Diagnostic and Classificatory Dilemmas

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CHAPTER 4

Introduction

The late medical historian, Roy Porter, began his final book *Madness: A Brief History* (1) by expressing dissatisfaction with how doctors distinguish mental disorders from normal states of mind. “Isn’t insanity the mystery of mysteries?” he asked. He noted that even psychiatrists were agreeing with him and identified Thomas Szasz as one who made a reputation denying any reality to mental illnesses. Indeed, he quotes from several books where Szasz claims that mental illnesses were man-made “myths,” and that defining psychiatry as “the medical specialty concerned with diagnosis and treatment of mental diseases…places [it] in the company of alchemy and astrology and commits it to the category of pseudoscience” (1).

But surely, one might respond, the American Psychiatric Association in its recent editions of the DSM (2) tried to eliminate mystery from the official definitions of mental illness. The authors of these manuals announce that they use an “operational approach” for identifying mental disorders that, they claim, brings clarity and diagnostic consistency to psychiatry. Given that DSM-IV was published 8 years prior to Roy Porter’s book, why was he not reassured that mental illnesses were becoming less mysterious? After all, DSM-IV names the disorders psychiatrists treat and lists the specific symptoms they are to use in spotting case examples. If psychiatrists are agreeing on both terms and diagnostic guidelines, surely they are dispelling old mysteries.

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The basis of both Porter’s and Szasz’s opinions is obvious, though, to anyone who comes to psychiatry from another medical discipline and takes up DSM-IV. Such a person immediately notes that DSM-IV is not a systematic classification. Rather than providing a methodical taxonomy of psychiatric disorders, it lists them by name and describes the symptom features that identify patient examples. It thus is best construed as a naturalist’s field guide in which the objects of study—here, mental disorders rather than birds, flowers, or trees—are identified by the manifestations any observer can recognize. This is quite different from the standard medical classificatory system, and, although most useful in bringing consistency and reliability to the diagnostic exercise, such a manual does not (a) differentiate the disorders according to the basic natures from which the manifestations flow, (b) demonstrate any interrelations among the disorders, or (c) prove that they have some criterion that makes them more than social artifacts.

A systematic classification, such as medicine’s *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10) (3), identifies and interrelates clinical disorders according to fundamental biological and etiopathic distinctions such as vascular, neoplastic, infectious, and autoimmune processes, and through the effect of these processes on bodily organs such as the heart, the gastrointestinal tract, and the muscular skeletal system. It does not simply catalog clinical problems under an arbitrary label according to their manifest symptoms. Imagine teaching internal medicine or pediatrics from *Dorland’s Illustrated Medical Dictionary* (4), rather than from a text organized around human biology, system pathology, pathogenesis, or pathophysiology, and you immediately appreciate the critic’s view of DSM-IV. Because DSM functions for psychiatrists as a field guide does for naturalists, it has grown over time as its backers have drawn more and more distinctions among the variety of patients presenting to the clinic. Indeed, during the reign of the “operational”
(i.e., “appearance-driven”) approach to diagnosis, the manual grew enormously. DSM-II ran to 134 pages, DSM-III expanded to just less than 500 pages, and DSM-IV-TR has just weighed in at 943 pages. Depression, which DSM-II saw as having but 8 subtypes, multiplied under transmission through DSM-III and DSM-IV to reach more than 2,000 subtypes if one multiplies the different varieties of depression by the symptom and course specifiers those “expert” consultants adjudged for this state of mind.

From this growth alone, a “run-of-the-mill” psychiatrist cannot but wonder how many mental disorders actually exist distinct from one another in nature, how many display similar symptoms but are different in kind, how many present different symptoms during their course, and how many have been imagined by some zealous believers just as the “expert” witch hunters of the 16th and 17th century identified witches and wizards (with “operational” definitions from the Malleus Maleficarum) (5). Strong reasons exist to suspect that diagnostic zeal drives DSM subtypes of post-traumatic stress disorder and all examples of multiple personality disorder.

In essence, because psychiatry has stayed now for some years with a field guide classificatory method—emphasizing consistency and reliability rather than validity—it has grown long on disorders, short on explanations and treatment guidelines, and ever vulnerable to accusations of invention and mystification.

THE PROBLEM TODAY

We raise the Porter and Szasz challenges to our discipline not because we agree with them—we are well aware of why in 1980 it was crucial for psychiatry to accept a method of proceeding that would bring about terminological reliability—but because these contentious students identified contemporary obstacles to our capacity to work effectively with other physicians in our consultation role where we must explain how to launch a program for treating patients presenting to those physicians.

