SEMIOTIC PERSPECTIVE OF PSYCHIATRIC DIAGNOSIS

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Introduction

Diagnosing has long been described as a semiotic undertaking par excellence, an activity that ‘involve[s] a process of sorting out various possible interpretations or explanations, by which a complex set of signs, either reported, observed or measured, is reduced to a limited number of significations, i.e., to one or a few possible diseases, disturbances, or syndromes’ (ten Have 2001). Given the physical reality of immediately observable symptoms, the diagnostician elicits hierarchical configurations of signs from the proto-significant domain (Kahn 1978), while obeying certain pre-set rules of interpretation (Ostwald 1971). As argued in (Brands et al. 2000), the essential effort of making diagnosis lies in establishing the truth-value of propositions about the condition of the patient, namely, ‘this is disease’ or ‘this is not disease’. To this end, the physician seeks to build a mental holistic picture of the patient’s internal state, which would reconcile the observed symptoms and signs with the preexisting notions of illness and health.

We attempt in this paper to point at several notions that inform the rules of diagnostic interpretation in psychiatry. The argument is that psychiatric diagnostics can be meaningfully approached from the viewpoint of concepts of normality, sincerity and pathology. These concepts apply to different stages of the decision-making process, and form the basis for epistemological propositions that the diagnostician needs to account for. We will further aim to demonstrate how the truth-values of derived propositions structuralize the differential description of several psychiatric phenomena – such as health, mental illness, deceptive disorders, Munchausen syndrome, malingering, and personality disorders – along with a range of non-medical experiences. By introducing the triad of diagnostic concepts (normality, sincerity and pathology) we do not aspire to offer a new method of assessing mental disorders, nor do we redefine norm or suffering. It is rather assumed that placing a vast variety of clinical presentations in the new conceptual framework will allow for explication and structural modeling of diagnostic decisions that the psychiatrist makes routinely.

Propositions of Diagnostic Procedure

To illustrate the scope of applicability for the concepts and related propositions, we adopt here the ‘process-analysis of medical categorization’ from Brands et al. (2000). This scheme discerns the following phases of the semiotic process, where the physician has a direct involvement:

- observation of the patient’s narrative;
- induction of the preliminary hypothesis (i.e. diagnosis);
- deduction of data to be collected, data collection, rejection or confirmation of the hypothesis [this step may require multiple repetitions];
• inference of the diagnosis through confirmation of hypothesis; and
• attribution of symptoms to disease-category.

We argue that the phase of observation bases itself on the concept of normality, which pertains to patients’ behavior and precedes formulation of any diagnostic hypothesis. As put in Romanucci-Ross (1997), ‘whether behaviors indicative of mental disturbances are biochemically induced or willfully intended, it must be acknowledged that the data on mental illness are always and everywhere products of observations, analyses, and theoretical explanations of the (professional) observers of mental illness’. Professional perception of the patient’s signs (with an emphasis on the narrative, in psychiatry), specifically concentrates on detecting deviations from the abstract construct of health (Canguilhem 1989). In other words, observation seeks to establish verity of the proposition ‘this is normal’ vs. ‘this is not normal’. Turner (2003) emphasizes the importance of the subjective, culturally loaded aspect of normativity in psychiatry, since ‘mental symptom-concepts, particularly those of minor mental illness and personality disorder, have broadly rational conditions of application; they relate to individuals’ other beliefs, desires and actions in a normative way that cannot be captured by a theory that is formulated in a physical vocabulary’. It is a common sense of psychiatry, however, that only rarely deviation and norm are separated by a distinct dividing line; deviation is rather a matter of degree to which observed constellations of symptoms are articulated in one’s behavior. Therefore, we oppose the term ‘normal’ with ‘abnormal’, and not with ‘pathological’, thus restricting the reach of normality to experiential results of observation.

