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Psychiatrists' accounts of clinical significance in depression

Clinical significance is a crucial element in the diagnosis of mental illness, yet, it is practically untheorised and significantly under-researched. This article takes up the question of how the criterion of clinical significance is translated into psychiatric practice. More particularly, it examines how psychiatrists account for the threshold between health and depression. The paper is anchored in the constructionist view of discourse underpinned by the assumptions of critically oriented discourse analysis. It is based upon a convenience sample of 39 semi-structured interviews with specialist-psychiatrists in south-western Poland. There is no discursive space for clinical significance in psychiatrists' accounts. There is no boundary, no decision to be taken as to whether the symptoms are clinically significant. Depression, invariably constructed in terms of diagnostic criteria, is always represented as fully developed, appearing out of thin air, with no period of falling ill. The article raises the issue of the validity and usefulness of psychiatric diagnosis.

Keywords: *Clinical significance, diagnosis, depression, psychiatric practices, discourse*

Introduction

In the late spring of 2009 I was diagnosed with hypertension. This means, according to the current version of the International Classification of Diseases (10th edition) that my blood pressure had been systematically above 140/90 mmHg. Even though my GP said first that the British National Health Service recommended treatment when one's blood pressure is over 150/100 mmHg, after I started medication, he re-asserted the diagnostic target – getting my blood pressure below the value of 140/90 mmHg. Regardless of the potential arbitrariness of the diagnostic criterion (note that the treatment criterion is actually different), medicine has been able to set a very clear cut-off point beyond which you have primary hypertension (ICD-10 I10).

I was actually quite impressed by the clarity of the criterion. After investing in a blood pressure monitor, I could actually see for myself whether I was ill. I knew exactly what constituted illness. But this clarity got me thinking about mental illness. What is the point at which you are mentally ill? Or, more specifically, what is the point at which sadness changes into depression? This is indeed the question I would like to explore here.

Aims and assumptions

In this article I am interested in how the criterion of clinical significance in the diagnostic criteria of mental illness is translated into psychiatric practice. And, more particularly, I am concerned with how psychiatrists account for the threshold between health and depression.

Exploring and identifying the boundary of mental illness is important for a number of reasons. As Zimmerman and his colleagues (2004) write, it influences prevalence rates (with clear implications for healthcare or insurance policies), it has legal implications; it helps prevent potential diagnostic abuses and, finally, it instils confidence in the profession. One could add that clarity as to the boundary between illness and health would also improve the service for those seeking help, by making it more transparent and, crucially, more consistent, while the diagnosis would be more valid.

As doctors engage in the process of deciding whether a particular patient seeking help from them should or should not be treated, they in effect make judgements as to whether the patient has or has not crossed the threshold between health and illness. Exploring these judgements seems key to understanding the clinical and diagnostic practices of psychiatry.

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Now, I would like to emphasise that my article is not about the difference between sanity and madness. I do not wish to engage with the discussions raised on the one hand by such milestones of critique as the studies by Rosenhan (1973) and Szasz (1987), or, on the other hand, critiques by Kutchins and Kirk (1997) or, more recently, Horwitz (2002), and also many others. This article, rather, is about how clinicians understand clinical significance - an altogether smaller and more practical question, quite different from the much more fundamental question of the borderline between normal and disordered. And, indeed, none of the clinicians who were interviewed rephrased the question in terms of sanity and madness. They were very clear as to what they were asked about - the practical question of clinical significance.

Methodologically, the paper is anchored in the constructionist view of discourse underpinned by the assumptions of critically oriented discourse analysis. I assume that social reality is constructed through and within language and that every language use designed to represent reality necessarily entails decisions as to which aspects of that reality to include, and decisions as to how to arrange them. Each of these selections, both in content and the lexico-grammatical form, made in the construction of a message carries its share of implicit assumptions, so that the reality represented is ideologically constructed (Hodge and Kress, 1993: 5). It is also through discourse (i.e. practices of language use) that language users constitute social realities: their knowledge of social situations, the interpersonal roles they play, their identities and relations with other interacting social groups (van Leeuwen and Wodak, 1999). No text, spoken or written, represents reality in a neutral or objective way, representation is never of reality 'as it really is', rather it is always looking at it through the tinted lens of ideological assumptions. (e.g. Fairclough, 1992; Halliday, 1994; van Dijk, 1993; Barker and Galasiński, 2001).

This article is about how psychiatrists talk about diseases they diagnose and the decision process in which they find themselves in; I am interested in how they narrate clinical significance and their practice in relation to it. Taking a textually-oriented approach (Fairclough, 1992), I focus upon the form of stretches of discourse, with an interest both in the semantics and syntax of an utterance, as well as the functions of what is said within the local context, and the social actions thus accomplished. I also focus on the content of what is said, relating it to the larger socio-political context in which it is used. Using both the systemic-linguistic analysis (Halliday, 1994) as well as a hermeneutic-like interpretation of discourses in terms of the context in which they were submerged (see Titscher, Meyer, Wodak and Vetter, 2000), I am attempting to reach practices of representation of clinical significance and their ideological underpinnings. I do not, however, wish to claim in this largely exploratory study, that they are a

result of some large-scale orders of discourse (Fairclough, 1995) which could be uncovered in speaking practices of psychiatrists. Such a claim would be premature.

Finally, my study is firmly rooted in qualitative discourse analysis. This means that I am interested in patterns of discursive representation that can be found in what the interviewed physicians said. In what follows therefore, I am going to offer typical extracts exemplifying such discourses. At the same time, I do not wish to claim that psychiatrists have no access or do not use other discourses, or, to put it simply, that they do not speak differently. I have no evidence either way, as I only have the interview data on which I report here. However, the main point of my article is that they do say what I shall be quoting - and it is problematic in view of the pronouncements of institutional psychiatry.

