

# *Un-diagnosing mental illness in the process of helping*

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A medical diagnosis of a mental illness is a powerful symbol of both the presumed nature of the person's experience and the authority of the person making the diagnosis. RICHARD LAKEMAN and MARY EMELEUS consider the meaning of diagnosis, its place in the ritual of health care, and the practical problems associated with not diagnosing and un-diagnosing. The traditional approach of western medical practice is to undertake an assessment and arrive at the correct diagnosis, which in turn determines the right treatment. Service users present frequently to helping agencies with a diagnosis of mental illness conferred already. This colours the therapeutic encounter and raises expectations of what needs to be done. The therapeutic potential and practical problems of deferring psychiatric diagnosis or 'un-diagnosing' mental illness in the context of providing care to people with complex presentations is critically considered. Un-diagnosing mental illness can be an important part of the care encounter as a way of opening a space within which the person's problems can be considered in a non-biomedical way, or in the final phase of the therapeutic encounter.

There are many ways to think about, or to account for, the constellation of issues or problems that people seek to address through therapy. This paper refers specifically to the psychiatric or medical diagnostic approach to mental illness. Other approaches such as psychoanalytic diagnosis may be useful and valid, however they are accessible to a small minority of the population. In the medical diagnostic system a person who exhibits a set of symptoms of particular severity (often listed in a formulary such as the *Diagnostic and Statistical Manual* or *International Classification of Diseases*) may be said to have a illness, e.g., 'major depression'. This diagnostic system is ubiquitous, embedded in most health systems (including Australia), and is understood more or less by both professionals and the public, although the assumptions that underpin diagnosis are seldom examined or made explicit.

Longstanding controversy about the diagnosis of mental disorder has been rekindled recently with the development and publication of the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (2013). Much debate has crystallised around the potential consequences of seemingly minor changes to diagnostic criteria, the medicalisation of ordinary life, and the unnecessary and dangerous medicating of large proportions of the population. As Frances (2013) sagely cautions, minor changes can, and have, led to false epidemics of disorder, extending treatment to those who can only be harmed, and shifting resources and attention away from those who are most in need. In short, many people who may meet diagnostic criteria might be better off without a diagnosis, as the consequences, he argues, are injurious to themselves and to wider society.

This paper will not extend the long running and vigorous debates

about the validity and utility of psychiatric diagnosis. We attempt instead to respond to the Australian context as it has actually evolved. This paper considers the concept of 'un-diagnosing' and the therapeutic potential of this activity. Clearly the removal of a diagnosis (to the extent this is possible) might liberate some individuals from the iatrogenic harm of unnecessary treatment. However, this paper further proposes the implications are much greater for several reasons. Individuals may use psychiatric diagnoses to help make sense of their experiences, and to elicit support from their family, carers and other systems. In addition, resource allocation in public health care and social services is frequently dependent on diagnosis, and the power of those who confer diagnosis is therefore significant. This paper considers the meaning of diagnosis, its place in the ritual of health care, and the practical problems associated with not diagnosing and un-diagnosing.

## What does a diagnosis mean?

The conferral of a psychiatric diagnosis has particular meaning to the person in receipt of that diagnosis and may colour the way they make sense of their experience. Labelling theory evolved to explain the social impacts of being diagnosed and the associated experiences of discrimination, stigma, and altered social relations (Link, 1987). The implications of diagnosis are complex and should be discussed arguably with the person concerned as part of the decision-making process surrounding care and treatment.

Some people speak not so much of having symptoms of illness or particular struggles, but of 'being' ill. For example 'I am...*bipolar*', '*schizophrenic*' or '*mentally ill*' in a manner that suggests it has become a part of their identity or who they are. While this may at times indicate an acceptance of illness, enmeshment in a patient role or a '*spoiled identity*' (Goffman, 1963), it can also be used as a statement of pride and belonging. For example, Muggleton (2012) states of being diagnosed with Asperger's syndrome:

*For me, and many like me, the diagnosis is much more than a label. It can be a source of pride; a badge of honour for surviving in a world that, for us, seems chaotic, overwhelming and downright scary. It can also be a part of our identity.'*