Whether the presentation of the patient is bona fide is the keystone of psychiatric evaluation (Resnick 1999; Rogers 1988): ‘[f]undamental to the diagnostic process is the ability to establish whether reported symptoms and concomitant impairment are real or malingered (i.e., deliberately faked)’ (Rogers 1990: 182). Therefore, the step of induction, where a diagnostic hypothesis is made, necessarily addresses the representational modality of observed signs (Rauch 1990). That is, the referential validity of symptoms, especially those consciously produced by the patient, needs verification. Naturally, an objective validation of the patient’s symptoms is not universally feasible (e.g. the content of hallucinations or delusions). Yet the physician needs to reach a conclusion on whether or not clinical signs are used to lie, something they are notoriously suitable for (Eco 1974). Operational tools for the detection of lie lean on the relevance and consistency of signs in a particular clinical context, and a conjectured patient’s motivation to inadequately reflect his/her internal state (Resnick 1988; Rogers 1990). Kress and van Leeuwen (1996) aptly state that ‘[a] social semiotic theory of truth cannot claim to establish the absolute truth or untruth of representations. It can only show whether a given ‘proposition’ (visual, verbal or otherwise) is represented as true or not’. Thus, the representational, or
existential, modality asserts the truth value of propositions advanced by the patient, by determining if they refer to existing objects, such as physical phenomena or mental representations. To give an example, the delusion of male pregnancy (e.g. Ali et al. 2003) can be considered a ‘true’ sign, despite the biological impossibility of the claim, since the referent is not the state of a male organism, but a belief held by the delusional patient.

It is convenient to consider the credibility of the patient’s sign production in terms of the Speech Act Theory, where sincerity, or the good faith intention to accurately represent the speaker’s wish, is a condition for a felicitous speech act (Searle 1969). Faking symptoms is based on different communicative presuppositions, and has to meet different felicity conditions, than those expected from the ‘sincere’ narrative. In our opinion, an insincere representation of reality may only be conscious. Thus, we view the unconscious production of false symptoms, such as observed in conversion disorders, e.g. hysteria, as sincere (cf. Resnick 1988b). Malingering, deceptive syndromes or other types of insincere symptom production affect the teleological dimension of the diagnostic endeavor, and cause both the doctor and the patient restructure their behavioral strategies (Cunnien 1988; Rogers 1988). Thus, establishing the truth-value of proposition ‘this is sincere representation’ vs. ‘this is insincere representation’ is a frequently unreflecting, yet inevitable part of psychiatric evaluation.

Finally, the crux of psychiatric diagnostics is to ascertain the presence/absence of impairment or deficiency in the internal state of the patient. Davtian and Chernigoskaya (2003) argue that the encounter of two individual worlds, those of the physician and the patient, creates a unique situation, where the patient’s Umwelt needs to be structured by the diagnostician’s perception equipped with awareness of the situational context. As suggested by Quintavalle (2002), the receiver (i.e. doctor) gradually directs his/her perception through representation of symptoms, in order to translate the hypothesized internal state of the sender (i.e. patient) into his/her own internal state. Once the existence of pathology is assumed by the physician, it substantiates the diagnosis of a mental disorder, as well as supports the necessity of treatment. Conversely, the recovery from illness is considered complete, only when the underlying pathology of the internal state is thought of as absent. In psychiatry, the situation of an existing impairment, i.e. pathology, can only be deduced (or, as repeatedly argued in Eco and Sebeok (1983), abducted) as the signified of the patient’s behavior. As a result, the stage of inference-making and confirmation assigns the truth-value to the ultimate diagnostic proposition ‘this is disease’.

To sum up, the diagnostician assesses symptoms in terms of normality (of presented behavioral symptoms and signs), sincerity (of the representation modality of observed signs) and pathology (of the hypothesized internal state). The discussed diagnostic concepts take the following values, cf. Table 1:
The much-debated question of what constitutes norm will be avoided here as immaterial for this discussion. Suffice is to note that every physician is required to determine normality and abnormality within the boundaries of the medical framework he/she belongs to. For practical purposes we will label one’s behavior abnormal, if it may be conclusively interpreted as a pattern known to be associated with a recognized disease-category. Likewise, we will overlook the semantic process by which the doctor establishes the presence of impairment, or confirms his suspicion of a foul play. What this paper concentrates on is the final stage of diagnostics, namely, the attribution of symptoms to a category. It is assumed that normality of behavior, the presence of pathology, and fidelity of representation have all been accounted for before this stage, in accord with the doctor’s professional competence, intuition, institutional regulations, social conventions, cultural affiliations, or personal affections.