The study

The study is based upon a convenience sample of 39 semi-structured interviews with specialist-psychiatrists in south-western Poland. They were recruited solely on the basis of their specialisation in psychiatry; i.e. they were physicians who completed a five-year specialisation training in psychiatry in addition to their medical studies. The psychiatrists were approached by 3rd-year students of the Warsaw School of Social Sciences and Humanities, studying for an MA in psychology, who all received training in conducting qualitative interviews. And so, after gaining informed written consent for participation in the research from the informants, they asked a number of questions concerning the onset and the end of depression.

More specifically the questions concerned what it means that someone is ill with depression, when someone starts being ill with depression, how and where the physicians see the borderline between health and the illness and whether fulfilment of the diagnostic criteria of depression is sufficient for the diagnosis. Similar questions (undiscussed here) were asked with regard to the end of depression. The questions were designed to be conducive to free narrative on the part of the physicians interviewed. It is also important to note that the semi-structured nature of the interviews meant that there was some leeway for the interviewers in using their judgement in asking questions. And so, if an interviewee pre-empted a question and offered an answer in an earlier response, the question might not have been asked at all.

The decision to ask students to contact the informants and conduct the interview was primarily logistic. This study was part of a larger one in which approximately 100 psychiatrists and 100 psychiatric nurses were interviewed. However, student-interviewers also meant that the interview situation was very likely to be non-threatening, and possibly even dominated by the informants, who, as

senior doctors, were in a position of prestige and power. The interviews were carried out in Polish, were digitally recorded and subsequently transcribed, with fragments which I use for analysis translated.

The analytic procedure was as follows. After the transcription, the data were thematically coded with the use of qualitative data coding software. The coding allows initial sorting of large amounts of data. After the coding, thematically congruent fragments are analysed discursively with a focus upon grammatical, lexical as well as narrative patterns in the data.

I would like to stress again, however, that my study does not aim to be representative. I am not trying to demonstrate how widely the phenomena I discuss here occur in psychiatry, or even in the language of the psychiatrists that were interviewed. Rather, I am interested in describing a certain problem in clinical practice by showing evidence of the occurrence of a certain discourse. Its scale or the potential consequences remain to be taken up in future research.

Clinical significance

The rationale for introducing the concept of clinical significance into psychopathology was a practical one: the Epidemiologic Catchment Area and National Comorbidity Surveys yielded unexpectedly high prevalence rates for some mental disorders. They were too high both for social and political-economic reasons, as indeed, Regier and his colleagues (1998) put it quite directly: the introduction of clinical significance is a response to the need to reduce the number of 'the ill' for economic reasons. In addition, the results were also immediately accused of overinclusivity and generation of 'false positives'.

The remedy was 'clinical significance', a new criterion which was introduced into the DSM-IV. From then on meeting of diagnostic criteria was not sufficient in diagnosing a disorder. The presentation of symptoms had to be clinically significant (Regier and Narrow, 2002). Indeed, at present both main diagnostic manuals introduce the criterion of clinical significance in their definition of mental illness. And so, according to the ICD-10, a mental disorder implies:

the existence of **clinically recognizable** set of symptoms or behaviour associated in most cases with distress and with interference with personal functions (WHO, 1992:5).

while the DSM-IV-TR sees the mental disorder as:

a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased

risk of suffering, death, disability, or an important loss of freedom. (APA, 2000: xxxi).

Both manuals associate the criterion of clinical recognisability or significance with distress and/or impairment. Neither, however, is clear as to what exactly counts as distress or impairment that constitutes clinical significance. The criterion itself is explained further by the DSM.

It is to help establish the threshold for the diagnosis in those situations in which the symptomatic presentation by itself (particularly in milder forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of 'mental disorder' would be inappropriate. (ibid., 8).

This is seconded by a commentary by Spitzer, the chairperson of the DSM-III taskforce, who explains that:

The phrase 'clinically significant' acknowledges that there are many behavioural or psychological conditions that can be considered 'pathological', but the clinical manifestations of which are so mild that clinical attention is not indicated. (Spitzer and Williams, 1982: 19).

In a nutshell, the so-called 'normal population' might well display symptoms of mental disorders, yet, as they are mild, they do not qualify for clinical intervention. It seems crucial therefore to define what is actually meant by the phrases 'clinically significant' or 'clinically recognisable: it is on these two phrases that the difference between normality and mental disorder is hinged. Quite astonishingly, they are quite fuzzy and quite far from clarity (e.g. Bolton, 2008), despite the fact that the DSM explicitly says that:

Assessing whether this criterion is met, especially in terms of role function, is an inherently difficult clinical judgment. (APA, 2000: 8)

The difficulty, it seems, is left to the clinician to grapple with.

Approaching the topic, I expected extensive literature on what constitutes clinical significance. Quite surprisingly, the literature is scarce and offers very little in terms of how clinicians can understand the criterion of clinical significance or, indeed, apply it in practice. In fact, I have found only one study devoted to clinical significance in clinical practice. The remainder takes the issue up either in epidemiological perspective or as a theoretical matter.

Defining clinical significance

Clinical significance is supposed to be understood in terms of distress and disability. This is indeed how most of the studies taking the issue up understand it (e.g. Üstün and

Kennedy, 2009; Lehman, Alexopoulos, Goldman *et al.* 2002), although some operationalise it in terms of either the need for treatment or, putting it more directly, as help-seeking (e.g. Regier and Narrow, 2002; Beals, Novins, Spicer *et al.*, 2004; Slade and Andrews, 2002; Narrow, Rae, Robins *et al.*, 2002). There are also a few studies which operationalise clinical significance only in terms of an instrument score, a value beyond which the disorder is taken to be clinically significant (e.g. Baumeister and Morar, 2008; Lehman, Alexopoulos, Goldman *et al.* 2002; Zimmerman, Chelminski and Young, 2004).