While stigma and discrimination may still accompany a diagnosis of mental illness, receiving a diagnosis may also confer material support, access to services, welfare payments, and dispensation from particular responsibilities. In recent years, much of the stigma associated with diagnosis and treatment of mental disorder (at least for high prevalence problems) appears to have diminished, and people are seeking medical explanations and interventions for their problems in unprecedented numbers. This has been (in part at least) a consequence of public policy to encourage the identification and treatment of mental illness in primary health care settings (See World Health Organization, 2008). In Australia, an explicit diagnosis is usually necessary to access subsidised assistance and this is most commonly conferred by a medical doctor (usually a General

Practitioner). Previously people might have gone to their priest, mentors or other counsellors for some of these problems. Authoritative guidelines on the management of mental illness in primary care stress the importance of diagnosis and reinforce that mental illness is a medical problem. For example, the WHO education package on '*Mental Disorders in Primary Care*' (1998) states that depression '*... is a medical disorder like hypertension, diabetes or arthritis that requires medical treatment. It can occur at any age and can be overcome with medical help*'. It

psychiatric diagnosis can be analogous to a priestly function that also presents a form of absolution. It not only claims to explain, but also forgives—the person is absolved from moral responsibility for their symptoms, may be excused from carrying out some of their usual social roles, and may elicit many types of support from others and from society.

A psychiatric diagnosis can render the veracity of a person's testimony suspect and unreliable, essentially taking away their voice (Lakeman, 2010). A diagnosis may also absolve

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is notable that WHO should choose analogous physical health problems that are typically considered chronic.

Some people speak of relief when they receive a diagnosis as it appears to offer an explanation for symptoms, a confirmation that their experience is explicable, and that help may be available (Dinos, Stevens, Serfaty, Weich, & King, 2004). Conferring a

abusers, bullies, tormenters, and guardians who failed to protect or provide '*good enough*' (Winnicott, 1960) parenting from responsibility or guilt for the damage they might have wrought. If the recipient is a child, the diagnosis can have the effect of diminishing the responsibility to assist the 'systems' of the child to change the way they are operating.



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## Jason

Jason, a 13 year old, was referred to the child and youth mental health service by the police, who were called to his home by his father. Jason had broken a glass door and was marching around the back garden wielding a machete. As soon as the police arrived he settled, and agreed readily to go with them to hospital for a mental health assessment. His behaviour was reported to be unpredictable, often aggressive, and he was unable to comply with classroom rules at school. Based on the preceding few months he met the diagnostic criteria for 'oppositional defiant disorder', however the assessing psychologist deferred making this diagnosis and discovered there was significant emotional and physical abuse of Jason's mother by his father, and had been for many years. A week before this incident, the father had hit the mother with a piece of timber in front of Jason. Child protection services became involved, extensive psychosocial supports were offered to the family members individually and as a group, and over some months Jason's 'mental illness' resolved.

Receiving a diagnosis of mental illness is a complex matter with weighty implications, therefore it is interesting to consider how it actually proceeds in Australia.

### Who makes the diagnosis?

Certain professions are recognised as qualified to assess and diagnose mental illness, including clinical psychologists and mental health nurses, however access to many of the Australian systems require a medical practitioner certified diagnosis (e.g., Centrelink, Disability Support Services, Insurance companies, Educational Institutions etc.) and only doctors can prescribe medications (with the exception of Nurse Practitioners who practice under supervision from doctors). It has long been recognised that diagnosis is central to the medical enterprise (Mechanic & Volkart, 1960) and the public also quite reasonably expect when they visit a doctor that after some questions are asked, an account of symptoms elicited and investigations are ordered, the treating doctor will make a diagnosis and

recommend a treatment. This is part of the ritual of health care and part of an implicit contract whereby the patient is absolved from particular social responsibilities and assumes a 'sick role' (Parsons, 1951), striving to get better and acquiescing to medical advice in order to achieve recovery.

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Mental illness, addiction and chronic disease have long posed a challenge to the concept of the sick role (Siegler & Osmond, 1973). Here it is not clear whether this process or the assumption of the social roles of acquiescent patient and insightful physician/technician is either generally possible or leads to good outcomes. Nevertheless, the marketing of 'mental illness' as a medical problem and the concerted campaigns to inspire confidence in medical treatment appear to have been successful.

