

## 19. Classifying and diagnosing mental disorder

### INTRODUCTION

It was noted in the previous chapter that assessment is the process of collecting information relevant to the diagnosis, management, and treatment of a patient's clinical condition. The recording of a patient's symptoms, and the conduct of any special investigations, is initially undertaken to identify the type of disorder from which he suffers. A diagnosis is a short-hand way of describing what is wrong with a patient and it involves assigning the patient's case to a particular known class, such as schizophrenia, by reference to an accepted classification of mental disorders. Conclusions can then be reached about the causes, probable course, and treatment of the condition in question. Before considering the diagnostic process the way in which mental disorders are classified must therefore first be dealt with.

### THE CLASSIFICATION OF MENTAL DISORDERS

Classification is the grouping of things according to a logical scheme for organising and classifying them and assigning them their proper places. More particularly, phenomena are assigned to designated classes on the basis of perceived common characteristics. Both legal and medical classifications of mental disorders exist. Medical classifications indicate which conditions are regarded as being mental or behavioural disorders and therefore suitable for medical treatment. Particular diagnoses are considered to be associated with particular prognoses and outcomes. The precise diagnosis may profoundly affect the clinician's opinion about whether in-patient treatment is necessary for the patient's health or safety or to protect others and, more specifically, the extent to which treatment is likely to alleviate or prevent a deterioration of the patient's condition. Sartorius, until recently the Director of the World Health Organisation's Division of Mental Health, ascribes part of the wide-ranging interest of lawyers in medical classifications to the fact that "the absence of physical signs and laboratory abnormalities in many psychiatric disturbances makes psychiatric disorders much more dependent on the consensus of what in a given society is normal, what is abnormal, what is asocial and what is part of a disease."<sup>1</sup>

### LEGAL CLASSIFICATIONS

Section 1 of the Mental Health Act 1983 distinguishes between four legal classes of mental disorder (mental illness, psychopathic disorder, mental impairment, severe

<sup>1</sup> N. Sartorius, in *Sources and Traditions of Classification in Psychiatry* (ed. N. Sartorius, et al., World Health Organisation/Hogrefe & Huber, 1990), p.1.

mental impairment) three of which are defined. Various sections of the Act provide for reclassifying the legal form of mental disorder from which a detained patient is recorded as suffering. Legally defining "mental disorder", and sub-dividing mental disorders into different statutory classes, serves the purpose of defining as far as practicable the group of citizens to whom the various compulsory powers conferred by the Act apply and the circumstances in which resort may be made to them. The legal classification of mental disorders set out in section 1 of the Mental Health Act 1983 has already been considered (051). Here, it may simply be noted that the classifications set out in mental health legislation have tended to adopt the classification of mentally abnormal states set out at the time in the World Health Organisation's International Classification of Diseases, that classification having been in official usage in the United Kingdom for half a century.

## MEDICAL CLASSIFICATIONS

Sartorius has emphasised that classification is a way of seeing the world, a reification of an ideological position and of an accepted standard of theory and knowledge: "Classifying means creating, defining or confirming boundaries of concepts. Through these, in turn, we define ourselves, our future and our past, the territory of our discipline, its importance and its exclusiveness. No other intellectual act is of such importance."<sup>2</sup> These views are shared by Kendell, the foremost authority on the classification of mental disorders, who has variously described the process of classification as one of the most fundamental activities of any branch of learning and necessary if any useful communication is to take place. The whole process of language is based on classification and on assumed associations and relationships between certain objects or phenomena: every common noun, such as a tree, denotes the existence of a category or class of objects. Furthermore, not to attempt to delineate mental disorders is still to classify them, because rejecting the notion of distinct categories of disorder is in essence a statement that there exists only mental health and mental disorder and no distinct sub-types of each.<sup>3</sup> Classification also has important practical benefits. In the first place, until categories can be identified, "one is unable to begin to count, and until counting is possible one cannot know how big the problems are or deploy the resources intelligently in an endeavour to control the problems."<sup>4</sup> The identification of specific syndromes is also an essential first-stage in identifying their aetiology and pathology and "rational treatment can only be based upon a satisfactory system of classification of diagnoses."<sup>5</sup> A distinction between different kinds of mental disorder "is therefore inevitable. The only open issues are whether this classification is going to be public or private, stable or unstable, reliable or unreliable, valid or invalid."<sup>6</sup> Attempting to avoid classification altogether would be "crippling clinically and scientifically."<sup>7</sup>

2 K. Menninger, *The vital balance: the life process in mental health and illness* (Viking Press, 1963).  
 3 See e.g. R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.277. Psychiatrists are sometimes said to have either "lumpers" or "splitters." The former believe that schizophrenia is a single "disease," with variations in presentation being accounted for by different individual responses to the "disease." The latter consider that there are a number of distinguishable sub-types of schizophrenia, such as hebephrenic schizophrenia, and so forth.  
 4 *International Classification of Impairments, Disabilities, and Handicaps: A manual of classification relating to the consequences of disease* (World Health Organisation, 1976), p.35.  
 5 A. Sims and D. Owens, *Psychiatry* (Baillière Tindall, 6th ed., 1993), p.34.  
 6 R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.277.  
 7 J.K. Wing, "Differential diagnosis of schizophrenia" in *Schizophrenia — An overview and practical handbook* (ed. D.J. Kavanagh, Chapman & Hall, 1992), p.19.