**Structurization of Semiotic Choices**

Truth-values that the physician associates with the three diagnostic propositions determine the concluding attribution of observed semiotic complexes to one of major syntactic categories, listed in Table 2 below. The proposed categorization includes such fundamental topics of medicine, as health and illness. However, not all of the categories fall into the realm of medicine per se, since the diagnosing practice witnesses and sorts human experiences far beyond the scope of medical jurisdiction. Even if not necessarily of an immediate clinical relevance, the categories represent the differential of semiotic choices available at the final stage of decision-making when symptoms are to be mapped into a single signified. Importantly, truth-values of propositions are a subjective decision of the psychiatrist, rather than objective realities. Therefore, any of the classification units exclusively refers to what a particular diagnostician infers from his specific consideration of epistemological propositions at stake. A different assessment of the same clinical case may yield different truth-values and thus end up in attribution of the case to a different class of phenomena.

Table 2 illustrates the application of proposed diagnostic concepts to structuring of human experiences in the context of psychiatric evaluation.

[TABLE 2]

**Comments to Table 2**

*Health*, being the reference point of any medical system, translates into normal behavior and the absence of underlying pathology, together with the sincere representation of internal state (*item 1*). Besides the general non-psychiatric population, this category includes those who have been cured of mental illnesses and behavioral disorders, or stopped malingering or lying. In a sense, the category of health is defined by the way of negation, i.e. as a condition
whose significations carry only positive truth-values: this brings health in opposition to every other phenomenon encountered in the diagnostic practice.

The construct of *mental illness* is the focal point and raison d’être of psychiatry. In the medical hierarchy of significations, i.e. symptom, syndrome and disease, mental illness receives a status of ‘disorder’: cf. Kirmayer and Young (1999: 448):

> The notion of disorder attempts to go beyond the notion of syndrome by implying that there is some distinctive underlying disturbance of functioning that characterizes these syndromes. The concept of disorder, therefore, lies somewhere between syndromes (correlations of symptoms and signs) and diseases (pathophysiological entities defined in terms of their etiological agent and underlying pathology).

In terms of diagnostic propositions, mental illness may be interpreted as a pathological internal state sincerely reflected in the behavioral signs deemed abnormal (*item 6*). As boundaries of normality and pathology are constantly reviewed by practitioners of medicine, new areas may be lost to the extent of mental illness, or freed from it. Since our categorization is restricted to the field of mental health, cases of somatic diseases uncomplicated by psychological problems will be grouped together with healthy individuals. It is a known practice of non-psychiatric doctors, however, to transfer somatic complaints to the responsibility of psychiatric expertise, if an observed case is not attributable to any disease-category of somatic medicine. In this event, the patient is considered by ‘somatic’ physicians either a mental case (suffering, say, from the somatoform disorder or Muncha usen syndrome) or a malingerer, any of which necessitates examination of the mental health status. Organic etiology for psychological impairments is not always known; therefore the self-establishing activity of psychiatry concentrates on behaviors. The ongoing medicalization, such as seen, say, in the broaching of the Chronic Fatigue syndrome, exemplifies the expansion of the psychiatric authority to previously untouched behavioral grounds, while de-pathologization of some patterns (e.g. homosexuality) demonstrates the shrinking of the psychiatry’s application domain.