In Australia, the introduction of General Practitioner (GP) Mental Health Medicare items in 2006 has led to an annual 17% growth rate in mental-health related GP encounters, culminating in 2.1 million subsidised GP related services to 1.2 million people in 2010 (Australian Institute of Health and Welfare, 2012). GPs provide the majority of prescriptions for psychiatric drugs and are the gatekeepers to the majority of Medicare subsidised psychological services. This funding and gatekeeping structure means that almost everyone receives a psychiatric diagnosis, or might infer one, from the prescription of medications (e.g., a prescription for 'anti-depressant' suggests strongly that the person 'has' depression). The total expenditure on mental health related Medical Benefit Scheme subsidised consultations has increased annually by 18.8% since 2006 to \$852 million in 2011, closely followed by expenditure on mental-health related subsidised

prescriptions which reached \$834 million in subsidies in 2011 (Australian Institute of Health and Welfare, 2012). Over 31.1 million mental health-related medications were dispensed in 2011 of which 86% were prescribed by GPs (Australian Institute of Health and Welfare, 2012). The recipients of

these services and prescriptions are likely to receive a psychiatric diagnosis, implicit or explicit. Some may argue that this indicates people are accessing the help they need, indeed even more people should have this help, based on the reported prevalence of mental disorders. However, it is by no means clear that the help provided is effective. For example, a recent Australian national survey concluded that there has been no improvement in adult mental health during a period when the availability of pharmacological, psychological and population interventions has increased (Jorm & Reavley, 2013).

### Improving the reliability and extending the reach of diagnosis

Psychiatric diagnoses have been critiqued extensively in terms of their validity, uniformity, reliability and impact. Perhaps the most famous experiment that drew attention to the problems of psychiatric diagnosis was by Rosenhan (1973) in which twelve otherwise 'normal' people presented to hospitals stating they heard a voice uttering the word 'thud'. All were admitted to hospital where they ceased to report any psychiatric symptoms (although they did not disclose their deception). The 'pseudo-patients' (as they were called) were diagnosed with schizophrenia or manic depressive psychosis and were discharged from hospital with the qualifier 'in remission'. Rosenhan (1973) concluded that '*...we cannot distinguish the sane*

from the insane in psychiatric hospitals' (p. 257). Spitzer (1975), the principal architect of the DSM-III (1980) undertook a scathing critique of the study. He suggested that the qualifier of being 'in remission' was a clear sign that the diagnosticians *did* detect a profound difference between the pseudo-patients and others as rarely, if ever, did anyone with such a diagnosis present as 'asymptomatic' or have their diagnosis coded as 'in remission'.

The publication of the DSM-III (1980) with its simple lists of diagnostic criteria meant that Rosenhan's pseudo-patients would be unlikely to receive a diagnosis of schizophrenia again. The reliability of diagnosis was improved to such a degree that non-specialist primary care physicians could arrive at a DSM-III-R diagnosis with a high degree of inter-rater reliability within an eight-minute consultation (Spitzer et al., 1994). Psychiatric diagnosis and treatment became and remains everybody's business but particularly that of primary care physicians and GPs, rather than specialists.

It is acknowledged widely that a large proportion of people present to primary care physicians and GPs with mental health problems (Serrano-Blanco et al., 2010; Roca et al., 2009). Many doctors in general practice see intrinsic problems with psychiatric diagnosis (Jacob, 2006; Lynch et al., 2012), and downplay the significance of diagnosis in the way problems are formulated, addressed or discussed with service users (Lillis, Mellisop, & Emery, 2008). Some claim to have a more holistic grasp of people's problems that transcends a reliance on standardised taxonomies (Schumann et al., 2012). Nevertheless, the provision of a psychiatric diagnosis is a frequent accompaniment to a medical consultation relating to psychosocial problems because 'the system' requires it, regardless of any reservations the doctor might have.