## ASSOCIATED TERMS

Nomenclature, nosology, ontology, and diagnosis are related and, to some extent, overlapping terms that refer to various aspects of the conceptualisation of disease. The first three of these terms have not yet been dealt with although they are routinely referred to in medical literature. They are therefore briefly mentioned here.

### Nomenclature

Nomenclature (literally, "class name") denotes the agreed or approved list of categories or titles of disorders within a classification which are used to communicate the results of the diagnostic process, schizophrenia being one example.

### Nosology

Nosology is the study of the classification, grouping and ordering of diseases and their relationship to one another. It includes the formulation of principles for differentiating one disease from another. Ideally, nosology would provide a differentiation of discrete diseases and for each describe a specific cause and specific treatments; a typical clinical picture, natural history and outcome; and objective tests for confirming the diagnosis. The nosology of mental disorders has, however, remained problematic ever since the endeavour was first attempted and the area remains split into rival schools.<sup>8</sup>

### Ontology

One definition of classification is that it is "a means of giving order to a group of disconnected facts."<sup>9</sup> Underlying the question of nosology is that of ontology, which is the study of whether things actually exist in the real world or are merely products of our own ways of studying and classifying the world. For example, although we still classify stars by constellations, we now know that their apparent unity is an illusion caused by the perspective of the observer. The different stars within each constellation most often lie not together in space but many light years apart. Akin to this, Allport's view of psychiatric classifications was that "all typologies place boundaries where boundaries do not belong. They are artificial categories ... each theorist slices nature in any way he chooses and finds only his own cuttings worthy of admiration."<sup>10</sup> It is possible therefore that differentiating between different classes

8 In very general terms, this contemporary biomedical approach reflects the Platonic tradition that the different categories of mental disorder constitute a number of discrete disease entities ("the categorical view"). The Hippocratic or Aristotelian tradition holds instead that mental health and mental disorder form a continuum: differences in presentation relate to the chronicity and severity of mental phenomena, being stages and variants of an indivisible unitary psychosis.  
 9 *A Dictionary of Epidemiology* (ed. J.M. Last, International Epidemiological Association/Oxford University Press, 3rd ed., 1995), p.29.  
 10 A point made by Eliot in the nineteenth century: "Your pier-glass or extensive surface of polished steel made to be rubbed by a housemaid, will be minutely and multitudinously scratched in all directions; but place now against it a lighted candle as a centre of illumination, and lo! the scratches will seem to arrange themselves in a fine series of concentric circles round that little sun. It is demonstrable that the scratches are going everywhere impartially, and it is only your candle which provides the flattering illusion of a concentric arrangement, its light falling with an exclusive optical selection. These things are a parable. The scratches are events, and the candle is the egoism of any person now absent ..." George Eliot, *Middlemarch* (Penguin English Library, 1965), p.297.

of mental disorder is similar to the division of painters or musicians into different schools, a matter of convenience rather than science. While it may be convenient to classify certain music as jazz or certain art as post-impressionist, these distinctions are essentially artificial and no real, or objectively measurable, unity between the works so classified can be discerned. At any rate, the classification of certain paintings as abstract may, as with mental disorder, be based on a conception that their essential distinguishing feature is a lack of any order. If so, the objects may be placed in the class "disordered" but attempting to then order that class may be contradictory and offend reality. The issue has important practical implications. For example, Schneider was concerned that clinical facts are often ignored in order to prevent the classificatory system breaking down. Consequently, he preferred what he called "unsystematic typologies," within which the different names represented descriptions rather than diagnoses of mental states.

### THE STRUCTURE OF A CLASSIFICATION

Ideally, a classification (or "taxonomy") should be characterised by naturalness (the classes correspond to the nature of the thing being classified); *exhaustiveness* and *mutual exclusivity* (every member of the group will fit into one and only one class in the system); *usefulness* (the classification is practical); simplicity (the sub-classes are not excessive); and *constructability* (the set of classes can be constructed by a demonstrably systematic procedure).<sup>11</sup> There may be tiers, sub-classes or subdivisions. Classes may be dimensional (height 5' 2"-5'4"; IQ 100-120, etc.) or categorical (short, fat, etc.). Traditionally, psychiatry has always used a categorical classification or "typology." That is, "it has divided its subject-matter, psychiatric illness, into a number of separate and mutually exclusive categories like schizophrenia, mania and Alzheimer's disease."<sup>12</sup> The way in which the classification tree is constructed will inevitably affect the results produced so that a person may meet the criteria for a diagnosis of schizophrenia set out in one classification but not another.

