ARTICLE

The concept of context in psychiatric diagnosis

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Abstract

First, the author analyses the use of the concept of contextualisation in discussions of the possibility of a comprehensive diagnosis and, specifically, an idiographic diagnostic formulation. Certain blind spots and ambiguities are demonstrated in the concept as it is used in the WPA's *Institutional Program on Psychiatry for the Person* and in the supplements of the workgroup for the *International Guidelines for Diagnostic Assessment*. It is shown how these ambiguities in some cases lead to validity problems, in other cases to reliability problems. The author then explains why the concept of context is introduced into the theory of psychiatry at all and identifies its advantages and pitfalls. To avoid the pitfalls and sustain the advantages, the author presents a critically founded model of context motivated by contextual epistemology and epistemic logic. The model's use is demonstrated in the outline of a practical instrument of contextualisation. The model neither reduces contextual information to a detached supplement to diagnosis, which would undermine its validity value, nor does it give contextualisation the power to relativise the standardised typologies and scales, and thus opening up reliability problems. Instead, it shows how contextual information is used in justifying what evidence counts as relevant in applying the standardised typologies and scales.

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Introduction

Over the last couple of years, the recently published fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* and the forthcoming tenth edition of the *International Classification of Diseases* have sparked a debate about the concept of diagnosis in mental health care [1-6]. Is it possible, it has been asked, to create a comprehensive diagnosis that has a stronger focus on the whole person of the patient [7-15], a diagnosis that expands the limits of a purely criteriological approach and takes the context of the patient and her condition into account? The *World Psychiatric Association* (WPA) has been an important agent in this debate. With the *Institutional Program on Psychiatry for the Person* (IPPP), it has called for an idiographic (personalised) diagnostic formulation to supplement the standardised typologies and scales, to thereby facilitate a more comprehensive diagnostic manual.

The aim of this study is to explore how the WPA, in describing the idiographic diagnostic formulation, utilises the concept of contextualisation. I want to point out its central role in the model of comprehensive diagnosis and, specifically, I want to demonstrate certain blind spots in the concept as it is used in the IPPP and in the supplements of the workgroup for the *International Guidelines for Diagnostic Assessment* (IGDA). I will argue that these blind spots seem to stem from a lack of a critically founded

concept of context, and that this lack may imply problems with regard to both reliability and validity of diagnosis.

Against this backdrop, I will present an epistemic theory of context that may elucidate these blind spots. The theory draws on contextual epistemology [16-17] and epistemic logic [17-18]. To demonstrate the practical impact of the theory and how it keeps the idiographic formulation concrete and useful, I will also introduce and discuss an outline of a practical instrument of contextualisation. In the last paragraph, I discuss Tim Thornton's critique of the idiographic formulation and why the epistemic conception is not rendered invalid by his arguments.

The use of the concept "contextualisation" in IPPP and IGDA

In 2005, the WPA established the IPPP as "an initiative to place the whole person of the patient at the centre of mental health care" [3]. The person, it says, "is conceived of in a contextualised manner, in the line with the words of Ortega y Gasset, *I am I and my circumstance*" [3]. Another WPA project, the *International Guidelines for Diagnostic Assessment* (IGDA) [19-21], also reflects this wish for a more comprehensive diagnosis. The IGDA workgroup

states "the diagnostic process involves more than simply identifying a disorder or distinguishing it from another. It should lead to a thorough, contextualised and interactive understanding of a clinical condition and of the wholeness of the person who presents for evaluation and care." [20]

Both quotes use the term "contextualised". The first quote speaks of a "contextualised conception of the person", the second of a "contextualised understanding of a clinical condition". The call for contextualisation prompts questions concerning what this really consists of. What is context? How do we identify it? And what role can it play in psychiatric diagnosis and treatment?

There is some, although sparse, clarification of these questions in the publications of IPPP and IGDA. As a first step to realise a "contextualised understanding of a clinical condition", the IGDA workgroup suggests splitting the diagnosis in two levels: one that describes the condition of the patient by "standardised typologies and scales" [20], and one that consists of "an idiographic diagnostic formulation" supposed to complement the standardised formulation with a "personalised and flexible statement" [20]. But how, we might ask, is such a statement characterised by the IGDA?

