institutional work is concealed. The textual process of the institutional circuit obliterates the subjective element of the clinician and leaves an objective pathological category in the patient's medical record. M. K. Corman and K. Melon determine this type of unaccounted work as 'non-work': "work that is central to the everyday worlds [...] and integral to the functioning of the system as a whole, but is unaccounted for and thus remains invisible" (Corman and Melon 2014: 158–159). In this context, the actual work of diagnosing is not represented in the final diagnosis; the non-work of the clinician remains invisible, which makes the psychiatric diagnostic process appear more clear-cut and standardized than it really is. Thus, there is a disjuncture between the objective textual categories and the actual individual assessments of the clinician. This is a variation of what Whooley calls 'workarounds', which describes strategies clinicians use to carve out a space of autonomy in a practice heavily dictated by a diagnostic manual (Whooley 2010). Thus, clinicians like Paul and Heidi handle the diagnostic uncertainty inherent in the institutional circuit of diagnostics by applying a pragmatic strategy, and thereby giving themselves a room for manoeuvre. They see the symptoms of the patients from their specific standpoint. Since the young patients move around in the fragmented landscape of the psychiatric services, the patients often encounter multiple clinicians. This can – and often does – result in the patients receiving multiple diagnoses based on the same symptoms.

In the institutional setup, the circuit of diagnostics produces and legitimates a given diagnosis in which the therapist's experience and expertise are crucial for pinpointing and determining the exact diagnosis labeled to the patient's characteristics. At the same time, the produced diagnosis functions as an external identification (a disease identity) that patients necessarily must relate to – they are labeled with a mental disorder that can be explained with reference to an authoritarian text, the diagnostic manual, given to them by an authority, a clinician.

In accordance with IE methodology, I will in the following trace how the ruling relations coordinating the institutional circuit of diagnostics affect young adults with composite mental health issues who have received multiple diagnoses. A main reason why the participants in this study receive multiple diagnoses is their mobility inside the psychiatric apparatus; they have been in contact with many different services and different units inside these services, meaning that they have been evaluated and diagnosed by several different clinicians. At the same time, the participants often encounter many different clinicians inside a specific service, making the situation even more ambiguous and confusing.

Identifying with multiple diagnoses

All the young adults participating in this study have a clear opinion on their diagnoses and can speak in detail about which diagnoses they have, where they got them, and when. Both in interviews and in the self-filming accounts, the young adults explain how they relate to the diagnoses by rejecting some and identifying with others, thereby positioning themselves in an active relationship to the diagnoses they have received. Most of the young adults have "tried out" multiple diagnoses and treatments in their relatively short "careers" in the psychiatric apparatus. They look back on their time spent in psychiatric institutions, giving accounts of frustration and confusion when different clinicians from different psychiatric institutions have diagnosed them with different mental disorders. Many give accounts of being diagnosed and given medication based on very few meetings with a clinician – only to meet a new clinician six months or maybe a year later who gives them a different diagnosis and a different medical treatment. After a period, most participants explain that they have settled and, to a certain degree, identify with one or two diagnoses that they think are correct or useful. Still, the portfolio of diagnoses in their medical record is a source of frustration. A young woman, Anne, who has been diagnosed with seven different diagnoses in eight years, explains how she perceives her diagnoses today and how they interplay in her everyday life:

Interviewer: How do you perceive your diagnoses?

Anne: People are very fixated on what is written in the record. It's more like... It's cumbersome... Can you say that diagnoses are cumbersome?

Interviewer: Yes, you could say that diagnoses are cumbersome.

Anne: They [the diagnoses] are a strain. I believe that my main problems are not being talked about. They have not been elucidated. Actually, I think that I have some diagnoses that are correct, but they are presented wrongly. When I need help, I have a hard time explaining what I am struggling with... because I don't know what to say...

Interviewer: Do you experience that the diagnoses are a problem?

Anne: Yes! I don't want them. I wish that my entire medical record were erased from the psychiatric system, so no one [professionals] would have any preconceived opinion about me.[...]

Here Anne explains that her diagnoses overshadow what she experiences as being her actual problems and because the previous diagnoses are not removed from her medical record, she experiences that when she encounters new front-line professionals, the diagnoses listed in her medical record color the professionals' understanding and view of her. Anne says that some diagnoses are simply wrong, while some seem correct but are misunderstood by some front-line professionals she encounters. There is a mismatch between Anne's understanding of herself and her situation, and the way the diagnostic objectification affects how professionals understand Anne and her situation. Just prior to the

transcript extract quoted above, Anne says: “I feel like I’m being labeled, which I have felt since I first entered this system [the psychiatric system]”. From Anne’s point of view, her experiences of having mental problems do not correspond with the different diagnoses she has been given.