### The use of hierarchies

Almost every psychiatric symptom of significance is capable of appearing in the presence of nearly every other symptom. Because this is so, Kendell has variously commented upon the problems which then arise in applying to psychiatry one of the fundamental principles of medicine: to try to account for a patient's symptoms by a single diagnosis. The approach usually adopted is to arrange symptoms in an arbitrary hierarchy, with the least common at the top and the most widespread at the bottom, since this represents almost the only way of making a single diagnosis. Thus, if there is clear evidence of brain disease that establishes the diagnosis and, likewise, in the absence of such evidence, clear features of schizophrenia often establish that diagnosis even if affective symptoms are also present. While the approach allows for some sort of ordered classification, the danger is that the classification provides order rather than reflects reality, so that the classification is dictating to the latter rather than accounting for it.

<sup>11</sup> *A Dictionary of Epidemiology* (ed. J.M. Last, International Epidemiological Association/Oxford University Press, 3rd ed., 1995), p.29.

<sup>12</sup> R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.292.

### The classificatory criteria

As a matter of logic, the different methods of classifying mental disorders focus on the different stages of the disease process:

Aetiology → Pathology → Manifestation → Outcome

The classification and diagnosis of physical diseases are mostly based on their aetiology or pathology, that is diseases are classified according to their known causes or biological abnormalities. Most authors take the view that a classification based on aetiology and pathology is most desirable since it is most useful in practice. However, because most psychiatric disorders (including schizophrenia and mood disorders) have no known unifying aetiology or pathology, they must be classified by their outcome, response to treatment, or according to patterns of symptoms observed to frequently occur together (the "syndrome" approach).

### Classification by aetiology and pathology

An aetiological classification describes the cause of the disorder and, if it is unique to the specific condition, provides a clear prognosis and treatment plan or focus for research into treatment. Consequently, a classification of infectious diseases based on the identity of infecting organisms is more useful than one based on purely clinical phenomena, such as the presence of fever.<sup>13</sup> It is, however, impossible to describe disease purely in terms of an external cause such as an infectious agent because the same agent can produce very different diseases. Many mental disorders are also aetiological very diverse, that is they have a "multi-factorial aetiology" rather than any simple single cause. For example, "depressive disorder can be regarded as a final common pathway which may have multiple causes, even in a single case."<sup>14</sup> Thus, the same cause may produce very different diseases and the same disease may have many different causes. Consequently, Bradley notes that even if our knowledge of aetiology was complete the classification of disease in terms of cause could never be satisfactory. Abnormalities of structure and function — the pathology which is the basis of symptoms and signs — must be taken into account when diseases are classified. Again, though, pathology cannot provide a satisfactory taxonomy alone because the nature of the infecting organism is often crucially important in the management of the patient. Moreover, in some cases, such as Alzheimer's disease, the precise pathology is not clear until after the patient's death, following post-mortem examination of the brain. In any case, because the aetiology and pathology of the vast majority of severely disabling psychiatric disorders remains unknown — both pre and post mortem — classification by such means is presently impossible.

### Classification by outcome or treatment response

Classification by outcome alone is of limited practical value. Such a classification affords no prediction of the outcome since it is the outcome which retrospectively defines the diagnosis, whereas most doctors wish to know the diagnosis and prognosis before commencing treatment. Furthermore, many disorders have a wide range of outcomes. A classification based on response to a particular treatment is similarly unsatisfactory. There are few, if any, specific treatments in psychiatry and

<sup>13</sup> R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), pp.278-279.

<sup>14</sup> J.M. Pfeffer and G. Waldron, *Psychiatric Differential Diagnoses* (Churchill Livingstone, 1987).

the different therapies are not mutually exclusive. Response to EC does not establish that the individual had a depressive disorder, nor does failure to respond to antipsychotics mean that he is not psychotic or does not have schizophrenia.