In the publication *IGDA 8: Idiographic (personalised) diagnostic formulation* [20], the idiographic formulation is characterised as the "identification of clinical problems and their contextualisation." This includes (a) a description of disorders, symptoms and problems (based on the standardised formulation) "in a language shared by the clinician, the patient and the family"; and (b) "key complementary information and elucidation of pertinent mechanisms and contributory factors, from biological, psychological, social and cultural perspectives." [20]

This line of thought shows that the IGDA considers contextualisation as a kind of *information*. A "contextualised understanding of a clinical condition" is an attempt to add to the standardised formulation a new kind of information drawn from the described perspectives. The information collected in the standardised formulation, however, stays the same.

When talking about this form of information, a central issue is what the information is relevant for. A clinician may have access to all kinds of information, but the important thing is to decipher which information is relevant in and has an *impact* on the diagnostic formulation. Characterising the contextualisation as "key complementary information" therefore prompts the question of the role of such information. What is its epistemic function? What, if any, kind of impact does the contextual information have on the diagnosis and understanding of a clinical condition?

The *IGDA 8* does not provide any clear answers to these questions. The formulation "complementary information" might indicate that the contextualisation is supposed to be conceived of as a *supplement* to the standardised understanding of the clinical disorder, rather than as a contextualisation of the standardisation *itself*. In other words, the concept of contextualisation can go in two different directions, (1) a contextualised conception of the standardised information itself (collected with the standardised methods), and (2) a contextualisation that

functions as merely an *addition* to that information. In the first case, the contextual information is supposed to have the ability to somehow (determining how exactly is essential) change the understanding of the information collected with the standardised methods. In the second case, the contextual information cannot change anything about the standardised information but merely appears as a supplement or addition to it. The talk of "complementary information" points toward this second possibility.

In another publication of the IPPP, however, the chair of the IGDA workgroup, Juan Mezzich, seems to be advocating a contextualisation of the concept of the disorder itself, rather than a mere addition to the standardised understanding. Together with George Christodoulou and Bill Fulford, he presents the idea of a "multiperspectual analysis" [3], which is supposed to offer a "biopsychosocial" framework for the understanding of mental disorders. The term "biopsychosocial", originally coined by Engel (1977) [22], posits that biological, psychological and sociological factors, as well as their interactions, contribute to the development of mental disorders. The idea is then to integrate these different perspectives in the very concept of mental disorders, and hence in the diagnostic system. In this case, these different perspectives do not simply supplement the information given in the standardised typologies and scales, but ideally transform them.

Hence, we see an ambiguity in the use of the concept "contextualisation". Contextualisation can either be understood as (1) information that supplements the standardised information, or (2) information that can somehow alter the understanding of the standardised information. Both of these possibilities imply further questions. Affirming possibility (2) prompts the question of how exactly the contextualising information has an impact on the standardised information. Stating *that* information can influence conclusions and knowledge is a potentially empty statement without explaining *how*. Information is determined by the commitments and entitlements it involves for the agent in her judgment. Lack of clarity on how exactly contextualising information might commit or entitle the clinicians to change their understanding of the standardised information therefore obscures the impact of contextualisation overall. It becomes uncertain how the clinicians are supposed to use the information, enabling uses that are in principle widely divergent, and thus creating a severe reliability problem; the very problem that standardisation was supposed to overcome.

Affirming possibility (1), however, begs another difficult question. If contextualisation is to be understood as an idiographic diagnostic formulation, and this is considered a mere addition or supplement to the standardised formulation, in what sense, then, is it a "diagnostic formulation" at all? If the formulation has no impact on the standardised formulation, it is difficult to see why it should be considered a diagnostic formulation at all. Reducing the contextualisation to a matter of reporting information on *circumstantial conditions* without any genuine consequences in the understanding of the *clinical condition* prevents reliability problems, but opens up a

validity problem instead: Why do we need this information and to what concrete use do we collect it? This question is not only of clinical importance but also implicates the ethical issue of clinicians collecting personal information about patients that is not of direct relevance to clinical practice.