A young woman, Maja, gives a ‘classic’ account of being diagnosed with PTSD by a clinician after meeting him three or four times:

I had to fill out a form with different kinds of questions, and then he [the clinician] concluded that, “well you have PTSD.” Then later I talked to another psychologist and he didn’t just fill out a form, but talked to me, and he said that I didn’t have it [PTSD]... I don’t want it in my papers when it is not true! I can’t identify with it at all.

Maja’s account of being diagnosed after a clinician has asked questions and has ticked off boxes in a form is a typical account in my data material; the young adults often find this practice frustrating and confusing. Maja puts it forthrightly:

They don’t know what they are talking about, they don’t even try. You can’t just give me a form; ‘you ticked off these boxes, then we will find your diagnosis’. That is just fucked. You cannot do that! That is bullshit.

As the examples reveal, the over-diagnosing is coordinated in part by the number of different clinicians the young adults encounter, and in part by the textual institutional practice of diagnosing. This makes possible a situation where a person can potentially be diagnosed with one specific mental disorder by a clinician in one outpatient clinic or hospital ward, and then shortly thereafter be diagnosed with a different mental disorder by another clinician in a different outpatient clinic or hospital ward. Related to this, several of the young participants give accounts of particular clinicians who are known for their use of specific diagnoses. One participant puts it like this: ‘Everybody knows that if you enter into his [a specific clinician’s] office you will come out as bipolar no matter what your problems are’.

Ideally, good diagnosing practice using the standardized criteria of the diagnostic manuals (the DSM and ICD) should secure a high reliability, which would subsequently secure a high validity. Seen from the standpoint of persons being in the psychiatric apparatus over an extended period of time and thus being in connection with different therapists, both the reliability and the validity seem to be weak, which is experienced as frustrating and confusing.

Identity-work

When encountering a multitude of diagnoses in a relatively short period, the long-term service users I have met are rarely presented with a unilateral disease identity they can construct their self-identification around. In Jenkins’s terminology, when one nominal identification is supplemented with a new identification – an additional diagnosis – the young service users are in a situation where they have to renegotiate their self-identification. A young man, Lasse, with mental health problems and long-term drug abuse recounts that he is diagnosed with ADD/ADHD, bipolar, chronic anxiety, eating disorder and suicidal ideation. After years of relating to these different nominal identifications, Lasse only identifies with ADHD; ‘I get Ritalin for my ADHD and it works, the rest... well, they do not exist [...] I got the bipolar after three meetings with a doctor, and then I was bipolar, that was it. I got a lot of medicine that didn’t work.’ For a period, Lasse took the prescribed medicine and somewhat identified with the bipolar diagnosis, but when he did not find the medicine helpful, he could not recognize himself in the bipolar categorization: ‘I don’t think I have bipolar, I think I have ADHD... But as they [clinicians] say, ADHD and bipolar are very similar.’ After years of receiving treatment related to substance abuse and different psychiatric disorders, a doctor revived his childhood diagnosis, ADHD. Lasse recognized himself in this identification, since the categorization and treatment of this disease made sense for him: ‘I don’t care about which letters they use, the only thing that matters is if it works for me.’ For Lasse the validity of a diagnosis is measured by the effect of the medicine: ‘The Ritalin worked within the first week,’ he concludes as proof of the ADHD diagnosis’ accuracy.

The accounts above show that when a patient gets a (new) diagnosis, the self-identification is interrupted and takes new paths. In addition, when the external identification is multifarious and changing, the self-identification will reflect this unstable identification. Moreover, being in a transition from youths to adults, as my informants are, they are already dealing with the general identity-work that comes with this period of life (Ødegård 2016). Thus, the young adults I have met often express being in an unresolved position. This corresponds with the research of Bjørg Mari Hannås and Zulmir Bečević that shows a similar type of identity-work done by people being diagnosed with ADHD (Bečević 2017; Hannås 2010, 2012). Hydén, among others, argues that a diagnosis can function as an organizing principle in a person’s self-narrative, which helps transform previous dislodged experiences into a whole (Hydén 2005: 224–5; Karp 2017; Martin 2007). The disease identity can function as a positive identification that makes a chaotic mental life comprehensible and gives a sense of direction (Hacking 2009).

As shown above, the young adults do not reject a disease identity, they actively self-identify as a person being sick, but they do reject the over-identification where they experience being placed in different disease categories at the same time. The young people’s accounts show that receiving multiple diagnoses gives them neither a sense of direction nor an experience of unity.

