COMMENTARY TO "EVALUATING ALTERNATIVE PERSPECTIVES ON PSYCHIATRIC DIAGNOSIS"

SUZE BERKHOUT
DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF TORONTO

METADATA
doi.org/10.4245/sponge.v12i1.24244

CONTACT
suze.berkhout@uhn.ca

In this paper, on the need for new approaches to psychiatric diagnosis and the possibilities therein, the reader is invited into the challenges of diagnosing mental experiences as disorder. And while the challenges are many, the author directs our attention to issues of trust: psychiatry service users are often not treated as credible knowers in relation to their own experiences, and psychiatric practices surrounding classification and taxonomy lack public trust — in many ways and for many reasons. As Leach describes, alternative frameworks have been developed to attempt to address this lack of trustworthiness in the diagnostic process at the institutional level. Psychiatry services users might be a patient representative on a DSM revision "task force" group, for instance, but this does little to shift the larger challenges surrounding public epistemic trustworthiness in psychiatric nosology, especially given the history of nosological practices. Drawing on the work of Lucy Johnstone and Serife Tekin, Leach argues that traditional practices relating to nosology and diagnostic criteria in psychiatry undermine both public epistemic trust and individual epistemic self-trust. This is an important consideration, even in instances where people might find a diagnosis helpful in a variety of ways.

I wondered, though, to what extent Tekin and Johnstone are advocating for something somewhat different from, although often concurrent to, what a psychiatric nosological system is doing and how these are engaged with by practitioners. The function of the classificatory system (DSM or otherwise) is quite different from the function of formulation, and clinicians at a one-on-one level are typically engaging with all of it — the meanings, the narrative, and how one's experiences might reflect patterns that can be generalized to a category or type (idealized or one's experiences might reflect patterns that can be generalized to a category or type (idealized or otherwise). Where we *don't* typically see lived experience enter the conversation about diagnosis is within the research practices that generate the knowledge that is included in DSM and ICD systems. We also don't see much acknowledgement in psychiatry about the ways our own practices can create looping effects that further sediment and materialize diagnosis. Trust and the refusal to confer epistemic credibility are certainly a part of these exclusions and are also exacerbated by them, as articulated by Nev Jones, Jasna Russo, Peter Beresford, and other consumer/survivor/ex-patient scholars. As these standpoints are taken up and engaged with, other questions arise that this paper (and related works) could help us think through: as Cheryl Misak has argued, employing scientific evidence (including evidence relating to diagnosis) requires judgment, which introduces positionality and subjectivity into the enterprise of medicine — it's inevitable, even in evidence-based medicine (EBM). So, why not expand what constitutes credible evidence? Another area where this analysis might be especially pertinent is in the move toward digital technologies to capture biometric data, with the notion that this kind of information is more reliable and credible than first-person testimonies. Here is an important area for the kinds of considerations raised by the paper, which have been echoed by consumers/survivors/ex-patients, including Anna Swartz. Leach's analysis offers us a number of important avenues for more epistemically just practices in psychiatry