A short example might illustrate this problem about how contextual information tends to become either irrelevant or unreliable as evidence. During a diagnostic interview a clinician learns that the patient is unemployed and lives on the streets. According to diagnostic criteria, this information cannot in itself serve as evidence for any psychiatric diagnosis (although a psychiatric diagnosis might in some cases explain it). In that sense it is – initially at least – nothing more than contextual information about the patient's social situation and background. If contextual information is considered merely an addition to the information collected in the standardised typologies and scales, it seems unclear what the diagnostic value of the information is. A clinician might ask about a patient's occupation and accommodation to create an intimate atmosphere and get the interview started, but why should it be registered in an "idiographic diagnostic formulation" that a patient is unemployed and homeless if it has no impact on the diagnosis itself?

If, on the other hand, we consider such contextual information as potentially relevant in the understanding of the clinical condition, it is necessary to clarify exactly how. Can unemployment and homelessness serve as evidence for a clinical condition under certain circumstances after all? What circumstances, i.e. what combination of other information, might that be? Without clarification of such questions the reliability problem seems to be lurking just around the corner.

Some of these ambiguities in the IPPP publications about the role of contextual information seem to stem from the lack of a critically founded concept of context. Without a more theoretically elaborated conception, the status of the information contained in the idiographic formulation risks loosing its validity value and reliability, and thus its relevance and use. Disregarding either of these makes the formulation problematic, both clinically and ethically. In the following, I will present an epistemic model of context that can maintain a genuine contextualisation and at the same time resolve these problems. The model neither reduces contextualisation to a detached supplement, nor does it give contextualisation the power to relativise and destabilise the standardised information.

I want to introduce the model in three steps. First, I will look at how the concept of context is introduced in the philosophy and theory of psychiatry in the first place. I argue that, in explaining how diagnostic concepts and criteria are applied correctly in clinical practice, theories make use of a reference to (1) the power of judgment and (2) the concept of context. Because the correct application of a rule cannot ultimately be regulated, since the rule of such regulation would itself need correct application, reference to good judgment and context is necessary to prevent an endless regression of rules [23]. In this way, the

concept of context marks the limits of schematised methods.

From a less technical point of view, this means that knowledge of objects that are difficult to isolate (in controlled, randomised experiments, for example), such as a singular person's psychiatric condition, is understood as context dependent knowledge. The rules that regulate the generation of such knowledge are more difficult to apply because the object is, so to speak, a moving target. And since the application of a rule cannot be regulated by another rule, problems regarding such application are essentially "context problems" (i.e. under the premise that the rule is already formulated as clearly as possible).

I then argue that while context is indeed the concept that marks the limits of a schematised method (the "endpoint" of theory), an unwanted dichotomy seems to arise from that insight. On the one hand, context cannot be defined by further rules, since its function is to halt the succession of rules. On the other hand, however, it threatens to become a black box, an empty concept, if the price of this functionality is that it cannot be explicitly and rationally discussed.

Lastly, I present an epistemic concept of context that balances between these two ends. The concept is based on David Lewis' contextual epistemology [16-17] and Jaakko Hintikka's epistemic logic [18]. I then utilise the concept to form a model that can be used as a tool to make explicit the understanding of context that underlies a concrete rule-application such as a diagnosis. Furthermore, it can be used to clarify how such an understanding can be justified.

Why is the concept of context introduced at all?

One of the important questions that the philosophy of psychiatry is concerned with is how a clinician can know whether she uses a diagnostic concept correctly in a specific case. What are the criteria of a distinction between the correct and incorrect application of a diagnostic concept? The question stems from a philosophical problem formulated among others by Ludwig Wittgenstein [24]. The problem is this: correctly following a rule cannot itself be governed by a rule. Such a rule, regulating how to follow another rule, would have to be followed itself – begging the question or opening an endless regress of rules [25-27]. The problem is well known in psychiatry. One of the primary aims of the operationalisation of DSM and ICD was to improve the diagnostic reliability. Solely studying the diagnostic criteria is insufficient for learning the correct application of them in a specific case [28]. It must be learned by practice, i.e. through extensive clinical training under supervision of senior psychiatrists.