This exchange of conditions and signs across the borders of defined disorders mainly takes place between the category of mental illness, and the category characterized by the condition of pathological internal state and sincere symptom production, accompanied by the absence of clear signs of mental abnormality (*item 2*). For the lack of a better name, we will call the latter category *under-recognized illness*. It embraces cases where diagnostic status is made uncertain either by limitations of observation, or by temporary fluctuations in the dynamics of illness. Among such cases are conditions with the faint pre-morbid signs that precede the full-fledged manifestation of malfunction. Same holds for situations demonstrating ulterior symptoms of a potential existing disorder, which are not conclusively identifiable in a specific clinical setting (for example, in the unconscious patient with the recorded history of psychotic episodes).
Another frequent diagnostic situation falling into this category is the full remission of illness: i.e. when illness is still affecting the patient, yet does not manifest itself in noticeable symptoms. For example, even upon the patient’s full recovery from the affective episode psychiatrists may assess his condition as bipolar affective disorder in remission, and continue administering treatment (e.g. mood stabilizers) to prevent the next morbid episode. Under-recognized illness also serves as the primary ground for psychiatry to spread out beyond its borders, since it only differs from mental illness in the status of behavioral normality. Thus, assemblage of subclinical signs into a syndrome will enrich the category of mental illness on expense of the under-recognized illness. Similarly, signs previously considered subclinical may be declared symptoms, and this will allow for medicalization of one’s behavior. This kind of sign-to-symptom transformation is evident in the description of symptomatology of the Chronic Fatigue syndrome (Rundell and Wise 1999: 292):

*Impaired memory or concentration, sore throat, tender cervical or auxiliary lymph nodes, muscle pain, multijoint pain, new headaches, unrefreshing sleep, and postexertion malaise*

In the Chronic Fatigue syndrome, significations such as fatigue and lack of energy claim the rank of symptoms, and are further united with the known non-psychological symptoms of muscular pain or insomnia to form a new nosological unit allegedly threatening mental health. Another context of clinical examination which places cases with the category of under-recognized illness is the presumption of existing pathology, which cannot be proved or refuted with the contemporary medical knowledge. Application of new diagnostic instruments, for instance, genetic or biochemical analysis, produces signs that are by and large regarded as symptoms, so that cases of under-recognized illness are redefined either as mental illness or as health.

Diagnostic scenarios where representation mode is assessed as insincere are extensively studied in research of psychiatric malingering and other deceptive disorders [Note 1]. The spectrum of behavioral patterns marked by fake symptoms includes:

- **malingering**, i.e. ‘the intentional production of false or grossly exaggerated physical or psychological problems, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs’ (APA 1994)
- **factitious disorder, or Munchausen syndrome**, i.e. fabrication of false physical or psychiatric problems driven by psychological motives, rather than by any external gain or motivation.
- **Munchausen syndrome by proxy**, i.e. fabrication of false (predominantly, physical) symptoms in another person, often the patient’s child.
dissimulation, or defensiveness, i.e. ‘the concealment of morbid symptoms: the chronic paranoic conceals his delusional system and knows that everyone considers it quite mad; the melancholic hides his profound despair beneath a quiet and smiling exterior so that he is thought to be recovered and thus can gain an opportunity for the suicide’ (Jaspers 1963: 828)

Übersimulation, or sursimulation, i.e. fabrication of psychiatric symptoms to deliberately disguise an existing illness, and finally,

non-pathological lie, i.e. production of false non-symptomatic signs, including fabrication of the case history.

Listed insincere manifestations give rise to several taxonomic units, accounting for different truth-values of normality and pathology. Faking illness, or malingering (item 7), presupposes imitation of morbid signs of psychological abnormality or deficiency. Whether or not malingering expresses pathology has been a long-standing debate in psychiatry. A puritanical trend of psychiatry existed that presumed an underlying pathology inherent in every case of malingering (e.g. Jaspers 1963). This opinion is widely replaced today by the adaptational approach, which views malingering as a behavioral pattern prompted by situational circumstances and needs other than psychological (e.g. Resnick 1999). In this paper malingering, or fake illness, is viewed as a combination of abnormal symptoms, false representational modality and the lack of pathology.