There are two main problems with such considerations: practical and theoretical. First, they are not based on any clinical or psychopathological, or indeed, theoretical ground. To a considerable extent they are simply practical means to make the results of prevalence studies acceptable (Regier, Kaelber and Rae *et al.*, 1998; Spitzer, 1998). Second, their critics point out that they do not offer a theoretically sound solution to what is perceived as a social rather psychopathological problem. There are a number of charges against the inclusion of the limitation criteria in epidemiology, ranging from diluting the purity of diagnosis, to lack of empirical evidence for the need to include the CS criterion, or potentially weak links between mental illness and disability or functioning or, finally, the more general problems in defining disability or indeed distress (see Üstün and Kennedy, 2009; Spitzer and Wakefield, 1999; Kendler, 1999). In sum, it is fair to say that the literature on clinical significance in psychiatric epidemiology is still far from reaching an agreement as to what exactly clinical significance might be and how to operationalise it. Indeed a recent special issue of *World Psychiatry* in 2009 shows that the debate still live and very much on-going.

However, as much as these discussions might be useful for the future of research into mental illness prevalence in the society, they are quite irrelevant from the point of view of clinical practice. As I said earlier, quite astonishingly, the issue of clinical significance has so far been considered almost exclusively in reference to psychiatric epidemiology and has not been either conceptualised or indeed researched with regard to clinical practice.

I have found only one study taking up the issue of clinical significance in clinical practice (Zimmerman, Chelminski and Young, 2004). Using the Structured Clinical Interview for DSM-IV (SCID), the study consisted in making a 'symptom-only' assessment of patients with a number of mental disorders and then included the clinical significance criterion, which was understood in terms of distress (assessed, rather than measured, also on the basis of the SCID). It turned out that the additional criterion had practically no impact upon the diagnosis. The interviewers, the authors claim, used their judgement in the symptom assessment and in such a way were able to diagnose the patients correctly. In my view, however,

the study, while acknowledging the importance of disorder boundaries side-stepped the issue. For even if one assumes that the interviewers did succeed in making an appropriate diagnosis, the authors have actually not shed any light onto the issue of clinical significance. By claiming that it is judgement that the clinicians used, the question of what exactly the judgement should include remains. There is still no attempt to offer any insight into what the boundary between disorder and 'normality' might actually look like.

For the confirmation of clinical diagnoses by an instrument does not actually answer the question of where the boundary might be. Moreover, the fact that the clinicians reliably diagnosed disorders on the basis of symptoms only, might in fact have resulted from the characteristics of the sample. As the authors offer no indication as to severity of symptoms, it is reasonable to suspect that they might have been severe enough not to have raised any boundary issues. The only indication of symptom severity in the case of the depressive disorder the authors offer is to say that 'many' patients would not have qualified for anti-depressant therapy, based on their score on the Hamilton Rating Scale for Depression. The fact, however, that a patient might or might not be treated pharmacologically does not raise the issue of the diagnosis itself (Spitzer, 1988).

More generally, both this study and all others on clinical significance, tacitly assume that identifying the threshold between a disorder and non-disorder is about classification of people into two discrete and clear categories: ill and not-ill. No study I have found actually focuses upon the threshold itself and so upon those people who might pose difficulties in classification. Despite the DSM's acknowledgement of the inherent difficulty of the judgement on clinical significance, there has been no research into what it actually involves. Indeed, even operationalising clinical significance in terms of help-seeking enables researchers to create an all-or-nothing reality. Thus questions such as "Did you tell a doctor...", "Did you take medicine...." (Regier and Narrow, 2002) exclude a number of possibilities such as thinking about or agonising about telling a doctor, or talking to friends, family, as well as many others. And in view of the fact that research into experiences of depression shows that its development and reporting is a rather long-term process (Karp, 1996), the all-or-nothing world can hardly be considered useful.

Clinical significance and depression

Finally, let me briefly consider the issue of clinical significance in depression. Perhaps no longer surprisingly, I have found practically no literature considering it. While there are a number of studies simply putting a score on, say, the Hamilton Rating Scale for Depression (Zimmerman, Chelminski and Young, 2004), there are no studies I know of that consider the issue of clinical significance in the (major) depressive episode in any significant detail.

However, Spitzer and Wakefield (1999: 1862; see also Kendler and Gardner, 1998) note that the clinical significance criterion is redundant in the case of depressive disorders as:

Most of the symptoms are either intrinsically distressing (e.g. depressed mood, psychomotor agitation, fatigue) or are almost invariably accompanied by distress about having the symptom (e.g. diminished interest or pleasure, weight loss, thoughts of death).

Quite interestingly, the two scholars refer to a personal communication with the chair of the DSM-IV committee on mood disorders in which he is quoted not to remember an individual meeting the symptoms and not being in significant distress or impairment. Moreover, the authors caution against understanding clinical significance too narrowly lest false negatives should occur. Thus, they posit, a person meeting the diagnostic criteria and yet not presenting distress with the condition, might still suffer from depression.

Furthermore, the assumption that there is an inherent distressfulness in the symptoms of, say, depressed mood is questionable to say the least (Fee, 200; Martin, 1999; Moreira, 2003). More significantly, the problem with the statement is that the two scholars position the symptoms as always fully developed, as if they appeared out of thin air, already in their full intensity. And yet, there is evidence to the contrary – people do not start with a fully formed depression, they experience what is referred to prodromal symptoms (for a review see Fava and Tossani, 2007), and indeed a number of unnamed experiences leading to the moment of acute crisis (Karp; 1996; also Stoppard, 2000).