As the analyses above highlight, since the process of diagnosing is in fact vague, it is very likely that one diagnosis produced by one clinician is contested by another clinician. Therefore, the chance of receiving multiple diagnoses for people who move around inside the psychiatric service landscape is high. Thus, the dialectic identification process can take years of identity-work as the young patients are faced with different nominal identifications and related medical treatments.

Different persons handle the diagnostic identity-work in different ways. As shown above, some reject a specific diagnosis because they find the way it is produced questionable ('just ticking of boxes'), some reject their diagnoses because the objective categorization does not correspond with their subjective experiences and problems, and some reject diagnoses because they do not find the corresponding treatment useful. Hence, producing and receiving psychiatric diagnoses is by no means a straightforward or neutral process. The process is rather filled with complex ruling relations that coordinate which disease identity the individual person experiencing mental health problems will get. On the other hand, most of the young adults settle, and accept (and to some degree internalize and identify with) a diagnosis that is produced in a way they find trustworthy (not after meeting a random doctor or clinician twice in a psychiatric ward), or a diagnosis that they experience as corresponding with their characteristics and where they find the treatment helpful. Thus, the young adults' reactions when receiving multiple psychiatric diagnoses are multifarious (Jutel 2009). Felicity Callard describes it like this: 'Psychiatric diagnoses are engaged and lived with in multiple, ambivalent and often contradictory ways' (Callard 2014: 528). The young adults participating in this study are not merely trying to negotiate with and internalize one disease identity, but multiple disease identities at the same time, making the institutional circuit of diagnoses an institutional circuit of identification. The circuits of identification give the young service users the impression that their disease identity is out of their control since different diagnoses subjectify the person experiencing mental health problems into specific types of people with specific modes of conduct, behaviour and ways of being. In addition, the experience of being identified with multiple diagnoses affects the young adults' trust in the validity of the psychiatric apparatus; they find both the ease with which their subjective characteristics are categorized, the number of these categorizations, and the way in which the categorizations are used, to be disturbing and confusing. Furthermore, due to the large number of professionals the young adults encounter, many of them express a loss of trust in the competences of clinicians, doctors and care workers they do not know. A young woman who has been diagnosed and medicated a couple of times by clinicians, who she only met a few times, explains that she is afraid of being evaluated and helped by random clinicians: 'I really don't like to seek help outside normal working hours, because when my people [front-line professionals] are not available, I don't know what kind of help I will get. Often you are not taken seriously.' This illustrates that the experienced consequences of the institutional reality make the young adults perceive the psychiatric apparatus with distrust. Consequently, the young adults place their trust in specific clinicians and care workers that they know and with whom they have a longer relationship.

Conclusion

This article underlines how clinicians and patients are affected by the institutional circuit of diagnostics in different ways. Clinicians are obligated to use the classification system of the ICD-10. Since the patients' embodied characteristics are more irregular than the categorization in the diagnostic manuals, the clinicians must perform an individual assessment when producing diagnoses. This work is central and vital to the function of the diagnostic process specifically, and psychiatry in general. Due to the systematic overlap of diagnoses in the ICD-10 (and DSM-IV), without the non-accountable work (the individual assessments) of the clinicians, the psychiatric service landscape would not be effective, and the actual diagnostic process would not be feasible. Thus, clinicians have the power to, and must find ways to work the system. The strategic non-work of the clinicians, from their standpoint, to some degree tames the uncertain element inherent in the classification system of the ICD-10, but by doing this they transfer the uncertain element in the diagnostic process to the patients. In short; the logical flaw embedded in the ruling categorization system, that Hacking points out, moves down through the institutional complex and stops at the person with the fewest means to affect the service apparatus: the patient.

Consequently, the uncertain institutional work of categorizing the young people places a large amount of identity-work on the shoulders of the individual person. The experience of going through multiple circuits of diagnostics, and of being diagnosed with multiple diagnoses, provides neither a stable sense of self-identification, nor an experience of recognition. This shows how the institutional production of psychiatric diagnoses has negative and distressing consequences for people with composite mental issues who frequent numerous parts of the fragmented institutional landscape.

In summary, this article highlights how the everyday experience of living with mental health problems is bound to, and coordinated by, the major diagnostic manuals. When receiving several diagnoses in a relatively short period of time, the ambivalent and often contradictory ways of dealing with the institutional identifications are multiplied. As this article has shown, the uncertainty of the diagnostic process is often experienced as a strain by the young people being diagnosed.

Competing Interests

The author has no competing interests to declare.

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