The two-level illness expresses itself in the situation where an existing mental illness is accompanied by the fabrication of symptoms of another impairment – more often than not, a physical one. To give a clinical example, a schizophrenic patient that has no insight into his illness, may attempt to fabricate symptoms of the ‘second-level’ illness, such as amnesia, in the legal-criminal setting. This category (item 8) includes such diagnoses as sursimulation, or factitious disorder (Munchausen syndrome) with psychological signs. Patients suffering from these pathologies tend to go through unnecessary and painful medical procedures, including surgeries, on the grounds of self-fabricated health complaints.

The category of concealed illness (item 4) stands for the coexistence of pathology and normal behavioral signs that disguise illness. The most notorious examples are diagnoses of dissimulation, or defensiveness, that describe the effort of a patient to downplay his disease by demonstrating a normal (usually, narrower) symptomatic range. A classic instance of dissimulation is the situation where the depressive patient with suicidal ideation tries to convince his physician that he is cured, in order to make suicide possible. A rare, yet dangerous representative of this group is Munchausen syndrome by proxy. Under this condition, the ill individual who inflicts damage on another person may not display any sign of deviation himself. Even when his actions (poisoning, contamination of clinical samples etc.) are
detected, they often appear abnormal from the legal and not psychiatric point of view. This condition differs from Munchausen syndrome proper, as the latter presupposes fabrication of indicators of abnormality in the actor, not the third party.

Previous approaches to differentiation between numerous types of dishonest behavior tend to structuralize experiences similarly to the method taken in this paper, yet using different criteria, namely, the deceiver’s conscious motivation towards the gain, and his awareness of producing deceit (cf. Nicholson and Glenn 1994; Szoke 1994; Trowbridge and Frank 2002). Along these lines, Resnick (1988b) explains the difference between conversion disorders (e.g. hysterical paralysis) and malingering by that ‘[p]atients with conversion disorders deceive themselves as well as others; malingers consciously deceive others, but not themselves’. In the categorization proposed in this article, the presence of external motives is insignificant, while awareness of the symptom production is a requirement for insincere representation. In particular, this implies that here conversion disorders are grouped together with genuine mental illness in Table 2.

With the behavior deemed normal, the patient’s experience may also classified as a casual, non-pathological lie (item 3), which distorts the reality neither due to the underlying pathology, nor to simulate illness. This brings to life the combination of normal behavioral patterns that are falsely produced, and the nonpathological internal state. The flavor of a lie that is particularly interesting to psychiatrists is the unsubstantiated narrative about morbid experiences in the past, while no demonstration of actual symptoms is attempted at the time of interview. In extreme manifestations, lie may grow into pseudologia phantastica, or mythomania, i.e. ‘a condition involving compulsive lying by a person with no obvious source of motivation. The affected person believes their lies to be truth, and may have to create elaborate myths to reconcile them with other facts.’ (Wikipedia 2004). Once the patient loses awareness of the fictional character of his stories, his internal state changes to pathological and his overall condition moves from the category of casual lie (item 3) to that of mental illness (item 6).

If the diagnostician observes a behavioral deviation, he is to decide whether this is a potential indicator of mental pathology, or a non-psychiatric sign. The category of quasi-mental illness (item 5) is a grouping of heterogeneous phenomena that are united by their observational similarity to psychiatric symptoms yet give no evidence of underlying pathology. What falls into this category, among many other patterns, is aggressive or suicidal behavior, stalking, jealousy, permanent tiredness, distractedness and lack of concentration, insomnia, etc. Likewise, some somatic impairments symptomatically resemble psychiatric disorders, yet are caused by organic, not psychological, deficiencies. For instance, speech of an aphasic patient is often confused with psychotic speech, while the presence of catatonia may signal acute poisoning rather than catatonic schizophrenia. Similarly, mania or depression may show themselves as
symptoms of thyroid function abnormality (hyper- and hypo-functioning, respectively). Quasi-illness, in terms of diagnostic propositions, is then characterized as the abnormal behavior, sincere representation and healthy internal state.

