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Perspective

Psychiatric Diagnosis as Situated Practice in Institutional Psychiatry

Ingrid Falk*

Department of Personality and Psychological Assessment, University of Seville, Seville, Spain

DESCRIPTION

In the quiet corridors of psychiatric clinics, where patient histories intersect with institutional policies and human emotions, Mental Health Professionals (MHPs) make hundreds of nuanced decisions each day. One of the most influential tools they wield is the psychiatric diagnosis ostensibly a technical classification of symptoms. But in practice, it is much more than that. Diagnoses serve as social, clinical and institutional tools that shape patient care, construct agency and delineate responsibility.

This article presents findings from four months of ethnographic fieldwork, including participant observation and interviews in Danish psychiatric inpatient and outpatient settings. The study explores how MHPs use and negotiate diagnostic boundaries in their everyday work not merely as instruments of classification, but as dynamic constructs embedded in a broader context of care, responsibility and institutional necessity.

From categories to care: Diagnosis as situated practice

Mental health diagnoses are often assumed to be objective, static labels "Discovered" and applied with clinical neutrality. However, field observations challenge this assumption. During a routine morning handover, for instance, staff discussed two patients who had returned intoxicated from leave. One was seen as manipulative and disruptive; the other as self-medicating and anxious. These divergent interpretations, though referring to similar behaviors, had real consequences whether patients were discharged or retained, blamed or supported, judged as ill or culpable.

This illustrates how diagnoses are actively negotiated in everyday practice. They help MHPs sort complex, ambiguous human behaviors into categories that are actionable within the institutional logics of psychiatry. These negotiations are rarely explicit, but their outcomes affect treatment trajectories, eligibility for services and even the perceived legitimacy of a patient's suffering.

The article proposes two core concepts to understand this dynamic situated rationality and psychiatry as a multiple institution. Situated rationality refers to how decisions are made within local, context specific norms and pressures. Psychiatry as a multiple institution recognizes that it is not a monolith but a constellation of overlapping, sometimes contradictory practices, purposes and ideologies.

Multiplicities within psychiatry

Psychiatric diagnosis exists at the intersection of medicine, law, social services and everyday life. Consequently, it serves multiple, sometimes conflicting purposes. While healing and symptom management may be primary goals, diagnoses also serve secondary purposes such as containment, clarification, housing eligibility, or relieving caregiver burden.

For example, a psychiatrist may support a diagnosis not only to reflect a clinical judgment but to ensure the patient's access to housing or social support services. Conversely, a behavior might be downplayed diagnostically to avoid institutionalization or stigma. Such decisions are embedded in what scholars call trajectory of care the shifting path a patient takes through different services and systems, shaped by ongoing negotiations around diagnosis, treatment potential and institutional fit.

This negotiation does not end when a diagnosis is written in the chart. It continues in daily conversations among MHPs, in formal care plans and in subtle shifts in how staff interact with patients. Diagnoses are tools of navigation as much as they are representations of medical truth.

Academic literature has long debated the objectivity of psychiatric diagnosis. Early models treated diagnosis as a mirror of biological dysfunction, independent of culture or context. Critical studies, however, have shown how diagnoses reflect broader social, political and economic dynamics.

CONCLUSION

Psychiatric diagnosis is not merely a label it is a living practice. As this study shows, it is shaped by institutional demands, inter

Corresponding Author: Ingrid Falk, Department of Personality, Psychological Assessment and Treatment. University of Seville, Seville, Spain

Email: falk@gmail.com

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professional negotiations and the pragmatic realities of daily care. It does not reside solely in the pages of diagnostic manuals but is continuously enacted, questioned and revised on the clinic floor. By adopting a situated social practice perspective, we gain a richer understanding of how MHPs navigate the complexity of diagnosis not as technocratic gatekeepers but as active agents calibrating care, responsibility and inclusion. This perspective does not reduce diagnosis to arbitrary labeling, but acknowledges its role as a contingent, negotiated act embedded in multiple psychiatrist.In recognizing these complexities, we move toward a more humane, realistic and responsive model of mental health care one that respects both the social construction of diagnosis and the real lives that hinge upon it.