However, since we are talking about the crucial distinction between correct and incorrect application of diagnostic criteria, a mere reference to practice alone is not satisfying from a theoretical point of view. Some theoretical ground is needed to explain and secure the possibility of an explicit and rational discussion of real

practice. But given that such discussion cannot simply be based on further criteria and rules, philosophers look to the power of judgment (as in the phrase "having good judgment") and the concept of context [28]. What cannot be schematised in advance by a method depends on the context of the specific case. And it is the job of the power of judgment to understand the context and to assess how the criteria or rules in question are supposed to be interpreted in that context. Yet, because context, by its very nature, cannot be known beforehand, theory cannot help the power of judgment any further. In other words, it is not up to the theory but to the specific case and its circumstances how to proceed.

In this sense, context is the endpoint of theory. If an eager student keeps asking questions about how to interpret and apply the diagnostic criteria, at some point the teacher can rightly answer: it depends on the specific case – we would have to sit down with a real patient and find out. At some point the right answer simply is not a further proposition but an invitation to "just do it." Such an invitation is *practical*, i.e. it is an act. The reference to context is the theoretical counterpart to such an act.

There is, however, a problem with this approach. If a *reference* to context is supposed to give the theory a solid ground, an argument as to *how such a reference is possible* is necessary. Without some sort of criterion of how to identify or at least define, what a context is, the reference appears empty. And while the invitation to "just do it" might work in practice, because practice always already takes place in a concretely given context, theory lacks such a concrete context. It becomes unclear, then, what it is theory wants us to "just do".

On the other hand, coming up with a criterion of how to identify or define a context is just not going to solve the problem, since the emergence of new rules was exactly what the concept of context was supposed to stop. The challenge therefore is to find a way to talk theoretically about context without ending up with new rules and criteria. What we need is a concept of context that is neither a black box nor a disabling, inflexible definition. This challenge can be met by a theory of context that offers tools that can be used actively in practice to discuss context in an *explicit* and *rational* way, without at the same time regulating in advance how to settle such a discussion.

4. An epistemic concept of context

In David Lewis' contextual epistemology, context plays a significant role that can give us a hint about how we might meet the challenge. David Lewis' notion of knowledge is as follows.

"S knows that P if and only if S's evidence eliminates every possibility in which not-P" [16]

Simply put, the way you check the truth-value of a hypothesis is to imagine all kinds of possible scenarios that would make your hypothesis false and then eliminating these possibilities using evidence. Possible scenarios can be alternative explanations, descriptions or interpretations that are different from yours but nevertheless compatible with what you already know. Jaakko Hintikka puts it like this:

"What the concept of knowledge involves in a purely logical perspective is thus a dichotomy of the space of all possible scenarios into those that are compatible with what I know and those that are incompatible with my knowledge" [18]

For example, let us say that a patient states that she feels "depressed". Her statement prompts the question: What exactly does she mean when she says "I feel depressed"? Stanghellini *[29]* and Fuchs *[30]* discuss the following possibilities.

"Some patients may use the word 'depressed' to express that they feel sad and downhearted, discouraged by a setback or another adversity. That means, they are depressed by or because of something, their feeling is intentionally directed – corresponding to the diagnosis of reactive depression. Others may use it to mean that they feel dull, empty, bored and dysphoric, as is often the case in borderline patients. Others may denote that they are unable to feel anything at all, that they have lost the affective resonance with others, like being petrified – corresponding to the 'feeling of loss of feeling' in endogenous depression. Some patients may also try to convey their sense of an inner void, a lack of inner nucleus or identity, feelings of being anonymous or nonexistent, as occurring in the prodromal phases of schizophrenia. Finally, some patients may use it to describe a blunting of affect, loss of drive, initiative and goal-directedness, corresponding to the phenomenon of aboulia in chronic schizophrenic states." [30]

