The diagnosis debate

Debating psychiatry's less tangible aspects is frequently complicated by semantic misunderstandings. We can find ourselves in irreconcilable positions not due to incompatible opinions, but instead dependent on the ascription of different meanings to the same term.

I therefore thank Boyle and Johnstone[1] for attempting to clarify what they mean by "diagnosis".[1] Their definition encompasses more than the contents of the International Classification of Diseases, and they see the dimensional approach of the National Institute of Mental Health's Research Domain Criteria project as more-of-the-same. Their alternative to diagnosis seems to mean the total rejection of classification and categorisation. If this is not their implication, then our differences might indeed be a semantic misalignment, rather than fundamental disagreement.

Concrete examples clarify concepts that otherwise appear ill defined. At present one can read about cracks in the foundations of diagnosis and the architecture of a diagnosis-free system, however, the bricks that would build this new structure are harder to find. I am interested to hear how practical issues in research, clinical practice, and service structure would be dealt with.

Boyle has postulated[2] that many patients diagnosed with schizophrenia in the past had encephalitis lethargica. If we accept this statement, would biologically based research targeting the clinical diagnosis have been indicated even though no tests existed to suggest a biological cause? A modern parallel can be seen with NMDA receptor encephalitis. I believe attempting to carve away these patients from an amorphous mass of troubled humanity is a worthwhile endeavour. I cannot see how this research could proceed if one did not attempt to separate the population into clusters that can be investigated with discrete hypotheses and distinct techniques.

Boyle and Johnstone[1] suggest that dementia is a diagnosis that would not necessarily have to be exiled. One step forward in the debate would be to clarify which diagnoses are to be forbidden. I am unclear as to where many diagnoses that are clinically based stand. Would we be allowed to speak of learning disabilities, Korsakoff syndrome, autism, motor neuron disease, delirium tremens or anorexia nervosa, etc? Disagreeing with the concept of schizophrenia is quite different to recommending the abolition of diagnosis.

I cannot see how we could manage the care of the millions of individuals seen by mental health services without some degree of classification. Would there be a one-stop shop for those who have had a brain injury, refugees traumatised by torture, people having non-epileptic seizures, individuals addicted to heroin, etc? How could clinicians develop the skills to optimally work with such a disparate group? If we still keep, for example, a service for addiction and one for dementia, and we accept that some therapies are more effective for some groups, then diagnosis remains enmeshed within the mental health system.

A diagnosis-free paradigm can only develop once rigorous research addresses these questions. While this research is missing, diagnosis remains the worst possible method of dealing with the issues at hand—until one considers the alternative.

I declare no competing interests.

Robert McCutcheon
Robert.mccutcheon@kcl.ac.uk

Lambeth Mental Health in Learning Difficulties, Clinical Treatment Centre (CTC), Maudsley Hospital, Denmark Hill, London, SE5 8AZ

1 Boyle M, Johnstone L. Alternatives to psychiatric diagnosis. *Lancet Psychiatry* 2014; **1:** 409–11.

2 Boyle M. Schizophrenia: a scientific delusion? 2nd Edition. New York: Routledge, 2002.

Hayes and Bell,[1] responding to Boyle and Johnstone,[2] argue that the "distinction between purely functional and purely organic does not exist" and that the causes of mental health problems are likely to be multifactorial in most cases. This observation might be true, but offers little assistance to the practising clinician. In the absence of biomarkers that are both testable and map to symptoms with any regularity, the organic contribution to an individual's mental difficulties cannot even be identified, let alone analysed in a clinically useful way. In most cases, all the clinician has to work with is what the service user tells them.

The limitations of available clinical information are a fundamental issue and have led some to propose radical solutions. Bracken[3] argued that "interpretation and "making sense" of the personal struggles of our patients are to psychiatry what operating skills and techniques are to the surgeon".[3] He advocates giving up the idea that psychiatry is a natural science akin to other branches of medicine, and instead accepting it as an essentially hermeneutic practice. Kinderman,[4] too, notes that although organic factors are necessarily associated with the production of all psychological phenomena, accounts based on biology offer no way "to differentiate between distress … and 'normal' emotions"[4] since this is, irreducibly, a question of interpretation and meaning. His pragmatic, if blunt, solution is to take the day-to-day operation of mental health care out of the hands of the medical establishment entirely, presumably in the hope that the dominant biomedical model will ultimately fall into disuse.

While these battles for the soul of psychiatry rage on, we offer a practical suggestion that all mental health practitioners can get along with in the meantime. In clinical practice, try as far as possible, to let the service users themselves identify the conceptual