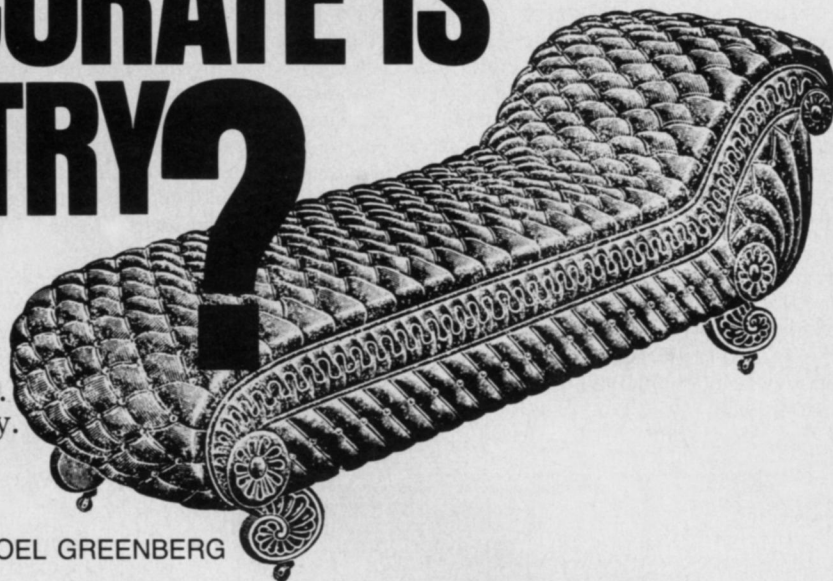


HOW ACCURATE IS PSYCHIATRY?



Misdiagnosis is fairly widespread, according to some professionals. But DSM III is on the way.

BY JOEL GREENBERG

A psychiatric patient at Bellevue Hospital in New York was diagnosed as a "borderline personality, with latent schizophrenia and depressive-hysterical features." In Pittsburgh's Western Psychiatric Institute and Clinic, a man with psychomotor epilepsy was repeatedly misdiagnosed for five years as a schizophrenic (SN: 4/30/77, p. 281).

As in no other medically related discipline, psychiatry has spawned an avalanche of symptom labels that not only mystify the public but also, to a large degree, confuse and frustrate behavioral experts themselves. A recent study of diagnosis reliability revealed that when presented identical sets of cases, psychiatrists rarely agree on the specific nature of the illness.

As a result, poor diagnoses and subsequently inappropriate treatment are "fairly widespread" throughout the psychiatric community, says Robert L. Spitzer, chief of psychiatric research at the New York State Psychiatric Institute and professor of clinical psychiatry at Columbia University. And with the almost endless combinations of symptoms a possibility with many patients, such diagnostic problems are not particularly surprising to Spitzer or others. With each patient, the clinician must narrow the choices down from among the neuroses, psychoses, psychosomatic illnesses, personality disorders, brain damage or nervous system impairment and the scores of individual illnesses that fit within each category.

The psychiatric bible that attempts to define and categorize such terms is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). But the current manual, in use for the last 10 years, is already woefully outdated, according to Spitzer. So the psychiatrist has designed the new DSM III. The document already has the solid backing of the American

Psychiatric Association and is scheduled for adoption in 1978. Some clinicians rely heavily on DSM, while others ignore it and use their own criteria. Nevertheless, the manual's use is required by many insurance companies, and DSM remains the only formal diagnostic document in psychiatry. Spitzer and his colleagues believe DSM III—based on numerous studies of diagnostic effectiveness—is far more accurate than its predecessors and "will alleviate" many improper diagnoses and treatments that continue to plague behavioral science today.

For despite the growing list of labels, psychiatry much of the time has failed to approach the precision of general medicine, where most afflictions are not only apparent but visible. Mental illness can be much more amorphous and complex, often defying attempts to match diagnoses with patient symptoms.

"Large numbers of patients coming for treatment cannot be fitted neatly" into current categories, John S. Strauss and his University of Rochester colleagues conclude from a study of diagnostic methods. "A greater number of patients actually fall between the categories or exhibit low symptom levels," Strauss says. "A major problem with our current diagnostic typology is that it is based on archetypes which, although occurring in nature, do not provide sufficient coverage of the patient population to provide an adequate diagnostic framework for the great majority of patients coming to treatment."

One major problem is the evolution of schizophrenia into a catch-all tag for numerous combinations of symptoms. Since its introduction in 1911 schizophrenia has been perhaps the most widely applied psychiatric term, but even today "there is little agreement as to which signs and symptoms are crucial to the illness," says Victor R. Adebimpe, the Pittsburgh psy-

chiatrist who uncovered the misdiagnosis at the Western Psychiatric Institute and Clinic and correctly concluded the patient was an epileptic.

At first, clinicians regarded ambivalence, autism, disturbances of affect and looseness of associations as the prime features of schizophrenia, Adebimpe notes. Later, more emphasis was placed on other features, such as hallucinations and delusions. Now, "contemporary thought is beginning to stress the importance of premorbid history, family history, course of illness and other correlates," he says.

A recent World Health Organization study conducted in nine international centers listed a number of predominant schizophrenia symptoms. Among them were "behavioral abnormalities, delusions, hallucinations, variable mood, a desire to stay away from people" and others. "There are, however, a number of other symptoms that occur relatively infrequently in any sample of schizophrenics," Adebimpe says. "The difficulty of assigning accurate diagnostic weights to these symptoms contributes to the low level of agreement among psychiatrists and to the problems of recognizing medical diseases that have psychiatric features."