**Conclusion**

The relevance of the proposed structural model is clearly seen on the example of Ganser syndrome. Phenomenology of this syndrome has been described over one hundred years ago (Ganser 1898) and the description is considered valid up to this day. Yet there is no consensus as to what diagnostic group Ganser syndrome belongs in (Kaplan and Sadock 1995: 1621):

> Ganser’s syndrome, or the syndrome of approximate answers, is rare and described primarily in prison populations. It involves the production of answers to questions that are relevant but not quite correct, such as stating that the products of 7 times 4 is 29. It is classified in DSM-IV as a dissociative disorder not otherwise specified [item 6], but it has variously been regarded as a factitious disorder [item 8], a hysterical phenomenon [item 5], a psychotic disorder [item 6], and frank malingering [item 7].

The quotation shows historical attempts to attribute Ganser syndrome to categories listed in Table 2 as items 5 to 8: namely, it points to every category in our model that bears the negative value of normality. In other words, the only position that diagnosticians agree on is the presence of abnormal behavior. The sincerity of representation and the presence of pathology remain questionable, hence the range of diagnostic responses. The structural model that we argue for will not help diagnosticians to resolve the problem of correct attribution of this syndrome to a specific disease-category, be it malingering, psychosis or factitious disorder. Yet the model makes explicit what stands behind any diagnostic attribution, namely, specific truth-values ascribed to fundamental propositions of diagnostics. Thus, if Ganser syndrome is interpreted as a dissociative disorder, the psychiatrist implies abnormal symptomatology (normality-) linked to sincere conveyance (sincerity +) of pathological internal state (pathology -). Alternatively, the diagnosis of malingering translates into the healthy internal state (pathology +) and fabricated symptoms of mental illness (sincerity -) that appear abnormal (normality -).

As mentioned above, the proposed categorization does not aim at substituting present diagnostic classification systems, nor will it improve the accuracy of diagnostic decisions. This semiotic approach in psychiatry articulates the conceptual keystones of decision-making (normality, sincerity, and pathology), and structuralizes the diagnostic procedure in view of a small number of epistemological propositions. The resulting categorization of all phenomena that
psychiatric diagnostics comes across allows to specify the sign structure of illness, non-illness (i.e. health), quasi-illness, fake illness, two-level illness, under-recognized illness, concealed illness, and lie.

References


Note

[1] This paper uses terminology that originated in Jaspers’ General Psychopathology (Jaspers 1963) and is mainly used in the European psychiatric tradition. The nomenclature is not necessarily identical to the terms accepted in the North American psychiatry and the standard Diagnostic and Statistical Manual (APA 1994). All terms, however, are defined in the text.
### Tables

**Table 1. Truth-Values of the Diagnostic Concepts**

<table>
<thead>
<tr>
<th>Truth-Value</th>
<th>Positive (+)</th>
<th>Negative (–)</th>
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<tbody>
<tr>
<td><strong>Behavior</strong></td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td>Sincere</td>
<td>Insincere</td>
</tr>
<tr>
<td><strong>Internal State</strong></td>
<td>Non-pathological</td>
<td>Pathological</td>
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Table 2. Categorization of Phenomena under Psychiatric Diagnosis

<table>
<thead>
<tr>
<th>Category</th>
<th>Behavior</th>
<th>Representation Mode</th>
<th>Internal State</th>
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</thead>
<tbody>
<tr>
<td>1. Mental health</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>2. Under-recognized mental illness</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>3. Non-pathological lie</td>
<td>+</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>4. Concealed mental illness</td>
<td>+</td>
<td>-</td>
<td>-</td>
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<tr>
<td>5. Quasi-mental illness</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>6. Mental illness</td>
<td>-</td>
<td>+</td>
<td>-</td>
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<tr>
<td>7. Fake mental illness</td>
<td>-</td>
<td>-</td>
<td>+</td>
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<tr>
<td>8. Two-level mental illness</td>
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