The sense that psychiatry faces an “identity crisis” or “predicament of definition” preys on more folks than challenged psychiatric consultation-liaison (C-L) directors. Books describing this problem appear with subtitles such as The Growing Disorder in American Psychiatry (6) or Psychiatry in Crisis, a Call for Reform (7). These books usually note conflicts in the leadership of the discipline and deplore the progress of the impersonal and mechanistic in psychiatry. However, they tender unsatisfactory solutions despite the know-how of their authors. For example, Luhrmann (6), an earnest young anthropologist, recommends a reversion to the thinking and practice of the psychoanalytic era to resolve the contemporary problems. Hobson, a gra-}


cious and distinguished neuroscientist, and his co-author, Leonard, provide maxims and personal intuitions (e.g., “mental states lack fixed boundaries,” “the conscious and unconscious mind are friends”) but no conceptual scaffold on which to build clinical practice, teaching, or research (7).

We build on four ideas to promote a conceptual structure behind our consultation work, a structure directed to end the “mysteries” that confound our conversations with other physicians. (a) Psychiatry is a unique medical discipline in that it attends to disorders emerging in personal consciousness: “the domain of ‘mind’ rather than the domain of ‘body,’ and a ‘first person’ subjective realm rather than a ‘third person’ objective realm.” In this specific way, it differs from other medical specialties (e.g., cardiology, neurology, dermatology). (b) Several different classes of disorder exist in the first person realm, and these can and should be distinguished from one another by their common underlying etiopathic nature. (c) Each class of disorders can and should be linked to some characteristic feature of human psychological life that, with the disorders in this class, has gone awry. (d) The etiopathic distinctions that forge each class of psychiatric disorders also determine the general characteristics of the treatments to which the patients in each class succumb.

A PROPOSAL FOR PSYCHIATRY

With these ideas in mind, we identified the ideal characteristics that a classificatory system should seek to satisfy if it strove to gain support from other psychiatrists and advance the discourse both within the discipline and with the medical disciplines surrounding it. (a) The approach should be clear in what it proposes. (b) It should specify and differentiate classes of mental disorders by operationally defined methods—algorithms, speaking broadly, of step-by-step procedures that address the genesis of the disorders in each class, their interrelations, and their treatment. (c) These specific operationally defined methods should be progressive in being based on neurobiological and psychological evidence or assumptions and being capable of discerning tests for their confirmation or refutation.

Partly to encourage competing proposals for such a conceptual structure and partly to draw a blueprint for directing consultations, McHugh and Slavney authored The Perspectives of Psychiatry (8). In this book, we turned our attention away from the preoccupation with knowledge theory (e.g., operationalism, reliability) that built DSM. Instead, we studied the ways psychiatrists try to explain mental disorders to each other and to other physicians because we believed that several distinct explanations of mental disorders were implicit in psychiatric practice. We also believed that these explanations, if properly applied to and identified by
the conditions for which they were appropriate, would differentiate classes of disorder, promote better clinical practice, and encourage more successful consultations.

Indeed, we concluded that despite disciplinary enthusiasm for DSM-IV as a step toward a more “medical” psychiatry, it was now holding on to a classificatory stance that medicine had long passed through. Although DSM proffered names for disorders and “operational criteria” for their identification, and thus captured some aspects of the prior experience of psychiatrists with patients, internal medicine builds its classifications more prospectively by employing a *forward-looking* scheme that employs contemporary knowledge, along with clinicians’ presumptions of pathology and etiology. Medical classifications both grasp what doctors believe to be the nature of a medical condition (i.e., “this belongs with the genetic disorders, that with the nutritional”) and point the way for critical students to confirm or refute these presumptions as, for example, they did when changing peptic ulcer disease from an inflammatory condition to an infectious condition. The time has come for psychiatrists to propose a similar forward-looking scheme that employs contemporary knowledge, along with clinicians’ presumptions of pathology and etiology.

The Perspectives of Psychiatry

In essence, we held that patients come in need of psychiatric attention for several reasons—reasons that speak to the generative nature of their conditions and that should be differentiated in proposing prognoses or treatments. We referred to our way of thought as employing “perspectives of psychiatry” to emphasize, by this visual metaphor, that psychiatrists make sense of patients’ disorders by employing several informed “ways of looking,” each one of which has distinct characteristics and may singly or with other “perspectives” be used to forge a diagnostic formulation for any given patient. Table 4.1 lists the perspectives, their logical implications, and their common-sense essences.

