Letter the Editor

Heterogeneity in diagnostic criteria does not undermine categorical diagnostic classification.

A commentary on: « Heterogeneity in psychiatric diagnostic classification ».

In their interesting article, Allsopp and colleagues document what they call “diagnostic heterogeneity” in contemporary psychiatric classifications (namely, DSM-IV-TR and DSM-5). They describe a number of distinct aspects to this heterogeneity. (1) There are different “combination of symptoms” that can result in a similar diagnostic; therefore, “two people could receive the same diagnosis without sharing any common symptoms.” (2) This is true for some diagnoses (they give the example of panic disorder), but not for others where no such variation in symptoms presentation is possible (they give the example of social phobia). (3) Symptoms are sometimes defined based on a comparison, to either prior experience or a social norm, and sometimes just described as such, without a “comparator.” (4) Duration of symptoms is sometimes defined as a necessary minimum, sometimes as a discrete period, sometimes not specified. (5) Severity indicators include notions such as clinically significant distress, marked change in functioning, the necessity of hospitalization, or symptomatic intensity. (6) Distress can be assessed from the perspective of the patient or the clinician. (7) Similar symptoms can occur across different categories.

Such a heterogeneity in the elements that together build up diagnostic categories, the authors argue, “offer flexibility for the clinician” but “undermine the model of discrete categories of disorder.” We respectfully disagree. Our general argument is that medical diagnoses rely on a very heterogeneous set of elements, and that this does not undermine a model of diseases as discrete categories (numbers in parenthesis refer to our summary of the authors’ theses in the previous paragraph). (1) A stroke can present with a number of symptoms, and two people could certainly receive a stroke diagnosis without sharing a common symptom (as a side note: this is, in any way, quite rare in medicine, and definitely so in psychiatry: it would be difficult to find two patients suffering from schizophrenia or panic disorder who do not share a single symptom). (2) Other diseases have specific symptoms, such as diarrhoea in inflammatory bowel diseases or shortness of breath in heart failure. (3) Some diagnostic elements are considered as pathological per se (e.g., hemoptysis), others in comparison to a norm (e.g., arterial blood pressure), or in comparison to a previous state (e.g., loss of weight). (4) Dyspnea is episodic in asthma, sustained in pulmonary fibrosis. (5) The severity of a disease such as asthma could of course include such heterogeneous aspects as dosage of medication, number of hospitalization, necessity for respiratory assistance, socioprofessional repercussions, pulmonary functional capacity, or more broadly “quality of life.”(6) Diagnosis of asthma is based on typical acute dyspnea (perspective of the patient), but also on the auscultation of wheezing (perspective of the clinician). (7) Dyspnea is of course a symptom common to a large number of diesases. All these types of “heterogeneity” pose no problem to the physician, who will confirm a clinical diagnosis of asthma using pulmonary function testing, while a suspicion of pulmonary fibrosis will lead to radiological imaging and perhaps tissue biopsy: very “heterogeneous” diagnostic approaches. Moreover, as George Engel argued, human experiences are complex biopsychosocial phenomena[1 2]. The sociocultural context and individual psychological aspects such as expectations, emotions and representations all have an impact on how symptoms are perceived, and symptoms often also have a relational function. Shortness of breath, or suicidal thoughts, of Mr X are never identical to similar symptoms in Mrs Y. Heterogeneity is everywhere in medicine. It does in no way “undermine the model of discrete categories of disorder.”

Allsopp and colleagues argue, in line with other researchers and even the National Institute of Mental Health, that an approach to psychiatric diagnoses based upon the categories of classical

psychopathology is flawed[3]. We rather believe that many of our current diagnostic categories (e.g., melancholic depression, a spectrum of schizophrenic disorders, and many others) are clinically relevant. This lively and important debate has certainly been going on for some time in psychiatry. Our point is that the heteregenous nature of the diagnostic process is not a relevant argument here.

We agree with the authors that "provision of care that is specific to a person's individual needs" is important. And it is true that medicine at times neglects the individual experience. However, good clinical practice is about working through and with the reality of a situation, of which disagnoses are often an important component[4]. Since the 19th century at least (ref Foucault), medicine is a pragmatic affair, and so is the art of diagnosis, which should resist the temptations of abstract, idealized nosological systems and perfect logic.

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