The example as put by Fuchs here shows the different possible interpretations of the patient's statement. In figuring out what condition the patient's statement refers to, the clinician has to eliminate all possible interpretations by evidence (e.g. by further questions and answers) until only one interpretation is left that cannot be eliminated. Even though many factors might point to a certain hypothesis *P,* it is essential to the proof of *P* to eliminate all other possible hypotheses that might also explain these factors. Well, not exactly *all* other possible hypotheses. Lewis' definition of knowledge has a condition:

"S knows that P if and only if S's evidence eliminates every possibility in which not-P – Psst! – except for those possibilities that we are properly ignoring." [16]

What is this psst-condition about? What possibilities can be properly ignored? First of all, the condition is supposed to exclude sceptic possibilities. It might actually be possible that I am a brain-in-a-vat whose complete experiences of the world is one big manipulated delusion

made up by a mad scientist. But when I am at work trying to diagnose a patient, I am not concerned with eliminating this possibility by evidence before I draw a conclusion on the condition of the patient. I do not consider it a *relevant* possibility. I therefore – properly – ignore it. But how can I justify the relevance or irrelevance of a possibility?

Lewis' simple answer is that the *context* decides what the relevant possibilities are. When discussing epistemology, I might have to consider the sceptic possibilities, but when doing psychiatry, I can ignore them. But the sceptic possibilities are not the only ones I ignore. Let us consider the possibility that the patient saying she feels "depressed" is not depressed at all but is actually a very good actor with a bad sense of humour, doing a tasteless TV-show with a hidden camera. This possibility is not a sceptic possibility since it does not undermine knowledge all together (as the brain-in-a-vat possibility does). But it might still be a possibility the clinician does not eliminate by evidence, simply because it does not seem relevant to her given the context – a normal day at work at the clinic. This example shows that the exercise of assessing the relevance of possible explanations of a patient's condition is not just a matter of ignoring sceptic possibilities. As I shall try to illustrate, it is not even limited to extreme cases such as the example with the actor. In every diagnostic interview, the clinician evaluates the possible and relevant explanations and interpretations of symptoms in the context of the specific case. That means not only the context in its most general terms such as "a normal day at work at the clinic", but more specifically the context of a concrete case – a normal day at work at the clinic interviewing this specific patient with her specific background, way of communicating etc.

There are two important conclusions to be drawn from Hintikka's epistemic notion of knowledge and Lewis' use of context. First, the *set of relevant possibilities* is what *determines the truth criterion of a hypothesis*, the hypothesis being true if and only if all these possibilities are eliminated by evidence. Second, it is *the context that determines what counts as relevant possibilities* in a concrete epistemic situation.

Contextualisation as reasoning about relevant possibilities

How does this fit in with the psychiatric discussion about psychiatry for the person? I criticised the IPPP and the IGDA workgroup for lacking a critically founded concept of context and thereby leaving the epistemic status of contextualisation unclear. My suggestion is to use the epistemic concept of context as a starting point for a more substantive model of contextualisation and the idiographic diagnostic formulation.

The concept of context presented above offers a very concrete way to discuss and reason explicitly about context. Although there is no *general*, schematised method that can tell a clinician how to understand context, the clinician can make explicit how she understands context in

a *specific* case by discussing what possibilities she considers relevant. When stating a propositional judgment, such as a psychiatric diagnosis, she can contextualise that diagnosis by making explicit why she took certain possibilities into account and why she left others out. Inquiring into the patient's personal history will often be of the outmost importance for establishing a proper context in the sense that the history will provide information about the onset of the disorder, the duration and severity of the symptoms, and its possible relations to circumstantial events (e.g. the loss of a loved one). By using the contextual information to justify the set of possibilities that the clinician has considered relevant in the epistemic process of making the diagnosis, the clinician explicitly and rationally discusses what contextual information had which impact on her judgment and why. Doing this involves two simple steps.