Moreover, while dismissing the criterion of clinical significance for the entire disorder, the authors have merely moved it to the level of individual symptoms. A clinician must still take a decision as to when exactly depressed mood, diminished interest or pleasure, feelings of worthlessness etc. might actually require treatment. Indeed, Spitzer and Wakefield do acknowledge that a degree of interpretation in assessing whether a condition is clinically significant is necessary, they leave the interpretation unexplored and offer no clues as to what exactly such interpretation might actually involve.

A similar argument, although with a different outcome, is proposed by Horwitz and Wakefield (2007). They dispose of the criterion of clinical significance on a similar basis – symptoms of depression are likely to cause some distress and impairment, even in the cases that would not warrant a diagnosis. The problem, therefore, is that the criterion in effect fails to distinguish between normal and disordered (ibid.). The two scholars propose to replace the criterion with their own – harmful dysfunction (pointing out that it is not designed to offer a precise boundary between normal and disordered). Yet, the proposal is largely moot from the

point of view of this article, as clinicians still must consider their patients in terms of clinical significance, a very much an all-or-nothing criterion. And it is the latter problem that I am interested in exploring on the basis of psychiatrists' narratives.

To sum up my points so far. Despite the inclusion of the criteria of clinical significance in the DSM and clinical recognisability into the ICD, they are largely unexplored and ununderstood, particularly in reference to clinical practice. The ambivalence starts already at the level of formulation in the diagnostic manuals. While the ICD-10 offers no indication at all as to what 'clinically recognisable' might actually mean, the DSM's proclamation as to distress and impairment is left at the level of declaration. Moreover, there is practically no theoretical exploration as to how this criterion might be operationalised and why. To make matters worse, what research and discussions there are, they are practically all limited to epidemiological research.

The psychiatric profession seems to be happy to delegate the issue of where a disorder starts to 'clinical judgement', while the judgement itself is left unexamined. How to form this judgement, what to include in it, or indeed, how do psychiatrists cope with the issue – all these questions are left unexamined. The issue applies as much to psychiatry in general as it applies to depression. Clinical significance in depression, once again, starts with clinical judgement or interpretation, and one is none the wiser.

The problem of clinical significance can be seen as more acute in view of studies of experiences of depression, where the distress is reported not so much to do with the depression itself but with issues of masculinity, social expectations, unemployment. As recently reported in a study of men's experiences of depression – none of the interviewed men, diagnosed with depression, actually complained of depressed mood or loss of interest or pleasure (Galasiński, 2008). For them the problem was unemployment, inability to find and keep a job, and, consequently, inability to be 'a real man'. Where depression starts here is a question of great complexity, and the need to examine in some detail the issue of clinical significance or recognisability is even more acute!

In what follows, I shall discuss three aspects psychiatrists' accounts of the onset of depression. First, I shall explore its medicalisation, second, I shall talk about the primacy of the medical perspective and judgement, second, I shall show how fuzzy any lived notion of clinical significance is.

The appearance of depression

In the accounts of the onset of depression the illness is invariably constructed in terms of the diagnostic criteria as set out by the ICD-10, or, to be more precise, in terms of the diagnostic criteria as perceived or remembered by the speakers. Consider the following extracts:

(1) I: When can we say that someone starts being ill with depression?

P: When symptoms like that [he described the diagnostic criteria previously] start and when these symptoms exist and last too long.¹

(2) I: When can we say that someone starts being ill with depression?

P: We can say that when depressive symptoms occur, obviously with sufficient intensity and in a sufficient period of time for diagnosing the illness.

(3) I: When can we say that someone starts being ill?

P: with depression?

I: yes.

P: The diagnostic criterion of depression is among others a two-week period of occurrence of unchanged symptoms, determined according to strict rules.

There are two aspects of these extracts I would like to point to. First, the question explicitly (and deliberately) focuses on 'a someone', on a person, rather than a disease, a nosological construct. Yet, in all extracts (and they are very typical of the sample) the speakers choose to ignore it and focus on the criteria. The symptoms the doctors list are not related to any specific or hypothetical person. They exist independently of any potential experiences related to them. This was by far the dominant way of accounting for the 'onset' of depression, quite in tune with the responses to the previous (and the interview's first) question: What does it mean that someone is ill with depression. By far the most frequent were responses about the occurrence of symptoms.

Interestingly, attempts to see the onset of depression in terms of experience fail and the speakers revert to speaking about symptoms.

(4) P: when the patient or their immediate surrounding notice that he becomes unnaturally sad, has trouble with communicating, with doing things which had so far not been a problem, loses interest in the world outside, or in the environment, activities which gave him pleasure and stopped doing so, disturbances of sleep occur, it can be an increased sleepiness, it can be loss of sleep, often anxiety is present, also disturbances of the desire to take food are completely noticeable, a noticeable, almost palpable increase or loss of body mass, apart from that loss of interest in matters of sex.

The psychiatrist in (4) starts by talking about the ill person's and their family's perceptions and puts it in the lay language of experience, of lifeworld, as Mishler would put it (1984). Yet, very quickly he reverts to the language of medicine (cf. a report on doctors' medicalised accounts of depression Thomas-Mclean and Stoppard, 2004). The experience of being sad or perceptions of being sad give way to the occurrences of sleep disturbances etc.. What

starts as an account of personalised experiences and perceptions quickly changes into depersonalised symptoms which simply occur, are had, rather than experienced or perceived.

In the next extract, the psychiatrist explicitly marks the two perspectives: that of the patient and that of psychiatry, yet their construction is practically identical:

(5) P: I would see it like [...] when there is the physiological lowering of the mood, right? As you can't say that depression is a sadness after losing a child, a mother, at the funeral. It is a physiological lowering of the mood, it's part of physiology. [...] When it comes to the medical approach, the borderline of depression will be the occurrence of a typical depressive syndrome with a significance intensity, so lowering of the mood, and biological disturbances, like sleep disturbances [...].