### Pragmatic approaches to diagnosis

The conferral of a diagnosis always has meaning and indeed it shapes the meaning of experience. Symptoms of illness are stripped of inherent meaning, becoming targets for amelioration. Once a diagnosis

of illness, disorder or disease is made, it cannot be easily undone. As Frances (2010) points out, the entities described in diagnostic manuals are loose syndromes or clusters of symptoms that are essentially 'made up' categories of convenience with no natural boundaries and no common aetiology. Nevertheless, practitioners often behave and speak about 'mental illnesses' as if they are clearly defined brain diseases and can be dealt with as such. A medical diagnosis connotes a medical illness even if it is arrived at primarily by ticking symptoms on a checklist. Of interest, the DSM-5 (2013) preserves the mystique of the diagnostician by suggesting it is not enough to diagnose somebody by ensuring they have the requisite set of symptoms; one apparently needs to use 'clinical judgement' and have the 'right' kind of 'clinical training' (presumably medical). A pragmatic solution might be to explain to someone that they may meet criteria for an illness, but this does not explain why.

Often people seek assistance resulting in a diagnosis and a biomedical formulation that locates the problem within them. This may be suggested by others in the person's network, counteracting rather than colluding with it may be in itself therapeutic.

### Matthew

Matthew attends a primary care service after being encouraged by his longstanding girlfriend, Mavis. Matthew states that he has had depression for six months but the medications prescribed at another practice are not working. He experiences working as a mechanic in a busy garage the best part of his day, but lately he has found it harder to concentrate. When he returns home to Mavis each evening he feels even worse. They rarely talk, except to argue, and Matthew has taken to being sullen and withdrawn. He never really feels happy, his energy levels are low, and his libido is poor. He drinks alcohol to make himself feel better and this is a further source of conflict between himself and Mavis. They sleep in different rooms and Mavis has given him an ultimatum; that she will not sleep with him until he gets his

'depression sorted out'.

Matthew may meet the diagnostic criteria for 'major depressive disorder', but making this diagnosis might result in a missed opportunity to address his relationship concerns. Assuming the facts of the matter are clear, conferring a diagnosis of depression, then applying any of the arsenal of 'evidence-based brief psychotherapeutic treatments' or tweaking medications are unlikely to heal the growing rift between himself and his partner. This needs to be understood and named: *'Matthew you don't have major depressive disorder, you have a relationship that is in crisis!'* A diagnosis too often locates the problem within an individual rather than their life situation, their relationships, or other systems within which they live and move and have their being.

### Healing in the absence of diagnosis

Even in our western culture, many people experience symptoms that would meet criteria for mental disorder and yet they recover without ever seeking help from within the medical paradigm. When people do seek help, some argue that not having a diagnosis is helpful, rather than a hindrance. It has become increasingly common, at least in academic and service user circles, to refer to clusters of symptoms by names such as 'psychosis' without reference to a diagnostic label. This has the obvious advantage of encouraging a more idiographic or person-centred approach to assessment, care and treatment. It invites a collaborative understanding to evolve around the person's experience and symptoms rather than allowing the diagnosis to dictate the meaning of experience and the person's trajectory from that point forward. It is considerably easier to acknowledge that a person is no longer psychotic or distressed by experiences. It is much harder to suggest that a person no longer has schizophrenia. In many instances it might be preferable to acknowledge that a person is experiencing psychosis, depressive symptoms, anxiety or problems with emotional regulation rather than assigning a diagnosis. However, this may be an unreasonable expectation given the massive investment in

promoting the diagnosis of mental illness. A more feasible solution might be to encourage the judicious use of un-diagnosis and careful reframing of people's experience.

Asking what has happened or might be happening to someone does not require a diagnosis. Indeed, a diagnosis with its connotations of brain disorder may render important and meaningful aspects of the person's experience as little more than historical curiosities rather than important areas for exploration. Medications may be used judiciously to alleviate great distress or attenuate intrusive and noxious experience even if no diagnosis is made. However, a rush to 'medicate away' symptoms may prematurely foreclose on the opportunity to learn from them. The 'hearing voices' network has long held out the possibility that experiences such as hearing voices are inherently meaningful and this has been translated into practices such as 'voice dialogue' (Corstens, Longden, & May, 2012). The open dialogue approach to psychosis (which in small scale studies appears to have achieved the most successful outcomes for first episode psychosis to date; see Lakeman, 2014; Seikkula, Jukka, Aaltonen, Jaakko, 2001; Seikkula et al., 2006; Seikkula & Olson, 2003) views psychotic experience as a '*... temporary, radical, and terrifying alienation from shared, communicative practices...*', and the crisis as an '*... opportunity to make and remake the fabric of stories, identities, and relationships that construct the self and a social world*' (Seikkula & Olson, 2003, p. 409). Professionals, they argue, need to practice tolerating uncertainty and refrain from imposing hunches about what is going on, in order for open dialogue to occur. Reducing 'psychotic' speech to a disorder or even a symptom has the potential to close down dialogue, and is tantamount to refusing to listen to the person.