(1) By analysing the evidence that has been used in reaching a diagnosis, it can be made explicit what other possible explanations and interpretations of the patient's condition and interview answers have been eliminated by that evidence. The set of possible hypotheses (e.g. other diagnoses) that has been eliminated describes the understanding of context present in the diagnosis, i.e. analysing the set of possibilities the diagnosis has *de facto* been considered relevant to eliminate by evidence shows how the context was understood in the actual case. Such an analysis is the tool that makes an *explicit* discussion of context possible. The result is a listing of the possibilities that were considered relevant.

(2) When it has been made explicit which possibilities a clinician is taking (or has taken) into account in a diagnostic interview, a discussion of why exactly these possibilities where deemed relevant opens up. In a specific case, doing this is essentially a matter of making reference to what is known about context, e.g. a patient's background or her way to communicate. This is, in other words, the information that justifies the list made in step one. For each possibility on the list there must be some information justifying its relevance.

This approach can also say something about what is counted as relevant possible explanations in a clinical practice in a more general perspective. For example, when the IGDA workgroup writes that the idiographic formulation should contain information of contributory factors "from biological, psychological, social and cultural perspectives" [20], we can understand the *argument* for the necessity of taking these factors into account in the following way: If we consider the whole person of the patient (and not only symptoms of the mental illness) as the factor which posits the context of a psychiatric diagnosis, then biological, psychological, social and cultural perspectives *cannot properly be ignored* in the

diagnostic process because they *count as relevant possible explanations and understandings* in diagnosing the patient.

Looking at the concept of context in this way makes the contextualisation more than complementary information to the standardised typologies and scales. Yet, at the same time it does not relativise or destabilise the standardisation. Rather, it picks out the standard itself as a central theme by *making the conditions of its application explicit*. In other words, when contextualising the standardised diagnosis of e.g. depression, the clinician does not relativise the standard but explicates and justifies how she has applied it in the specific case: how did she show that the diagnostic criteria were met? Which of the patient's answers and which of the clinical observations were counted as evidence for assessing that the criteria were met, and what other possible interpretations of these answers and observations were explored, but eliminated by further answers and observations? So, for example, the information that a patient is unemployed and homeless does not serve as direct evidence for or against any diagnosis. But it can serve as justification for what possible alternative interpretations and explanations were considered relevant in understanding the patient's symptoms and making the diagnosis. In other words, it might be relevant in determining what evidence is necessary when applying the diagnostic criteria.

Let us have a look at an example in which an alternative *interpretation* of a piece of evidence is considered relevant. A clinician receives a patient who is a young teenage girl. It is the girl's mother who has brought her in. In a conversation with the mother before the psychiatric interview, the clinician learns that the mother is convinced that her daughter has a depression. During the interview the girl pronounces quickly that she does feel "depressed". However, the clinician feels uncertain about whether the girl is repeating a description her mother has given of her condition, if "depressed" is her own formulation, and not least what she means by "depressed". In finding out what the girl means and how she actually feels, the clinician considers the adoption of the mother's picture as a *relevant possibility*.

Let us take another short example in which an alternative *explanation* of a condition is considered relevant. Let us say that the clinician finds out that the girl does indeed feel very downhearted. However, the clinician also finds out that the family is having a difficult time in general. At home the girl is inward and passive, but at school and among friends she is less so. The clinician therefore considers it a *relevant possibility* that the daughter is not clinically depressed, but that her condition reminiscent of depression is not anomalous in the light of the personal problems at home. Showing that this is the case (or eliminating the possibility) involves the collection of new evidence. While it might be relevant in *general* to eliminate the possibility that a patient's discouragement and sadness are normal reactions to a given event and not a reactive depression, it depends on the context of the *specific* case *what counts as evidence eliminating it*. Making a comprehensive list of what interview answers would count as such evidence simply is not possible, partly because patients express themselves differently, partly

because it would depend on what kind of event we are talking about. This is a basic condition of the application of many diagnostic criteria, despite clever operationalisations. But in the light of the context model presented here, it is possible to take the condition into account, as the clinician can explicitly and rationally justify what she counted as specific evidence for the conclusion that the general criteria were (or were not) met.