So the lay perspective still is constructed in terms of lowering of the mood, as if it existed outside any experience. Even the 'non-depressive' experience of sadness is constructed without reference to any actual or potential person.

The second aspect of the construction of the onset of the symptoms of depression is that invariably they are represented as if they had all occurred overnight. Symptoms simply appear, occur, start and exist. There is no attempt to construct the long-term process of falling ill reported for example by Karp (1996; Karp and Tanarugsachok, 2000; Kangas; 2001), nor is there any recognition of the delay in making treatment contact in mood disorders which Wang and his associates (2005) estimate as six to eight years. Moreover, although there is some recognition of the fact that not all of the symptoms characteristic for depression must occur simultaneously, psychiatrists' accounts show a very simple (if not simplistic) picture of depression in which all symptoms seem to have the same intensity.

Fiat depression!

The sudden appearance of a depression which in its full presentation is complemented by its occasional construction as resulting purely from a medical decision. It is the medical gaze, to use the term coined by Foucault (1973), that brings depression into existence and, it seems, whatever existed before the act of diagnosis does not and cannot count as depression. The entire problem of assessing the clinical significance of a patient's symptoms is reduced to the clinical act of diagnosis which decides that depression may start. Consider the following extracts:

(6) I: When can we say that someone starts being ill with depression?

P: When the doctor decides.

(7) I: So when does depression start?

P: well, depression in a medical understanding starts when the patients sees the doctor and it is possible to diagnose the illness.

The simplicity of these pronouncements is quite extraordinary. There are no qualifications or additional contexts: depression is to do with the medical pronouncement, rather than anything else. It is noteworthy that the psychiatrist in extract (7) links the onset of depression more widely with the 'medical gaze.' For it is not about help-seeking, but, rather, seeing the doctor, being assessed and diagnosed. Similarly in the extracts below, the doctors see the start of depression as occurring in a clinical setting, in which any perceptions or experiences of depression must be confirmed.

(8) P: When does it start? Well, when it is diagnosed, when we have the interview indicating, when you could say that there were certain symptoms, not even symptoms, except that these symptoms influenced functioning disorders, for example in the family, or at work, or there are memories from a particular period that say at the particular time depression occurred. So, examination plus the interview.

(9) P: one of such indicators is seeing a doctor or a psychologist, or, when retrospectively one notices that they functioned worse, as people have various tolerance to their feeling badly, for various reasons, difficulties with seeing the doctor, some earlier, some later find their way.

(10). P: Depression starts when the patient feels it, when they stop functioning in their roles, suffers from the illness, you could also say that depression starts when the patient seeks help and finds their way to the doctor.

There is no depression outside the clinical setting, it seems. While in extract (8), depression is constituted by the doctor's diagnosis – a medical fiat dependent upon the doctor's decision, much as in extracts (6) and (7). What is also quite interesting in the extracts is the emergence of memories of depression during the examination and the interview. It is hard to say to what extent they exist outside of the clinical context, still it is the interview that seems to enable access to them. Extracts (9) and (10) are more direct in constructing the clinical context as authorising experiences of depression. Both psychiatrists construct depression as invoked by help-seeking. Note that the informant in (10) starts his turn by seeing depression in terms of experience or 'functioning', yet he immediately reverses to the medical context, as if the experience itself were not enough.

Depression appears out thin air, there is no process, no constructed period leading to the crisis or to the intensity of experiences warrant the label. Invariably seen in terms of symptoms, it is constructed as always appearing in the full swing, with all the symptoms presenting at the same time.

On the other hand, depression is associated with the clinical context. The doctor is the one who invokes depression into existence, the one who authorises the experiences as depression. Once again, depression simply appears.

It also appears fully medicalised. In the accounts collected, there was no space for Kleinman's (1988b) well-known distinction between illness and disease, the former being the experiences with which the patient comes to seek help, the latter being its medical transformation. The psychiatrists consistently saw their patients in terms of their symptoms, diagnostic criteria, or in terms of medical diagnosis. Their experiences were invariably secondary to the medical perspective. Moreover, this perspective was always introduced in an unmodalised (Halliday, 1994) language. The psychiatrists tell us 'how it is', with no qualifications, no hesitations. They communicate with the highest level of certainty.

The unbearable lightness of clinical significance

I was also interested in accounts of the very point beyond which a person becomes ill with depression, the boundary when depression starts. As psychiatrists make this kind of judgements on a daily basis, and in fact, as I pointed out at the outset of this article, they are required to do so by the diagnostic manuals, I was particularly interested in how they account for the borderline.

Quite interestingly, the initial certainty with which the onset of depression is constructed vanishes the moment the psychiatrists were asked the question about the cut-off point. The shift is clearly marked both explicitly, the informants start talking about the difficulty of the question, and through the linguistic form of the answer. What is, however, particularly interesting is that the responses could be summed up as exercises in how not to answer the question. Most generally, the point I am going to make here is that the interviewed psychiatrists have no discursive resources with which to deal with the question of the threshold, or, to put it differently, clinical significance.

And so, when asked the specific question of the borderline of depression, the interviewed psychiatrists more or less directly evaded the question, that is to say refused to offer a relevant response, one demanded by the question (on evasion, see Galasiński, 2000). Instead they chose to go back to the issue of diagnostic criteria. Witness the following examples:

(11) I: Please tell me about the borderline of the illness, its beginning. How do you see it?