Siegel (2010) states '*having difficult experiences early in life is less important than whether we've found a way to make sense of how those experiences have affected us. Making sense is a source of strength and resilience*' (p. 172). In many cases it also ameliorates the distressing experiences we call symptoms. A simple approach using a framework

with which most clinicians are familiar, might be to develop together a 'formulation' that covers predisposing, precipitating, perpetuating and protective factors, in the domains of biological, psychological, social and spiritual health. Out of this process, the person begins to 'make sense' of their experiences. In addition, areas for change can be identified clearly, and the person themselves makes the decisions about what to change, and in what order. The 'formulation' in this sense is simply a convenient framework for creating a comprehensive and coherent narrative of the person's experiences and there are many other equally useful frameworks. In addition, relationships themselves have inherent therapeutic capacities, and what works is the quality of the relationship (therapeutic alliance) not the specific content.

### Problems with un-diagnosing mental illness

When 'un-diagnosing mental illness' is entered into the modern day oracle 'Google' one is confronted with over half a million hits relating to 'undiagnosed mental illness'. 'Undiagnosed mental illness' is apparently the well-spring of our collective unhappiness. No matter what permutation of keywords is used to explore 'un-diagnosing', the intelligent search engine will offer 'Did you mean: 'undiagnosed' mental illness?'. Un-diagnosis or un-diagnosing does not seem to be construed as a possibility in the field of mental health. Once a formal psychiatric diagnosis is applied, or even a psychiatric treatment prescribed (without the formal conferral of a diagnosis), the person is henceforth affected by this in a myriad of ways, and the inferred or conferred diagnosis is difficult to shed. While new diagnoses might be added over the course of a person's mental illness career it is not so easy to excise the influence of the old diagnosis even if it was entirely wrong or unhelpful. Even where a diagnosis comes from the more optimistically phrased ICD-10 (e.g., 'depressive episode'), or is something where cure is considered possible (e.g., 'obsessive compulsive disorder') it is understood widely that the strongest risk factor for developing a mental

illness is having 'had' one already; so one is never really as 'normal' as before the diagnosis.

Un-diagnosing may, at least in a symbolic way, return the person's voice and credibility, but its implications may not be welcomed by other people in their lives, past or present (including health care providers). Excising a diagnosis is difficult, at least in part because of inter- and trans-disciplinary etiquette whereby it is impolite, and both professionally and medico-legally risky, to challenge the diagnosis of a 'superior' in the medical hierarchy. Non-medical health practitioners are expected to defer to medical practitioners in matters of diagnosis and medical treatment, and within medicine there is a well-established hierarchy from student to generalist to specialist. While it might be a reasonable practice for specialists or consultants to state that a subordinate's diagnosis or impressions were incorrect, it is quite another thing to suggest that a peer was incorrect, and risky indeed for a non-medical practitioner such as nurse, psychotherapist or allied health professional to directly challenge a diagnosis at all. Elaborate rituals have been described such as the 'doctor-nurse game' (Stein, 1967; Stein, Watts, & Howell, 1990) in which nurses and others, at least on the face of it, defer completely to the medical doctor's authority. This perhaps would not be such a problem if the diagnosis were simply descriptive, as the treatment manuals intend, and did not presume aetiology. However, acceptance of a diagnosis also often implies acceptance of speculative biological explanations and, crucially, the rejection of other more plausible formulations. Once a diagnosis is conferred it is almost automatic to begin to think about the problem in medical or more particularly biological terms. If the problem is biological, so ought the treatment be. As argued extensively elsewhere, there are strong financial and political investments in promoting this view (Frances, 2013; Whitaker 2010). That '*mental illnesses are brain diseases*' has become the dominant ideology of psychiatry (McLaren, 2013) that has populated and shaped the culture of mental health care

and the imagination of the lay public (Lakeman, 2012).