The conclusion here is that having a "contextualised conception of the person" and a "contextualised understanding of a clinical condition" can, in clinical practice, be translated into a reflection on what is counted as relevant evidence for assessing that the diagnostic criteria are met. That means making explicit and justifying the set of alternative possibilities, in which the diagnosis would be false, which were taken into account and eliminated. That is, when accounting for the factors that point to a diagnosis, one must ideally consider all other relevant possible interpretations and explanations of these factors and figure out if and how they were eliminated. In this way, the contextualisation can be given a distinct epistemic function in the diagnosis, in which it neither relativises the status of standardised typologies and scales nor plays the role of detached complementary information. The contextualisation in this model consists of information crucial to understanding why the clinician applied the standard criteria in a *specific* case as she did, without obscuring the standard criteria themselves.

Fig. 1 is a simplified outline of what an instrument of contextualisation might look like. P is a proposition such as a diagnosis or the conclusion that a diagnostic criterion is met. Each E stands for a piece of evidence for P. A list is the set of relevant possibilities in which not-P that E eliminates. Each E corresponds to a specific list of possibilities that is eliminated by that E. Ctx Info is the contextual information that justifies a list. Each possibility on a list is considered relevant in the light of some contextual information in Ctx Info.

The figure illustrates that the clinician starts out with one piece of evidence E_1. It supports P in eliminating a range of possible hypotheses formulated in $List_1$. $Ctx\ Info_1$ is the contextual information making $list_1$ relevant. E_1 probably does not eliminate all relevant possibilities in which not-P. So now the clinician will have to consider relevant possibilities that can explain or at least tolerate E_1 but in which not-P holds. Each new list must explain or tolerate the prior E. E_n illustrates that it is undefined how many pieces of evidence are involved. Crucially, it also shows that relevant possibilities can be listed without there being any evidence eliminating them. $List_n$ is the list of possibilities that no existing evidence eliminates. As long as $list_n$ has items on it, P is not proven. The more items are on $list_n$, the less certain P is. When going through her evidence the clinician uses $list_n$ to think about what possibilities she might not have taken into account but are relevant.

Figure 1. Model instrument of contextualisation
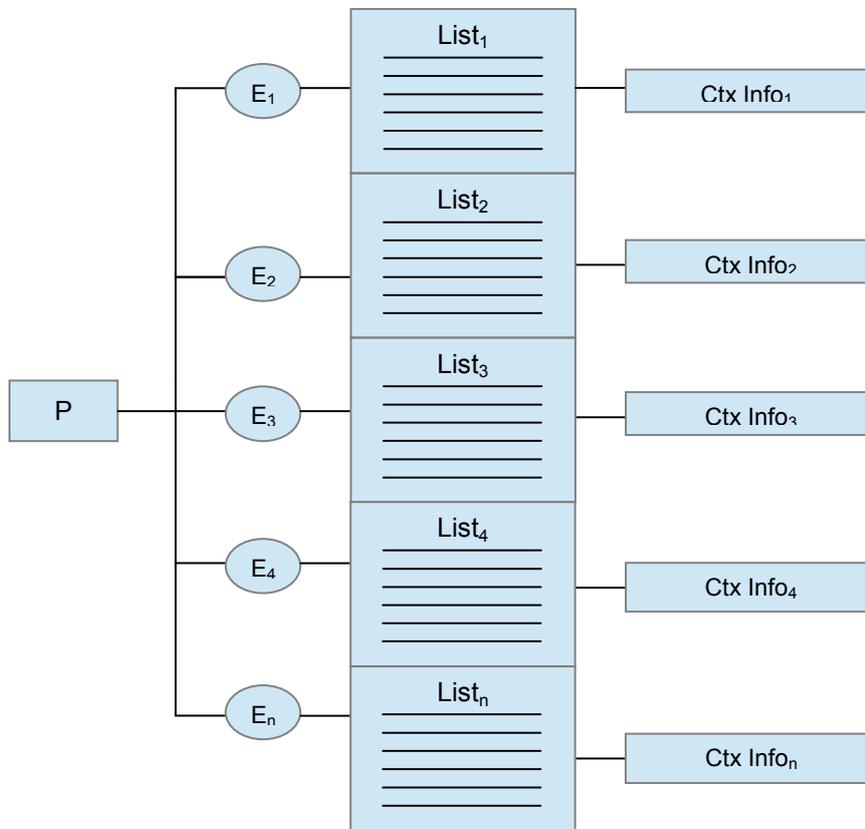
The idiographic formulation