P: The borderline, my God, this is not a simple question. Because it is, I mean, this is a very difficult question, to be honest. Because there are people who function somehow, and they may have symptoms but these symptoms do not have the intensity which would prevent them from functioning. So [he²] will go to work, [he] will meet people, [he] functions, but that does not

mean [he] does not have depression, [he] he may have and function somehow. The beginning of depression, well, it's when the symptoms I mentioned in the first [question].

(12) I: Please tell me about the borderline of the illness, its beginning. How do you see it?

P: The borderline of the illness is, you know, it could be, I mean if we wanted to look more psychologically, you could, perhaps in some way, try and create a vision of the illness, however, from my point of view. No I am not able to answer this question. I think I cannot [answer] in a way that you would expect, probably. I don't know.

I: The borderline of the illness, its beginning.

P: Beginning of the illness.

I: The borderline, when the illness starts.

P: When the symptoms obtain [...]

Neither speaker actually answers the question of the borderline and both seem to acknowledge the importance of the issue and speak of the difficulty in answering the question. What is crucial for me here, however, is that eventually in what they say they fall back on to the occurrence of symptoms, the diagnostic criteria. The problem is that the question of clinical significance is actually probing into the diagnostic criteria and tries to unpick them. Nothing of the sort happens in the responses above or, indeed, others in the corpus. Once again the informants invoke the notion of symptoms, as if they were uniform and unproblematic.

The falling back on 'the symptoms' was done in other ways. Note the following extract in which the psychiatrist is trying to put a sort of 'experience perspective' on what he says, eventually, he still refers to it as 'the symptoms'.

(13) Please tell me about the borderline of the illness, its beginning. How do you see it?

The borderline of the illness, when you must talk about the illness, right? Here you would have to turn to what we call the norm of psychological health. And it is very broad nowadays. And when we talk about depression, we shall talk when a person hitherto active, effective, smiling, changes, simply changes and we also talk about depression when it lasts, when the symptoms of the sort last longer than a week, than two weeks. Then we can say that it is depression, that the person is perceived by the people around him as totally lazy.

At first sight clinical significance seems to be the change from activity, smiles, effectiveness. Except that not only is the change not explored in any way, but, even more significantly, the changing aspects of the person – seemingly, their experiences – is reconstructed in terms of diagnostic criteria lasting 'a week, two weeks', the time perspective suggesting that the informant might not exactly be clear as to the time component in depression diagnosis. The clinical significance vanishes, as depression's conditions take over.

The final two extracts I would like to show here also indicate that the informants do not have a 'lived' notion of clinical significance. But I would also like to point to one other aspect the accounts. The speaking psychiatrists seem to be torn between accounting for clinical significance in terms of individual experience and a symptom-based account of mental illness. Consider:

(14) P: The borderline of the illness is a discomfort felt by a person, for me at the moment [he] stops coping with what goes on. I mean not so much helplessness, this is the person's helplessness towards the illness, so that the symptoms surpass the adaptive capacity and surpass the person's capability to accept [unclear], perhaps this, I mean [he] will take it to be depression [...], but for many years having not felt that it was depression. And it will be a moderate episode.

The initial construction of clinical significance in terms of discomfort puts the decision as to whether one is ill onto the patient. It seems that it is an individual's experience, his or her ability to cope with her/his experiences that constitutes an illness. But then, the illness starts when the person stops coping with....the symptoms. The experiences the informant is talking about are almost immediately transformed into objectivised symptoms or adaptive capacity, which are, presumably, to be determined by the doctor.

Similarly, in the next extract the doctor hovers between individual experience, with blurry edges and the psychiatric diagnosis.

(15) I: Please tell me about the borderline of the illness, its beginning. How do you see it?

P: There is no hard borderline between health, I mean, if you can say that mental health it's like imagining spatially it's like a tunnel, say, let's imagine a tunnel, or a canal with blurry edges, and on the vertical axis we have a diagnosis between schizophrenia [...], horizontally it's neurosis, diagonally depression. And the way we feel is like that we are closer to one of these axes in the tunnel. But there is no hard borderline. The hard borderline is crossed when usually, the patient feels poorly, that [he] will not cope on his own, or that the people around him notice that [his] behaviour is off the norm.

It is quite fascinating that the informant in one breath is saying that things are fluid, blurry with no hard borderlines, and then defines the hard borderline. It seems that the need to provide a criterion is stronger than his views on ambiguity of mental health. But then, the hard borderline is defined by how an individual feels – hardly an 'objective' measurement. The extract shows the ambiguity most acutely, with the informant weaving his way between experience and objective symptoms.

The two extracts show a tension in the narratives of the interviewed psychiatrists. The tension is between focusing upon individual experience, their illness, and the objectivised view of that experiences, the disease (on illness vs. disease, see Kleinman, 1988b). They are underpinned by two competing ideologies, that of medicine focusing on suffering, so to say, and that of medicine attempting to pass as objective a judgement as possible on the individual's problems. While the former is one focusing on the story, on the problem as seen by the patient (e.g. Crowe, 2002; Haidet and Paterniti, 2003; Kleinman, 1988a; Shaw, 2002), the other treats the experiences as being in the way, while the symptoms must be 'extracted' despite them (Verhaege, 2004). It is, however, the latter which is the dominant paradigm.

Conclusions

In this article I have been interested in how the criterion of clinical significance in the diagnostic criteria of mental illness is translated into psychiatric practice. And, more particularly, I have been concerned with how psychiatrists account for the threshold between health and depression and so, what constitutes caseness in depression. To put the conclusion most succinctly: they don't. There is no discursive space for clinical significance space in psychiatrists' accounts. Moreover, regardless of how widespread diagnostic and nosological discourses backgrounding or completely deleting clinical significance are, what is reported here is a cause for concern. What the interviewed psychiatrists told us is at odds with the dominant discourse of institutional psychiatry, which very explicitly asks for clinical significance of illness symptoms to be taken into account in the process of diagnosis. In other words, the psychiatrists were saying things they were not supposed to say.