As we employed these perspectives, our confidence in their coherence, their discriminatory capacity, and ultimately their clinical validity increased as they linked knowledge of mental disorders easily with information accumulating in the sciences of mental life itself—neurobiology, psychology, sociology, and even anthropology. The use of “the perspectives” thus encouraged a conception of mental disorders as expressions of life under altered circumstances that affect particular mental features and capacities and generate particular expressions.

Because the perspectives have distinct operational characteristics, they stand in some tension to one another theoretically, but in practice they interrelate and expand on one another in every patient formulation. The perspectives are thus distinct and complementary methods of explaining mental disorders and, in many patients, interrelate in ways that illuminate complicated clinical presentations. They are each informed by aspects of contemporary science—biological, psychological, and epidemiologic. To make these points clear, we now describe the method of causal reasoning tied to each perspective and then show how all four interrelate in practice.

CEREBRAL FACULTIES AND THE DISEASE PERSPECTIVE

Some mental disorders are the direct expression of disease of the brain, hence the term “disease perspective.” The brain is an organ of the body like any other and thus subject to all bodily pathologies (e.g., vascular, infectious, neoplastic), along with some pathologic processes (e.g., irritative, degenerative, neurotoxic) unique to it.

Psychiatrists have taken special note of those mental disorders that represent the psychological expression of brain disease (in the past, dubbing some “organic”). Because a partial list of the psychological faculties directly sustained by the brain would include consciousness, cognition, memory, language, affect, and executive functions, the disease perspective (Fig. 4.1) of psychiatrists should and does encompass the mental disorders (e.g., delirium, dementia, amnestic syndrome, bipolar disorder, schizophrenia) that are expressions of injury to these faculties.

Psychiatrists can expect that progress in investigations of the mental disorders that fall to disease reasoning would ultimately discern the structural or functional “broken part” (pathologic entity) in the brain hypothesized as producing the mental signs and symptoms. Eventually, successful investigations would discern the cause or causes for this broken part, whether they are abnormal genes, toxins, infections, or other kinds of injury. A complete knowledge then of a mental disorder resting on a brain disease
would be to link an etiology to the pathology through the discovery of its “pathogenesis” and then to discern how the pathology leads to clinical symptoms by its “pathophysiology.”

Thus, from clinical presentations that suggest a loss or defect in some basic cerebral faculty, psychiatrists using the disease perspective hypothesize that these psychiatric disorders are neuropathic and seek to employ treatments that will directly interfere either with the pathophysiology to correct the symptoms or with the pathogenesis to prevent the brain injury itself. An appropriate challenge for placing a particular psychiatric condition within the disease perspective would be a failure ultimately to demonstrate the neuropathic process hypothesized as its prime defining feature as a disease.

Consultation-liaison (C-L) psychiatrists are customarily called to identify patients with delirium, bipolar disorder, and schizophrenia. The disease perspective directs their consultative effort, the investigations they suggest to prove the correctness of their diagnostic opinion, and the treatment programs they propose for the patients.

**MOTIVATIONAL RHYTHMS AND THE BEHAVIOR PERSPECTIVE**

A prominent, manifest feature of human mental life is the regular and rhythmic alterations of attention and perception produced by such “drives” as hunger, thirst, and sexual interest. Sigmund Freud, in what can be considered his one enduring achievement in psychology, was first to draw attention to these “psychic motivations” and how they are characteristic of psychological life. These various drives wax and wane, swaying the perceptual “attitude” of the subject toward his or her setting. This psychic “attitude” ultimately impels complex goal-directed motor-sensory activities, such as eating, sleeping, and sexual behavior. These behaviors and their provocative affective “attitudes” are shaped by their psychosocial consequences and sustained by learning and conditioning.