As we have seen, determining what a patient means by saying that she feels "depressed" includes familiarising oneself with how the patient thinks and talks in a wider perspective. A clinician uses the context as a limitation of what she needs to explore and eliminate in order to assess if she understands what the patient means. She also uses it to determine the set of relevant possible explanations of the patient's condition. When asked about, or reflecting upon, the evidence for her conclusions the context becomes her justification of what she thought was relevant to take into account and what she thought was irrelevant. My suggestion is to understand the idiographic diagnostic formulation as such a reflection.

To make the suggestion a little clearer, let me briefly consider Tim Thornton's critique [4, 14-15, 31] of the idea of the idiographic formulation as an "individualised judgment", suggesting a so-called narrative understanding instead. Does the model of contextualisation presented in this paper fall prey to Thornton's critique?

Thornton's rejection of "individualised judgment" is based on epistemological arguments put forth amongst others by Wilfrid Sellars [27] and John McDowell [32]. I do not want to go into a detailed discussion of these arguments here, but the main point is this: All judgments must have propositional content that can qualify as either true or false. That is what makes it a judgment. For a judgment to meet this criterion, its propositional content must refer to general rules or conceptually explicable truth conditions. Even non-inferential perceptions can only count as experience under the condition that they are based on certain general rules of assessment specifying when such perceptions are reliable. Since all judgments refer to general rules they can never be fully individualised, in the sense that they make use of concepts solely applicable (and thereby solely sensible) in that unique situation. Even though you might only get the chance to apply a concept once, the concept itself must be abstract, i.e. defined by a rule, and thus in principle applicable again. For this reason, Thornton concludes, the contrast between the generality of standards versus "individualised judgement of particulars" [4] is the wrong place to start. He then suggests a so-called narrative approach instead.

This is not the place to discuss Thornton's narrative approach, however. Here, the important question is whether his negative argument rules out the idiographic formulation as a contextualisation in the sense presented in this paper? No. While Thornton is right that there can be no judgments that are not based on abstract concepts and general rules, he overlooks that the *application* of these concepts and rules does indeed take place in an individual and singular context. This does not imply that the rules of judgment themselves become individualised in any

obscure sense, but it means that the conditions of their application can change slightly from judgment to judgment. It is actually the ability of the rules to "fit" into different contexts that secure their applicability and usefulness in processing knowledge. In the terms of the model presented in this paper, the set of relevant possibilities can change from judgment to judgment and this poses a genuine individual or idiographic element. It is not individual, however, in the sense that it cannot be explicitly and rationally discussed.

Conclusions

WPA's efforts to put forward a more comprehensive diagnosis are both interesting and full of challenges. One problem, which I have discussed here, concerns pinning down exactly what contextualisation means and how clinicians can actively take the context into account in diagnostic and differential diagnostic procedures. I have presented a model that can serve as a starting point for a more elaborate instrument for contextualisation. It is indeed a balancing act in making the context neither too powerful, nor irrelevant. I have argued that an epistemic approach makes it possible to let the context influence the diagnosis in a sensible and controlled way, supporting the basic idea about a more comprehensive diagnosis. Placing the whole person of the patient at the centre of mental health care is about letting the patient be the point from which the context is defined. Making the context explicit as the set of relevant possibilities, in which the proposition in question (e.g. the diagnosis) would be false enables a rational discussion of the context. Obviously, it does not present fixed rules to guide individual cases – but it does present ways in which clinicians can reason about context in diagnostic procedures.

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