There are two aspects of this. First, depression, invariably constructed in terms of diagnostic criteria, is represented as fully developed, appearing as if out of thin air, with no period of 'falling ill', there is no decision to be taken as to whether what the patient presents with is or is not depression. Second, it is also this construction of depression that takes over the stories of clinical significance itself – the borderline of depression. The question remained unanswered, with the diagnostic criteria providing a prosthetic limb to hold the narrative and maintain the semblance of an answer.

This could be rephrased. The personal-professional narrative of individual practices could not be sustained in the interview. It had consistently veered towards a 'generic' psychiatric subject position. The individual psychiatrists became mouthpieces for psychiatry and its pronouncements, giving up their own voice in order to be able to answer

the questions posed. Now, noting the requirements of psychiatry that clinicians must develop a shared feeling of understanding (MacKinnon, Michels and Buckley, 2009), one can wonder to what extent clinicians without their own voice can in fact do it. Indeed, it seems that falling back upon the dominant discourse of psychiatry makes it even more unlikely to achieve what Kirmayer posits as a precondition of understanding stories of suffering and healing: a sharing of social worlds which make each other's stories intelligible (Kirmayer, 2003).

Now, in their study of clinical significance in clinical practice Zimmerman and his colleagues (2004) propose that it should be left to clinicians' judgement to make an assessment whether or not the symptoms identified should be seen as depression, as an illness. Moreover, their study suggests that, indeed, the judgement works, the inclusion of additional, clinical significance elements to the interview did not make any difference to the diagnoses given. And yet, the data here suggests that the judgement reference of Zimmerman and his collaborators seems quite empty. Yes, the psychiatrists might well be able to 'tell', to 'intuit' whether the patient is or is not ill, yet, they can't account for it. The narratives of clinical significance show that the psychiatrists interviewed have no explicit account of it.

Let me make two final points with regard to the above. First, it is probably not surprising that this is so. As I said at the beginning, the literature on clinical significance is scarce and almost entirely focuses upon epidemiological studies. Despite the crucial presence of clinical significance (or, as the ICD would have it, clinical recognisability) in the diagnostic system, only the abovementioned study of Zimmerman and his associates take the issue up in clinical practice. There are no (discursive) resources upon which the speaking psychiatrists could draw upon in their stories of the depression borderline. If there is no 'official' psychiatric story of clinical significance in a clinical encounter, how could psychiatrists have it? And so, second, every time a patient presents with problems which can be understood as depression, a clinician makes a judgement as to whether what they see constituted a nosological entity F32 or F.33 (according to the ICD, or 296.2-3, according to the DSM) or not. In contrast to the optimism of Zimmerman and his colleagues (2004), the judgement and the subsequent decision made by the psychiatrist appear to have no basis. It seems more to be a hunch, an intuition, hardly what psychiatry claims.

This, finally, raises a number of further consequences, the most important of which seems to be the validity of the diagnosis. With no account of clinical significance, the diagnosis is based on 'intuition', 'medical gaze', or whatever other belief the clinician might have, yet, it still is not only unsupported by evidence, but it is not based upon practice, in the sense of an explicit reflection of diagnostic activities, either. And although I am not attempting to claim

all diagnoses are useless (see, however, Pilgrim, 2007), it is quite clear that the data discussed here raise the question of usefulness of diagnosis particularly in borderline cases. It is also clear that there is an urgent need to explore both the concept of clinical significance in considerably more detail and its translation into clinical practice.