Spitzer adds that "a lot of manic illness is misdiagnosed as schizophrenia." Mania is characterized by excitement, elation, agitation and hyperactivity. The manic "has a thousand ideas a minute and must tell them to everyone," writes Harry Milt in *The Basic Handbook of Mental Illness*. "He has fantastically exaggerated notions about power and ability. He has grandiose solutions" to the world's problems "and if his friends and relatives fail to see the wisdom of his scheme and refuse to go along with him, he sees them as enemies and traitors."

It is not difficult to see how such behavior might be confused with certain forms of schizophrenia, where the personality is essentially shattered or disintegrated. The schizophrenic's thoughts and ideas become distorted, irrational and bizarre and are expressed in confused language, or no human language at all. This may be accompanied by frenetic and exuberant activity similar to that of the manic.

In such situations, the ability to pinpoint the diagnosis is, of course, critical to treatment of the disorder, Spitzer says. For instance, though the two conditions may appear similar in many ways, mania responds favorably to the drug lithium carbonate, and schizophrenia to phenothiazine. If interchanged through misdiagnosis, the drugs have no helping effect, Spitzer says.

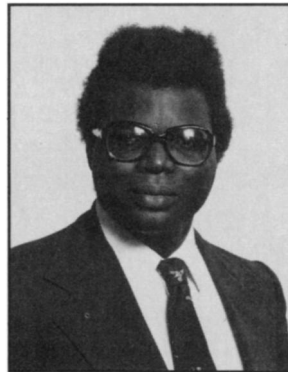
Improper treatment can also result from over-generalized diagnoses, which still exist in some illness areas today, Spitzer says, despite advances in labeling over the last 10 years. For example, anxiety neuroses (which include the various phobias) are widely treated with the behavior modification technique of desensitization in which the person is gradually exposed to the feared object or situation until he or she is able to face it without fear. "But a person with a history of being afraid of spiders is different from someone who has a fear of leaving home and being in crowds or open spaces [agoraphobia]," Spitzer notes. Agoraphobia and similar conditions that are characterized by "panic attacks" have been shown to react favorably to treatment with antidepressant drugs, but frequently not to desensitization, Spitzer says.

The DSM III will, among other things, subdivide anxiety neuroses into panic disorders and phobias. By being more specific in this and other areas, Spitzer says, it will encourage more precise diagnoses and treatment. Clinicians will be more or less forced to consider all aspects of a disorder and be more aware of appropriate ways to deal with it.

The new manual—10 times larger than DSM II—will revolve around a "multiaxial" approach that provides "a more comprehensive description of patients, and takes environmental factors into account," Spitzer says. Psychiatry has always been backboned by the traditional disorder diagnoses, he says, but the new guidelines will also stress psychosocial,



Spitzer: *Rewriting the diagnostic bible.*



Adebimpe: *When schizophrenia is not physical and personality factors as well.*

At the same time, the often unwieldy view of schizophrenia will be more "restrictive," to include mainly persons who have had delusions, hallucinations or marked formal thought disorder. While these changes are bound to help in some areas, DSM III has already met with criticism from those who think it may go too far in revising traditional thought. The manual's proposals "contain much that is of merit," say John Racy and J. Richard Ciccone of the University of Rochester School of Medicine. But "they also go further than is needed in overhauling our diagnostic scheme." The psychiatrists warn against the elimination of some terms, including "the disappearance of simple schizophrenia [an illness which generally does not involve hallucinations and delusions] from the proposed listing of schizophrenic disorders," and "the shifting of latent or borderline schizophrenia to the personality disorders."

Spitzer says the key problem, however, stems from the "many different conceptions" of schizophrenia. The range goes from the "narrow European concept" that stresses chronicity of the condition to the current, "broad concept" in America "that includes many nonpsychotic forms of the disorder."

Adebimpe suggests that the misdiagnosis he uncovered in Pittsburgh illustrates—to the extreme—the confusion that can result from a broad, frequently used diagnosis of schizophrenia. "It is not surprising that the diagnosis of schizophrenia

readily came to mind" with the various clinicians who treated the man over five years, he said. The patient exhibited, among other things, hallucinations, ambivalence, decreased organization of thought processes, agitation and depressive delusions at various stages. In addition, the man's elder brother was known to be under treatment for schizophrenia.

The patient, now 25, had been periodically seen in the institute's emergency room over five years with basically the same symptoms—frenzied movements, and abnormal behavior that included muttering, grunting, humming, rolling, rocking and crawling. Among this muttering were the words "Hare Krishna, Hare Krishna." After three hours and two doses of the antimanic drug chlorpromazine, the man would invariably emerge from the episode, rub his eyes and calmly ask for a cigarette.

Coming upon the man's record of 30 similar incidents, each of which were diagnosed as schizophrenia, Adebimpe became suspicious and admitted the patient to the inpatient service for study. "Despite the similarities [to schizophrenia], there are a number of critical differences," Adebimpe noted. For one thing, the man's attacks had become predictable at a frequency that is unusual in schizophrenia. For another, schizophrenic episodes rarely last less than 24 hours and terminate spontaneously. Finally, even a schizophrenic's abnormal activities usually appear to be directed at *some purpose*, says the psychiatrist, "in contrast to the nonpurposive nature of the movements seen in this patient."

On the basis of the inpatient observations, Adebimpe quickly concluded that the man was not mentally ill, but was suffering from "complex partial seizures" (psychomotor epilepsy). He was placed on antiseizure drugs and "remained well" with only one seizure over the next six months.

Adebimpe says he "would recommend DSM III," but acknowledges that psychiatry's inherent inexactness will create diagnostic problems for some time to come. "It so happens that this was a special case [at the institute]—it was curable. Other times it is not that easy to demonstrate misdiagnosis," he says. "You have no way of knowing whether your diagnosis is better than anyone else's . . . until you see if the treatment works. That's the proof of the pudding." □