#### Classification by symptoms (syndromes)

Although acknowledged not to be particularly satisfactory, the symptomological approach to classification is by default generally used in psychiatry. For a symptom to be used diagnostically, its occurrence must be typical of that condition and it must occur relatively frequently.<sup>15</sup> Clusters of symptoms may be observed to occur in conjunction and to develop or remit according to a broadly identifiable pattern, persisting for a characteristic length of time. These clusters of symptoms therefore occur together as identifiable constellations or syndromes — "syndrome" being a Greek word meaning "running together." The syndrome can be named and classified, e.g. schizophrenia. Such a classificatory scheme does not depend upon knowing the cause of the disorder or the abnormal pathology responsible for the patient's symptoms. It is based merely on the identification of a pattern of symptoms sufficiently distinctive to justify an inference that they are the product of some discrete medical condition. A doctor who then examines a patient and observes the characteristic symptom pattern may diagnose that the particular condition and prescribe a certain treatment. Research into the syndrome may later confirm that it is a "disease" with characteristic features in terms of its causes, the people whom it affects, its course and likely outcome. Thus, a person with a certain grouping of symptoms and blood test results has leukaemia, which can be shown to have a certain natural course and to respond better to some treatments than others. Blood tests and other routine examinations may confirm various distinguishable sub-types, the validity of which can be demonstrated by their relatively high predictive power in terms of response to treatment, outcome and test-retest reliability. The problem with many psychiatric disorders is that their existence as distinct illnesses cannot be demonstrated in this way, there being few tests of any diagnostic utility which can distinguish between different types of mental disorder. For example, there is no known organic or physiological abnormality which accounts for hebephrenic schizophrenia and is only found in patients with the disorder. Consequently, the psychiatrist must rely "upon the consensus among his colleagues that a particular constellation of symptoms or phenomena tend to occur together and can be recognised as a syndrome."<sup>16</sup> Whether or not certain recognised syndromes do in reality represent distinct disease processes depends upon the correctness of the observations and inferences made about the way in which symptoms and signs coalesce, as well as the validity of this kind of disease reasoning itself. As matters presently stand, conditions such as schizophrenia are ultimately concepts the validity of which has yet to be demonstrated. Nevertheless, most established diseases were originally defined by their syndromes and "as knowledge about their etiology slowly accumulated they came, one by one, to be defined at some more fundamental level. The clinical syndrome 'phthisis' became pulmonary tuberculosis, defined by the presence of tubercle bacilli in sputum or post-mortem lung ... and Down's syndrome became trisomy 21, defined by the presence of that additional chromosome, as soon as it was apparent that the syndrome was invariably associated with that chromosomal abnormality."<sup>17</sup>

<sup>15</sup> A. Sims, *Symptoms in the Mind* (Baillière Tindall, 1988), p.6.

<sup>16</sup> C. Thompson, *The Instruments of Psychiatric Research* (John Wiley & Sons, 1989), p.3.

<sup>17</sup> See R.E. Kendell, "Schizophrenia: A Medical View of a Medical Concept" in *What is Schizophrenia?* (ed. W.F. Flack et al., Springer-Verlag, 1990), p.64.

## PROBLEMS CLASSIFYING SYNDROMES

The difficulties involved in constructing any classification of mental disorders by syndrome are formidable and should not be underestimated —

- The approach depends upon pinpointing characteristic and recurring patterns of symptoms and signs. However, while the correct identification of a rump of features distinctive of an illness requires accurate observation, recording and deduction, decisions about even the presence or absence of particular symptoms have been shown to be relatively unreliable.
- This practical limitation is compounded by the absence of any agreed terminology with which to describe what is observed. Although a precise language is necessary to record observed phenomena, psychiatry lacks this. Once language cannot be agreed certainty is impossible. Every research finding must be translated and, as with any form of literature, some distortion and loss of meaning is inevitable. These limitations have led Professor Kathleen Jones to conclude that description and observation must come before the construction of scales and the formulation of hypotheses about associations between symptoms: "it is not only computers which suffer from the problem of 'garbage in, garbage out.'"<sup>18</sup>
- In theory, the construction of syndromes begins with pinpointing characteristic and recurring patterns of symptoms and signs which are not specific to a particular individual and so cannot be explained in terms of his peculiar characteristics but only as the peculiar characteristics of a distinctive illness. However, considerable practical problems arise from the fact that it is not illnesses *per se* which are being classified but people suffering from illness. This distinction is of fundamental importance. Variability "is the law of life. As no faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease."<sup>19</sup> In consequence, widely different symptoms and signs may result from a common cause so that Huntington's chorea, although transmitted by a known single gene, is associated with a wide variety of psychiatric syndromes.<sup>20</sup> The clinical picture is therefore "most often profoundly coloured and sometimes decisively shaped by factors specific to the individual and his environment. Hence the notorious difficulty in identifying separate disease processes in psychiatry."<sup>21</sup> Or, as Yellowlees put it: "As the symptoms of any form of mental disorder vary enormously in different patients, the results ... are analogous to those obtained by arranging

<sup>18</sup> K. Jones, "Social science in relation to psychiatry" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.12.

<sup>19</sup> Sir W. Osler, *Medical education in Counsels and Ideals* (Houghton Mifflin, 2nd ed., 1921).

<sup>20</sup> R.E. Kendell, "Schizophrenia: A Medical View of a Medical Concept" in *What is Schizophrenia?* (ed. W.F. Flack et al., Springer-Verlag, 1990), p.67.