References

- American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders (4th edition, text revision). Washington, DC : American Psychiatric Association.
- Barker, C. and Galasiński, D. (2001) Cultural Studies and Discourse Analysis. London: Sage
- Baumeister, H. and Morar, V. (2008) The impact of clinical significance criteria on subthreshold depression prevalence rates. *Acta Psychiatrica Scandinavica*, 118: 443–450.
- Beals, J., Novins, D.K., Spicer, P., Orton, H.D., Mitchell, C.M., Barón, A.E., Manson, S.M. and the AI-SUPERPFP Team (2004) Challenges in Operationalizing the DSM-IV Clinical Significance Criterion. *Archives of General Psychiatry*, 61: 1197-1207.
- Bolton, D. (2008). What is mental disorder. Oxford: Oxford University Press.
- Crowe, M. (2002). Reflexivity and detachment: a discursive approach to women's depression. *Nursing Inquiry*; 9: 126–132.
- Fairclough, N. (1992). *Discourse and Social Change*. Oxford: Polity Press
- Fairclough, N. (1995). *Critical Discourse Analysis*. London: Longman.
- Fava, G.A. and Tossani, E. (2007). Prodromal stage of major depression. *Early Intervention in Psychiatry*; 1: 9–18.
- Fee, D. (2000). The project of pathology. In Fee, D. (ed.), *Pathology and the Postmodern* (pp. 74-99). London: Sage.
- Foucault, M. (1973). *The Birth of the Clinic*. London: Tavistock.
- Galasiński, D. (2000) *The Language of Deception*. Thousand Oaks: Sage.
- Galasiński, D. (2008). *Men's Discourses of Depression*. Basingstoke: Palgrave.
- Haidet, P. and Paterniti, D.A. (2003). "Building" a history rather than "taking" one. *Archives of Internal Medicine*, 163: 1134-40.
- Halliday, M. A. K. (1994) *An Introduction to Functional Grammar*, (2nd edition), London: Edward Arnold.
- Horwitz, A.V. (2002). *Creating Mental Illness*. Chicago: The University of Chicago Press.
- Horwitz, A.V. and Wakefield, J.C. (2007). *The Loss of Sadness*. Oxford: Oxford University Press.
- Kangas, I. (2001). Making sense of depression: perceptions of melancholia in lay narratives. *Health*, 5: 76-92.
- Karp, D.A. and Tanarugsachock, V. (2000) Mental illness, caregiving, and emotion management. *Qualitative Health Research*, 10: 6-25
- Karp, D.A. (1996). *Speaking of Sadness*. New York: Oxford University Press.
- Kendell, R.E. (2002). Five criteria for an improved taxonomy of mental disorders. In J.E. Helzer and J.J. Hudziak (eds). *Defining Psychopathology in the 21st century*. (pp. 3-17). Washington: American Psychiatric Publishing.
- Kendler, K.S. (1999). Setting boundaries for psychiatric disorders. *American Journal of Psychiatry*, 156: 12.
- Kendler, K.S. and Gardner, C.O. (1998). Boundaries of major depression. An evaluation of DSM-IV criteria. *American Journal of Psychiatry*, 155: 172-177.
- Kirk, S.A. & Kutchins, H. (1997). *Making us Crazy*. London: Constable.
- Kirmayer, L. J. (2003). Failures of imagination: The refugee's predicament. *Anthropology and Medicine*, 10(2), 167-185.
- Kleinman, A. (1988a). *Rethinking Psychiatry*. New York: Free Press.
- Kleinman, A. (1988b). *The illness narratives*. New York: Basic Books.
- Lehman, A.F., Alexopoulos, G.S., Goldman, H., Jeste, D. and Üstün, B. (2002). Mental Disorders and Disability: Time to Reevaluate the Relationship? In Kupfer, D.J., First, M.B. and Regier, D.A. (eds) *A Research Agenda for DSM-V* (pp. 201-218). Washington: American Psychiatric Association.
- Mackinnon, R.A., Michels, R. and Buckley, P.J. (2006) *The Psychiatric Interview in Clinical Practice*. Washington: American Psychiatric Publishing
- Martin, M.W. (1999). Depression: illness, insight, identity. *Philosophy, Psychiatry and Psychology*, 6: 271-286.
- Mishler, E. (1984). *The Discourse of Medicine*. Norwood, NJ: Ablex.
- Moreira, V. (2003). The ideological meaning of depression in the contemporary world. *International Journal of Critical Psychology*, 9: 143-159.
- Narrow, W.E., Rae, D.S., Robins, L.N., and Regier, D.A. (2002) Revised prevalence estimates of mental disorders in the United States. *Archives of General Psychiatry*, 59: 115-123.
- Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science and Medicine*, 65: 536–547.
- Rosenhan, D.L. (1973). On being sane in insane places. *Science*, 179, 250-258.
- Regier, D.A and Narrow W.E. (2002). Defining clinically significant psychopathology with epidemiologic data. In: Helzer, J.E. and Hudziak, J.J. (eds). *Defining Psychopathology in 21st Century: DSM-V and Beyond* (pp.19-30). Washington, DC: American Psychiatric Publishing.
- Regier, D.A., Kaelber, C.T., Rae, D.S., Farmer, M.E., Knauper, B., Kessler, R.C., and Norquist, G.S. (1998). Limitations of Diagnostic Criteria and Assessment Instruments for Mental Disorders: Implications for Research and Policy. *Archives of General Psychiatry*, 55: 109-115
- Shaw, I. (2002). How lay are lay beliefs? *Health*: 6, 287–299.
- Slade, T. And Andrews, G. (2002). Empirical impact of DSM-V diagnostic criterion for clinical significance. *Journal of Nervous and Mental Disease*, 190: 334-7.
- Spitzer, R.L. (1998). Diagnosis and need for treatment are not the same. *Archives of General Psychiatry*, 55: 120.
- Spitzer, R.L. and Wakefield, J.C. (1999). DSM-IV diagnostic criterion for clinical significance: Does it help solve the false positives problem? *American Journal of Psychiatry*, 156: 1856–1864.
- Spitzer, R.L. and Williams, J.B. (1982). The definition and diagnosis of mental disorder. In Grove, W.R. (ed.), *Deviance and Mental Illness* (pp. 15-31). Beverly Hills: Sage.
- Stoppard, J.M (2000). *Understanding depression*. London : Routledge.
- Szasz, T. (1987). *Insanity*. New York: John Wiley.
- Thomas-McLean, R. and Stoppard, J.M. (2004). Physicians' constructions of depression: inside/outside the boundaries of medicalization. *Health*, 8: 275–293.
- Titscher, S., Meyer, M., Wodak, R. and Vetter, E (2000). *Methods of Text and Discourse Analysis*. London: Sage.
- Üstün, B. and Kennedy, C. (2009). What is 'functional impairment'. Disentangling disability from clinical significance. *World Psychiatry*, 8: 82-85.
- Van Dijk, T. A. (1993) *Principles of Critical Discourse Analysis*, *Discourse & Society* 4: 249-283
- van Leeuwen, T. and Wodak, R. (1999). Legitimizing immigration control. *Discourse Studies*, 1: 83-118.
- Verhaeghe, P. (2004). *On Being Normal and Other Disorders*. New York: Other Press.
- Wang, P.S., Berglund, P., Olfson, M., Pincus, H.A., Wells, K.B. and Kessler, R.C. (2005) Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication, *Archives of General Psychiatry*, 62: 603-613.

- World Health Organisation (1992). *The ICD-10 Classification of Mental and Behavioural Disorders : Clinical Descriptions and Diagnostic Guidelines*. New York World Health Organisation.
- Zimmerman, M., Chelminski, I., Young, D. (2004) On the threshold of disorder: a study of the impact of the DSM-IV clinical significance criterion on diagnosing depressive and anxiety disorders in clinical practice. *Journal of Clinical Psychiatry*, 65: 1400-5.