Just as the medical hierarchy can be understood as upheld by a set of implicit (and faith-like) beliefs (Lakeman, 2012), the conferral of a diagnosis has been likened to a religious ritual in which the medical practitioner assumes a priestly function (Welch, 2003). The medical practitioner possesses the power to name illness, thereby making it explicable and giving him/her medicine's power over it. Kleinman (2010) says of classification systems that they are '*...intended to domesticate and make known a 'wild' and unknown phenomenon, which threatens the very idea of social order and personal stability, and transform it into something known, named, and thus manageable*' (p. 87). The diagnosis is thus a potent symbol of medical, priest-like power and herein lies a further problem with un-diagnosing. Challenging the power of the individual medical practitioner or questioning the validity or utility of 'psychiatric diagnosis' in general, carries the weight of heresy. Un-diagnosing might even damage the person's prospects of recovery by undermining their faith in the practitioner and the institution; this faith appears critical to the realisation of the placebo effect, which in turn appears to account for much treatment response in mental health care (Kirsch & Sapirstein, 1998; Walsh, Seidman, Sysko, & Gould, 2002).

The removal of a diagnosis may also be considered a form of benediction or a final blessing. The medical doctor is granted the power to interpret symptoms, signs and investigations and assure a person that they are well and no longer disordered or ill. Unlike many physical illnesses it is rarely clear when a person is no longer mentally ill; no physical wound is visibly healed, nor is there a blood test to demonstrate that an infection is clear. However, pronouncing to the person that they may have once had a disease or disorder 'X' but they no longer have it any more, or indeed that they did not have one in the first place is a potent therapeutic gesture with major implications; one that again invites a consideration of the meaning of the experience and a shift in the person's identity.

Eric, aged 22, began hearing voices, firstly after fights with his girlfriend, but gradually occurring at other times as well. They were distressing and persecutory, and sometimes they told him to harm his girlfriend. He was a gentle and non-violent person, and was shocked and distressed by these experiences. His mood declined. He went to his GP who felt he might have psychosis, and commenced him on an atypical antipsychotic. This medication did attenuate some symptoms, however they did not stop and after some time he began to feel that he was 'going crazy'. He was referred to an Early Intervention service. He was offered psychotherapy and, over time, it became clear that his symptoms were related directly to his relationship, even though he did not have to be in the presence of his girlfriend for

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them to occur. She had a history of trauma, and had a low tolerance for distress and great difficulty regulating her emotions. Eric's gentle nature had resulted in him becoming disempowered in the relationship and he felt his mind was disintegrating. Eric learnt some skills to manage his symptoms, and heard that voices did not always indicate mental illness, (although since they were distressing it was good that he was seeking help). Over time he realised that he needed to end the relationship, which he did with support from his friends and his therapist. He gradually reduced his medication and ceased it, and returned to his former high level of functioning in his work, studies, family and social relationships. At his last appointment he asked if he could have a certificate to say he was 'sane'.

This final ritual is largely absent in the mental health field, and perhaps it is time to create ways of doing it. Crucially also, there are no established clinical guidelines for un-diagnosing another, particularly if the diagnosis was conferred by a different practitioner.

### **Possible processes for un-diagnosing**

Processes of un-diagnosing might take a number of forms and have different meanings. A person may be informed that they never had disease or disorder 'X' (or indeed any medical problem), or that they may have once but do not now. All invite an exploration of the meaning of the experience that may have led the person to seek assistance. For example, Sally, aged 19, is referred to her GP by a concerned welfare worker due to social withdrawal over two years, poor sleep, physical and psychological symptoms of anxiety, poor concentration, irritability and hearing voices every day. She believes people are 'out to get her' and is too scared to leave her home. She is refusing to attend work or training

courses, and is using cannabis daily to help her relax and sleep. Her welfare worker and some of her friends are worried she might have depression, or even schizophrenia. The GP recognises psychosis symptoms and refers her to the mental health crisis team.