<sup>21</sup> W.A. Lishman, *Organic Psychiatry, The Psychological Consequences of Cerebral Disorder* (Blackwell Scientific Publications, 2nd ed., 1987), p.3. There is no identifiable single set of symptoms which constitutes normal health and therefore no single syndrome of normal health. The many different syndromes of normal mental health each constitute a norm from which deviation caused by a single pathological process may be observed. Consequently, for each pathological process the number of different types of abnormality precisely equals the number of types of normal health ("no syndrome syndrome").

books in a library, some according to the author, some according to the subject, some according to the size, and some according to the colour of the binding.<sup>22</sup>

- Although marked individual differences can sometimes be explained as atypical presentations, it is often difficult in practice to determine whether a particular constellation of symptoms is an atypical variation of an established syndrome, such as schizophrenia; a discrete sub-type of the disorder, such as hebephrenic schizophrenia; or a mutation of two co-existing but distinct forms of mental disorder, such as schizophrenia and depression ("schizoaffective disorder").<sup>23</sup>
- Certain mental phenomena are found both in people considered to be mentally healthy and those believed to be mentally disordered. For example, a feeling which a person has that he has previously visited a place unknown to him may be a symptom of temporal lobe epilepsy or a manifestation of general anxiety or fatigue. The same symptom observed in two people may therefore be symptomatic of illness in one person but not another and, when considered in isolation, not merely of little diagnostic value but confusing.

- Even when not found in the normal population and so indicative of a pathological process, any given symptom may be symptomatic of several different disorders and, when viewed in isolation, incapable of sustaining a single diagnosis. For example, Schneider's first-rank symptoms of schizophrenia are encountered in temporal lobe epilepsy, brain diseases, and in amphetamine intoxication.<sup>24</sup> The significance of a symptom therefore often depends upon the precise context so that it is known by the company it keeps. Unfortunately, most symptoms are promiscuous and few, if any, are specific to a particular disorder. Symptoms may be commonly present and valuable diagnostically but not universally present or definitive. Some diseases have very few symptoms; others share the same symptoms; and a symptom may sometimes be primary and other times secondary, e.g. depression resulting from hypothyroidism.

- It has been noted that some of this variation may be explained as the different effects of the same disease in different bodies. Having regard to this, Kendell has pointed out that each patient has some attributes which he shares with all patients, certain attributes which he shares with some but not all patients, and yet other attributes unique to that individual. Because this is so, the same disorder or disease is likely to affect all people identically in certain respects, different classes of people distinguished by certain key attributes in ways common only to members of the class, and each person within a class in yet other ways peculiar to him. Accordingly, a particular disease or disorder may produce in one person or class of persons symptoms and signs identical to those manifested in another person or group as a result

<sup>22</sup> H. Yellowlees, *To Define True Madness* (Pelican Books, Rev. ed., 1955), p. 7.

<sup>23</sup> As to this, Crow has noted that schizophrenia and bipolar disorder share many characteristics and several research workers are beginning to wonder whether at least some of their determinants may be common to both. See e.g. T. Crow, "Psychosis as a continuum and the virogenic concept" *British Medical Bulletin* 43, 754-768.

<sup>24</sup> R.E. Kendell, "Schizophrenia: A Medical View of a Medical Concept" in *What is Schizophrenia?* (ed. W.F. Flack et al., Springer-Verlag, 1990), p.66.

of a quite separate illness, with the result that it is wrongly inferred that the same disorder is responsible for these common symptoms.<sup>25</sup>

- A further complication in defining disease in terms of a specific set of features is that disease patterns change over time for reasons that are poorly understood.<sup>26</sup> This partly reflects the fact that the characteristics of a country's people changes over time — even if there has been no immigration or emigration — so that England, both culturally and medically, is a vastly different country now than a hundred years ago. It is, however, impossible to know whether the people have changed but the disease itself has remained unchanged or whether variations in presentation also reflect an evolution of the disease, in which case even classifications by aetiology or pathology require periodic revision.

- More prosaically, advances in treatment also change the presentation of disease. Few seriously disabling diseases are now allowed to run their natural course and most textbooks describe features which are rarely seen today. Although, as Kendell has noted, this does not necessarily change the spectrum of disease, it influences the type of symptoms and signs commonly observed, upon which syndromes are constructed and classified.

- Some diseases are therefore both anachronistic and anachoristic. If a single disorder is subject to sexual, racial, cultural or temporal fluctuations, the underlying unity may go undetected and it erroneously be construed as a number of separate disorders.

- An imaginative way of addressing these problems is to attempt to identify points of rarity in disease patterns, symptoms which even if not commonly present are nevertheless, when present, evidence of a particular disease. Unfortunately, such attempts have generally been unsuccessful.