The behavior perspective (Fig. 4.2) for psychiatrists builds on this prominent feature of mental life by identifying those disruptions of choice and control manifest in such conditions as anorexia/bulimia, sexual paraphilias, sleep disorders, and drug abuse and dependency. Such disruptions of control can derive from several different kinds of injurious influence. Direct damage to the brain mechanisms controlling these vital drives can provoke some behavioral disorders such as hypothalamic hyperphagia. The exposure to drugs with high abuse potential such as alcohol, cocaine, or heroin can alter brain transmitter systems to produce, sustain, and reinstate an artificial drive state or hunger, in turn provoking continuing and difficult to control drug consumption. Social learning and conditioning can produce a misdirection of behavior, such as in anorexia nervosa, where brain mechanisms appear to be intact. In all these disorders, derangements of choice, physiological drive, and conditioned learning interact. Their explanations and their treatments come from understanding these interactions.

In the consultation services, patients with behavior disorders are common. Those with the medical and surgical complications of their addictions to alcohol or addictive drugs are frequent on the wards and helping the physician and nursing staff care for them is a common challenge. Again, recognizing how their physical condition is to some extent an outcome of the choices to which they have become habituated helps plan the extensive treatment programs they need to interrupt these habits.

**PSYCHOLOGICAL CONSTITUTION AND THE DIMENSIONAL PERSPECTIVE**

Many psychiatric problems depend not on some disease of brain or some misdirected drive, but on patients’
affective or cognitive constitution that, as innate aspects of their psychological makeup, bring vulnerability (“potential”) to distress under certain provocative circumstances. These latent constitutional features are graded (“dimensional”) psychological characteristics of humans, such as intelligence, extraversion, and “neuroticism” (the term for constitutional emotional instability).

These constitutional features bring their own issues—of normality and abnormality, distress and disorder—to psychiatric attention. These issues include their influence on character development and educational achievement and, especially for individuals who deviate to some extreme along one of these dimensions, they bring vulnerability to emotional distress and deviant behavior.

The central concept of the dimensional perspective (Fig. 4.3) is that disorders in this class are best explained as a combination of an individual’s affective or cognitive potential with provocative life circumstances that elicit emotional or behavioral responses excessive in frequency and degree. Particular problematic dispositions are suboptimal cognitive capacity (IQ less than 85) or an affective constitution of high neuroticism, low conscientiousness, or immaturity. Provoking circumstances are challenges to the analytic capacities of the suboptimally intelligent and challenges to the social satisfactions of the affectively deviant. In particular, a high score on “neuroticism” is most frequently a precondition for habitually strong emotional responses that may lead to a psychiatric consultation.

The dimensional perspective grapples with the typologies and categories of Axis II in DSM-III and IV and does so more successfully because of its emphasis on gradation in these human psychological variations; thus, it recognizes a problematic disposition long before its features reach the degree demanded by a DSM Axis II category. These factors are especially common in the C-L role, where subtle but persistent characteristics of a patient’s personality have led to complex difficulties with other doctors and nurses. Here, the recognition by psychiatrists of the need to develop a better approach to guiding the patient toward co-operation provides them with a great advantage and the capacity to aid in often problematic cases.

THE PERSONAL CHRONICLE AND THE LIFE STORY PERSPECTIVE

The ultimate emergent psychological feature of the human brain is self-reflection defined both as the sense of the self as the agent of a life plan and the reflexive subject developing expectations and assumptions on the basis of the outcomes of such plans. Just how the material brain can develop this maturing sense of engagement with one’s world and give the feeling of ownership and vitality to one’s choices and beliefs is part of the brain–mind conundrum. Some go so far as to say that work in this arena is not medical work because it is not tied to known bodily mechanisms, but surely the maturing and responsive brain carries these capacities in humans. Psychiatrists will ever be asked to guide and direct—in diagnosis, treatment, and prevention—patients facing issues of distress emerging from within this domain of their biography and their maturation.

The life story perspective (Fig. 4.4) thus identifies how psychiatrists make sense of some mental disorders as responses to life encounters, indeed responses of a kind one would expect from anyone faced with such circumstances. The expectations of psychiatrists working with life stories are that they can forge a narrative of setting and sequence that suggests some role of the self in each story, illuminates the troubled state of mind as the outcome of that role, and makes sense of the course the story took and the assumptions for the self that it generated.

Psychiatrists turn to the life story first to explain grief or shame from losses, homesickness from difficulties in acculturation, jealousy or hostility from threats to valued personal relationships, and anxiety due to real or suspected threats to one’s integrity as from advancing medical illness. However, the life story also helps explain how life experience can generate certain ways of looking at the world and habits of thought.
(i.e., assumptions and expectations about life and how to live it) that the individual’s experiences can be seen to promote. From this personal framework emerge disorders such as hysteria, adult gender identity disorder, false memory syndrome, and the various disordered expressions of “overvalued ideas,” such as in religious scrupulosity and sociopolitical fanaticisms. The life story perspective thus brings to attention those patients in need of help in reframing their thinking and planning—a reframing process that is at the heart of psychotherapy.