#### *Sally*

Sally has a cluster of symptoms that may contribute to her qualifying for a range of diagnoses depending on the diagnostic manual chosen. However, discussing her constellation of experiences as a medical syndrome may be of dubious benefit. When it comes to actual biomedical treatment it may be immaterial because psychotic symptoms tend to be treated with drugs marketed as 'antipsychotics' regardless of the syndrome. However, naming a syndrome communicates much about prognosis and chronicity, frames the symptoms as meaningless ('*You hear voices because you have schizophrenia ... and you have schizophrenia because you hear voices*') and relegates the person to being a passive recipient of care. In contrast deferring the provision of a diagnosis

(perhaps indefinitely), and simply acknowledging the symptoms invites exploration of the experience, what it might teach the person or conceal from them and begs an exploration of the reasons why they have arisen. Not only is there an increasing body of evidence that various kinds of trauma and attachment disruptions in childhood are predictive of the emergence of psychosis (Thompson et al., 2013; Varese et al., 2012) and poor responses to subsequent trauma (Bendall et al., 2012), but there is also evidence that reducing ongoing or current traumatic experiences reduces the incidence of psychotic symptoms (Kelleher et al., 2013).

Sally, now aged 30, with two children and a job in administration, moves to a new area for her husband's work. She has not used cannabis regularly for years. She attends an appointment with the mental health nurse at the local GP surgery. She requests repeat prescriptions for her anti-psychotic medication, because she has 'schizophrenia'. The nurse at the new service takes a trauma-informed approach to hearing Sally's story, and discovers she has a history of childhood sexual abuse, multiple family disruptions and major losses during adolescence, and at 19 years old was in a domestically violent relationship. The nurse reasoned that while she probably did meet diagnostic criteria for 'major depressive disorder' with psychotic features, 'substance use disorder (cannabis)', and arguably 'schizophreniform psychosis', her experiences could also have been viewed as an understandable response to a series of very difficult situations. The voices she heard (and continues to hear) were of a persecutory nature, telling her she was ugly, stupid and worthless and that she deserved only poor treatment. The nurse is now in the 'un-diagnosis' dilemma, and even the decision to discuss or withhold this from Sally carries significance.

If a shared decision is made with the person to consider un-diagnosis as a possibility, there are no clinical guidelines as to how to proceed. What will need to occur (for the person, the clinician, and various systems) in order to 'un-diagnose'? These questions are yet to be answered, whereas the question of how to help somebody

when there is no diagnosis has many answers.

## Conclusions

Jureidini (2012) describes psychiatric diagnoses as '*un-explanations*', as impediments to genuine understanding of the individual and their situation. Un-diagnosis may not itself offer an explanation but it may at times assist to create a space that enables open dialogue, explores alternative meanings and richer formulations. Time and the facilitation of a safe, containing and healing environment is as important today as it was in the time of Hippocrates but modern medicine tends to emphasise rapid diagnosis and specific treatments. Un-diagnosis or indefinite deferral of diagnosis may offer the opportunity to allow 'nature to heal'. Non-specific treatments including medication can still be used without a diagnosis, but their importance in shaping the identity and life trajectory of the person is de-emphasised.

Accessing subsidised professional psychosocial support often requires a diagnosis and more than at any time in history people are receiving one. Medical authority (and hegemony) and the biomedical ideology of mental illness are reinforced. The apparent 'epidemic' of mental illness and unprecedented medication of people who in previous eras would have been considered normal is seen by some as unintended consequences of a simplistic diagnostic taxonomy and pressure from a corrupt pharmaceutical industry (Frances, 2013). An obvious solution is to develop new taxonomies or more exclusive criteria. However, we have argued that given the present reality and central place of diagnosis in the health care enterprise a more pragmatic solution may be to defer diagnosis to the extent that this is possible, and formulate problems in a more idiographic way.

Adopting un-diagnosis in the process of care need not require the acceptance of a radical critique of the medical-psychiatric enterprise. Informing people that they no longer have a particular problem or meet criteria for an illness simply reflects good practice. It would appear to be a rarely discussed, but highly symbolic gesture, that could be

adopted easily and routinely in many forms of professional practice and is congruent with principles of good medical practice. We note, however that un-diagnosing (particularly by a practitioner who did not confer the diagnosis in the first place) may pose particular ethico-legal risks. However, given that people are being diagnosed with mental illness at unprecedented numbers consideration of the process and implications of un-diagnosis is essential for all mental health professionals.

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