- Underlying all these observations is the basic question of the validity of disease reasoning and the syndrome approach. Whether there are genuine boundaries between the clinical syndromes in current classifications, and between those syndromes and normality, is ultimately a conundrum. Although, as Kendell has variously noted, the existence of interforms does not of itself invalidate distinguishing between two different syndromes, most mental disorders do nevertheless appear to lack discrete boundaries and to shade into one another. The traditional research method of comparing people with one diagnosis with control subjects who have another diagnosis or no diagnosis "rests on the assumption that those with the target diagnosis have something in common which is absent in the case of the controls. If this assumption is invalid, the traditional research paradigm cannot hope to yield meaningful findings."<sup>27</sup>

<sup>25</sup> Most transparently, people of different genders, races or cultures have some personal characteristics not shared by persons falling outside their particular class. However, it is just as true that a man from one culture may have some characteristics in common with a woman from another culture which he does not also share with other men from his cultural background.

<sup>27</sup> G.W. Bradley, *Disease, Diagnosis and Decisions* (John Wiley & Sons, 1993), p.20.  
R.P. Bentall, "The classification of schizophrenia" in *Schizophrenia — An overview and practical handbook* (ed. D.J. Kavanagh, Chapman & Hall, 1992), p.24.

## Summary

The picture is therefore kaleidoscopic although it is unclear whether the primary problem is the phenomenal complexity of what is being observed or the perspective from which it is being observed. No single set of observations can ever be precisely replicated. Each individual patient gives the kaleidoscope a turn before the observer looks through the lens at the ever-changing patterns of crystals. Not surprisingly, Osler wrote in 1921 that "the problems of disease are more complicated and more difficult than any others with which the trained mind has to grapple."<sup>28</sup> Some 70 years later, Bradley reached a similar conclusion, writing that the difficulties "cannot easily be overcome making it unlikely that there will ever be a durable classification of disease."<sup>29</sup> It may well be that the symptoms of mental distress are more dictated by personality and environment than by any pathology, the effect of which is simply to imbalance what was previously, if precariously, balanced in the particular individual. Or the answer may be simply that it is logically impossible to classify disorder in an ordered way, to rationally arrange what is deranged. The essential and defining feature of mental disorder is the demolition of structure, disjunction rather than conjunction. Until some underlying and unifying pathology is stumbled upon, the syndrome approach, based as it is on the external manifestations of internal processes, may therefore be contradictory. Having invented the term "mental disorder" to express the idea of behaviour which appears to a rational observer to lack coherence, it is arguably mere vanity to then rigorously scrutinise the idea in the expectation of identifying organised sub-forms of disorder. Whether or not this is so, there may be much to be said for Bentall's suggestion that research should concentrate on particular symptoms before attempting to map their possible constellations—

"There is a perfectly logical alternative to using diagnostic classifications as independent variables in research into psychopathology: researchers could abandon the attempt to classify psychotic illness (at least for the time being) and make the actual phenomena they encounter in the clinic, that is to say particular types of complaints or behaviours (usually described as 'symptoms') the focus of their efforts. For example, investigators might study hallucinations, delusions, disordered discourse, flat affect, or any other symptom."<sup>30</sup>

## CONTEMPORARY CLASSIFICATIONS

Given these considerable problems, it is not surprising that the validity and reliability of both past and contemporary classifications of mental disorder has always been a matter of dispute. In particular, Menninger reviewed and listed many classifications spanning 2500 years and was dismissive of the usefulness and validity of the exercise.<sup>31</sup> Although syndromes such as schizophrenia and depression are still widely used, most attempts to create coherent links between clinical symptoms, causal factors, and prognostic types have failed.<sup>32</sup> Consequently, contemporary classifications vary both with regard to the types of mental disorder considered to be distinct entities and, when this can be agreed, their respective

<sup>28</sup> Sir W. Osler, *Medical education in Counsels and Ideals* (Houghton Mifflin, 2nd ed., 1921).

<sup>29</sup> G.W. Bradley, *Disease, Diagnosis and Decisions* (John Wiley & Sons, 1993), p.20.

<sup>30</sup> R.P. Bentall, "The classification of schizophrenia," *supra*, p.34.

<sup>31</sup> K. Menninger, *The vital balance: the life process in mental health and illness* (Viking Press, 1963).

<sup>32</sup> N. Sartorius, in *Sources and Traditions of Classification in Psychiatry* (ed. N. Sartorius, et al., World Health Organisation/Hogrefe & Huber, 1990), p.2.

hallmarks. Providing two or three competing classifications are being used appropriately, Kendell has emphasised that one must simply concede that the alternative definitions embrace different populations and examine which of the competing definitions most successfully meets some criterion like homogeneity of outcome or treatment response. This is because, in the last resort, "all diagnostic concepts stand or fall by the strength of the prognostic and therapeutic implications they embody. The ability to predict the outcome of an illness, and to alter this course of events if need be, have always been the main functions of medicine."<sup>33</sup> Unfortunately, although a diagnosis should provide therapeutic and prognostic indicators, these are often relatively weak in psychiatry<sup>34</sup> and "the existing evidence for the validity of most psychiatric disorders is rather meagre, but by no means non-existent."<sup>35</sup>

