Life & Times

Trying to carve nature at its joints:

respecting the complexity of psychiatric diagnosis

PSYCHIATRIC TAXONOMIES

It would be nice if the world of mental health fell neatly into a taxonomy. It would be nice if we could, as Plato wrote, carve nature at its joints:[1]

'Plato famously employed this "carving" metaphor as an analogy for the reality of Forms (Phaedrus 265e): like an animal, the world comes to us predivided. Ideally, our best theories will be those which "carve nature at its joints".'[2]

We would find it so much easier to cope if all human suffering could be allocated to a relevant, and distinct, category that encapsulated the likely cause and course of the disease. However, in psychiatry, the landscape is not so simple. It's just easier in many ways to pretend it is.

Psychiatric taxonomies such as DSM-5 and ICD-11 help us to categorise mental illness into a series of diagnoses based on observable characteristics. These taxonomies have helped guide research, and the diagnoses contained within them undoubtedly ground evidence and therefore guide treatment. We have been moving towards simplifying the diagnostic process, using tools in less expert hands to screen and categorise patients, allowing these decisions to guide our treatment pathways.[3] It is a seductive model, where diagnostic tools lead to psychiatric diagnosis that leads to evidence-based therapy. This industrial approach to care allows us to roll out increasingly simplistic protocols of care that can be provided, in aliquots, to tightly defined populations. And it works for some. Unfortunately, in general practice we are well acquainted with the large patient population who do not fit this botanical view of the world.

LIVED EXPERIENCE OF MENTAL ILLNESS

Fortunately, categorical diagnoses are not the only way to see mental illness. Throughout history, there have been ways of understanding mental illness that incorporate the lived experience of the person with the disorder, understanding aetiology and potential therapy in the light of this experience. Lived-experience narratives represent and respect culture, trauma histories, identity, and context. Psychological interventions utilise these narratives to shape therapy that is patient centred and recovery focused. Of course, one could argue that the patient's narratives are important with any illness. However, mental disorders are conditions that disturb a person's unique sense of self, a self that is biological, storied, encultured, social, political, and existential.[4] Bluntly, you do not 'have' schizophrenia the way you 'have' a broken leg, because mental illness is not just about 'having'. It is also about 'being'.[5]

ECONOMIC AND MENTAL HEALTH CONSEQUENCES OF COVID-19

Good psychiatric diagnosis respects both these perspectives: A good clinician will weave together the 'warp' threads of categorical diagnosis (such as major depression) with the 'weft' threads of lived experience (such as childhood trauma) to create an explanation that respects both points of view.

At the moment, our shared experience of natural disasters and pandemic will dramatically change the weaving. Post-COVID-19, we will not simply have 'more' mental health disorders to deal with: what we see will be qualitatively different, shaped by the changes in our collective lived experience.

We are expecting mental health fallout across the population, and it will not just be in disorders. Parents of newborns will not have access to social support, people will grieve alone, people who are experiencing homelessness will have temporary housing with its associated temporary empathy, and will have difficulty readjusting to life without support again.

The economic consequences of COVID-19 will mean the emergence of anxiety and depression in people who had previously enjoyed a life of generous privilege. We, after months of trying to project empathy through a mask or down a phone line, will have to confront the ongoing task of caring in a world where a sustainable life as a GP seems ever more precarious. And many people, including us, will know the pain of grief and loss.

GPs are masters of complexity and uncertainty, but complex tasks take time. It is undoubtedly quicker to make categorical diagnoses via checklists and questionnaires, but, without understanding the patient and their context, the risk of iatrogenic harm is high. It's time we recognised, respected, and researched the difficult process of holistic psychiatric diagnosis in the GP setting.

As GPs we see all patients, no matter what category they fall into. They all deserve our understanding and our care.

"... mental disorders ... disturb a person's unique sense of self ... Post-COVID-19 ... [those] *mental health disorders ... we see will be qualitatively different ..."*

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