In C-L work, these matters are often the most obvious, given that medical and surgical patients are facing serious life challenges and conditions that will affect their future in profound ways. The consulting psychiatrist helps most by identifying the natural circumstances of these patients and bringing to bear the supports they need. Here, psychiatrists need to explain to the doctors and nurses caring for the patient the sense of anxiety and depression generated by grim prognostic situations, as well as the sense of burden experienced when faced with the medical and surgical procedures called for in these situations. They also need to provide recommendations on how to “rescript” the hopeless expectation, attitudes, and assumptions that the patient has derived from the setting and sequence prescribed.

Combinations of Perspectives for Specific Services

The value of differentiating the perspectives as approaches to classes of disorders and as guides to treatment is only partially demonstrated when pure examples of each are described. A crucial assumption tied to the metaphor of “perspective” and appreciated from the interrelatedness of the domains in the hierarchical levels of mental life is that many patients demonstrate the interactions of several perspectives at once in their mental afflictions.

Such patients are common in C-L psychiatry. At The Johns Hopkins University, the psychiatrically most complex and intensely needful patients are those living with HIV infection. Their management requires close C-L relationships among several specialties, including psychiatry. Treisman and Angelino (9), using the perspective method for formulating patients’ interactive problems and launching coherent treatment programs, demonstrated the success of such a consultative approach.

A second group of patients in which an understanding of the interactions of perspectives was crucial to success were those with refractory chronic pain who came to pain services for assistance. Chronic pain is a significant public health problem, and patients with chronic pain can be frustrating to everyone trying to help them.

As pointed out by Clark and Cox (10) in leading the Hopkins Chronic Pain Treatment Program, psychiatrists can and should take a leading role in the care of pain patients. A comprehensive approach based on the perspectives has proven successful because most pain patients do not fit into one theoretic model to receive and accept treatment in such a program. They noted, “The perspectives appreciate not only that the pain patient is struggling through important life events but also that he is a person composed of vulnerabilities and strengths, having already made many choices and now is afflicted by physical and mental diseases” (10).

The perspectives of psychiatry identify the patient as a person who is a composite of vulnerabilities and strengths but afflicted with diseases, struggling through life events, and motivated for various reasons. Each perspective has its own logical process for evaluation and subsequently directed treatment.

Although the perspectives are complementary, they each remain distinct and essential to the formulation of a patient’s distress. This comprehensive and integrated formulation of a patient supports the premise of a psychiatrist being the physician best suited to coordinate the care of complex cases that defy a simple list of diagnoses.

Conclusion

There are two challenging questions to ask of an explanatory structure for psychiatry: (a) Is it an advance over what came before?, and (b) does it enrich our clinical, teaching, and research missions?
American psychiatry is closing on 25 years of experience with the field guide method of DSM. The manual’s original purpose of bringing reliability to diagnosis has been achieved. Now is the time to replace it by moving toward some systematic classificatory scheme that, like contemporary medical classification, differentiates disorders by what practitioners and clinical scientists presume to be their underlying natures and that offers some direction for their further study. To this matter, we use the perspectives approach at Hopkins, and we challenge others to implement and improve this approach. Table 4.2 demonstrates how most of the common diagnoses in DSM-IV would be encompassed within the perspectives classificatory structure. With this structure, we retain most of the reliability of the DSM terminology, while moving toward a hypothesis-based, operationally defined, explanatorily progressive classificatory system.

We believe that the structure outlined here (along with the clinical and academic actions it inspired) led directly to our department growing coherently, our students learning that they had joined a progressive discipline, and our clinicians and investigators flourishing collaboratively. With it as a guide, we were prepared to describe the nature of mental illnesses and how to study them, thereby dispersing the mysteries and myths that troubled Roy Porter and Thomas Szasz. We came to appreciate just how each explanatory method (perspective) provides distinct conceptual definitions specifying who is a patient, what is psychopathology, what is meant by “normal,” and which treatments are suitable. Finally, this structure identified the ways in which scientific psychiatry contributes to modern medicine by illuminating how all clinical disorders, including mental disorders, are examples of “life under altered conditions.”

REFERENCES