## THE ICD-10 CLASSIFICATION

The classification of mental disorders in official usage in England and Wales is the World Health Organisation's International Classification of Diseases and, more particularly, that part of it dealing with mental and behavioural disorders.<sup>36</sup> The tenth revision (ICD-10), published in 1992, took nine years to prepare and included field trials using the draft text in 194 different countries, after which further revisions were made. The *ICD-10 Classification of Mental and Behavioural Disorders* (the "Blue Book") contains clinical descriptions and diagnostic guidelines for the disorders listed within it.<sup>37</sup> In the tenth revision, the previous distinction between the psychoses and neuroses has been laid aside and all mood disorders are now in a single grouping. Inevitably, the classification reflects "compromises between scientists with the most influential theories and the practice of senior clinicians at national and international level."<sup>38</sup> The classification is not entirely coherent because of the tendency for each class to expand in order to incorporate alternative and sometimes incompatible concepts.<sup>39</sup> Nevertheless, its international status and the need to conduct research according to a common set of guidelines means that there is a mutual obligation to use it.<sup>40</sup>

## Format of ICD-10

The classification is divided into major groups ("blocks") of mental disorders. Within these blocks, each type and sub-type of mental disorder is separately listed and coded. Thus, one block is concerned with schizophrenia and similar disorders (Block F20-F29). Schizophrenia is given the code F20 and a further digit is used to record its various sub-types, such as paranoid schizophrenia (F20.0) and catatonic schizophrenia (F20.2).

<sup>33</sup> R.E. Kendell, "Diagnosis and classification" in *Comparison to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.290.

<sup>34</sup> J.M. Pfeffer and G. Waldron, *Psychiatric Differential Diagnoses* (Churchill Livingstone, 1987), p.4.

<sup>35</sup> R.E. Kendell, "Diagnosis and classification," *supra*, p.291.

<sup>36</sup> The sixth revision (ICD-6), published in 1948, was the first to include a classification of mental disorders (Section V: "Mental, Psychoneurotic and Personality Disorders"), although it was primarily a classification of psychoses and mental deficiency. The sixth revision and the subsequent (expanded) revisions have all been adopted by the Government.

<sup>37</sup> There is also a separate book containing diagnostic criteria for research (The "Green Book").

<sup>38</sup> I.K. Wing, "Differential diagnosis of schizophrenia" in *Schizophrenia — An overview and practical handbook* (ed. D.J. Kavanagh, Chapman & Hall, 1992), p.17.

<sup>39</sup> R.E. Kendell, "Diagnosis and classification," *supra*, p.287.

<sup>40</sup> R.E. Kendell, "Diagnosis and classification," *supra*, p.196.



## THE ICD-10 CLASSIFICATION — LIST OF CATEGORIES

<i>Code</i>	<i>Block (major group)</i>	<i>Examples of disorders in block</i>
<b>F00-F09</b>	<b>Organic mental disorders</b>	<ul style="list-style-type: none"> <li>Alzheimer's disease</li> <li>Pick's disease</li> <li>Creutzfeldt-Jakob disease</li> <li>Parkinson's disease</li> <li>dementia, delirium.</li> <li>due to alcohol</li> <li>due to opioids, cocaine, etc.</li> </ul>
<b>F10-F19</b>	<b>Mental and behavioural disorders due to psychoactive substance use</b>	
<b>F20-F29</b>	<b>Schizophrenia, schizotypal and delusional disorders</b>	<ul style="list-style-type: none"> <li>schizophrenia</li> <li>schizotypal disorder</li> <li>persistent delusional disorders</li> <li>schizoaffective disorders.</li> </ul>
<b>F30-F39</b>	<b>Mood (affective) disorders</b>	<ul style="list-style-type: none"> <li>manic episode</li> <li>bipolar affective disorder</li> <li>depressive episode</li> </ul>
<b>F40-F48</b>	<b>Neurotic, stress-related and somatoform disorders</b>	<ul style="list-style-type: none"> <li>hypochondriacal disorder</li> <li>phobic and anxiety disorders</li> <li>obsessive-compulsive disorder</li> </ul>
<b>F50-F59</b>	<b>Behavioural syndromes associated with physiological disturbances and physical factors</b>	<ul style="list-style-type: none"> <li>Eating disorders</li> <li>sleep disorders</li> <li>premature ejaculation</li> </ul>
<b>F60-F69</b>	<b>Disorders of adult personality and behaviour</b>	<ul style="list-style-type: none"> <li>personality disorders</li> <li>habit and impulse disorders</li> <li>transsexualism, fetishism</li> </ul>
<b>F70-F79</b>	<b>Mental retardation</b>	<ul style="list-style-type: none"> <li>mental retardation</li> </ul>
<b>F80-F89</b>	<b>Disorders of psychological development</b>	<ul style="list-style-type: none"> <li>childhood autism</li> <li>specific spelling disorder</li> </ul>
<b>F90-F98</b>	<b>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence</b>	<ul style="list-style-type: none"> <li>hyperkinetic disorders</li> <li>conduct disorders</li> <li>tics</li> </ul>
<b>F99</b>	<b>Unspecified mental disorder</b>	<ul style="list-style-type: none"> <li>not applicable</li> </ul>

### Operational definitions (diagnostic guidelines)

It has previously been noted that almost every symptom in psychiatry is capable of occurring in conjunction with almost any other symptom. Thus, for example, symptoms such as elation, flight of ideas and grandiose ideas are quite common in both schizophrenia and mania. Operational definitions (also known as diagnostic

guidelines or criteria) are therefore used to specify which combinations of symptoms are adequate to substantiate a diagnosis. They define what a clinician means when he uses the term "schizophrenia" or "mania" and represent an attempt to standardise clinical practice and understanding. The introduction to the blue book contains the following notes on the diagnostic guidelines set out in the ICD-10 classification—

"When the requirements laid down in the diagnostic guidelines are clearly fulfilled, the diagnosis can be regarded as 'confident'. When the requirements are only partially fulfilled, it is nevertheless useful to record a diagnosis for most purposes. It is then for the diagnostician and other users of the diagnostic statements to decide whether to record the lesser degrees of confidence (such as 'provisional' if more information is yet to come, or 'tentative' if more information is unlikely to become available) that are implied in these circumstances. Statements about the duration of symptoms are also intended as general guidelines rather than strict requirements; clinicians should use their own judgement about the appropriateness of choosing diagnoses when the duration of particular symptoms is slightly longer or shorter than that specified ...

These descriptions and guidelines ... are simply a set of symptoms and comments that have been agreed, by a large number of advisors and consultants in many different countries, to be a reasonable basis for defining the limits of categories in the classification of mental disorders.<sup>141</sup>

### THE DSM-IV CLASSIFICATION

The other main international classification of psychiatric disorders is the *Diagnostic and Statistical Manual of Mental Disorders* produced by the American Psychiatric Association, the fourth revision of which (DSM-IV) was published in 1994.<sup>42</sup> This classification is occasionally referred to in the text.

#### Format of DSM-IV

The classification describes the manifestations of the various mental disorders delineated within it and diagnostic criteria are provided for each of them. Epidemiological data is given for each disorder and differential diagnoses where appropriate. The most distinctive feature of the classification is that it is a "multi-axial" system containing five different axes—

- Axis 1 is used to record clinical conditions which may be the focus of medical attention, such as schizophrenia and mood disorders.
- Axis 2 consists of mental retardation and personality disorders, e.g. paranoid personality disorder.
- Axis 3 lists any physical disorder or general medical condition that is present in addition to the mental disorder, e.g. an endocrine disorder.

<sup>41</sup> *Classification of Mental and Behavioural Disorders, Tenth Revision (ICD-10): Clinical Descriptions and Diagnostic Guidelines* (World Health Organisation, 1992), p.2.

<sup>42</sup> DSM-I was published in 1952, DSM-II in 1968, DSM-III in 1980, and a revised edition of the latter (DSM-III-R) in 1987.

- Axis 4 is used to record psychological, social and environmental problems which have significantly contributed to the development of the current mental disorder or exacerbated it, e.g. "housing problems" and "problems with access to health care services."

- Axis 5 comprises the global assessment of functioning scale (GAF Scale), which is used to record the clinician's judgement of the patient's overall functioning during a particular period of time. The patient is rated on a 0-100 scale, with 100 representing superior functioning and 10 "persistent danger of severely hurting self or others" (222). Because the GAF scale provides a standard scale for gauging the risks associated with a patient's mental state, it is an extremely useful tool in practice.

Because it is not merely a diagnostic tool, the DSM-IV classification is in many respects superior to the ICD-10 classification. It allows for a more comprehensive recording of the main features of each case: underlying intellectual and personality problems; physical disorders possibly contributing to the mental disorder; contributory social problems; and the effect of the mental disorder on the patient's functioning.

#### OTHER CLASSIFICATIONS

It must be emphasised that the ICD-10 and DSM-IV classifications, and the diagnostic guidelines which form part of them, are but two of many medical classifications of mental disorder. For conditions such as schizophrenia, none of the competing definitions can be said to be right or wrong since there is as yet no external criterion of validity. It is impossible to decide which is the most valid because this would involve determining which of several different ways of defining the syndrome of schizophrenia most accurately picks out patients possessing an underlying abnormality which has yet to be identified.<sup>43</sup> Although a core of typical patients meet all definitions, there are significant differences in the populations of patients covered by each of them. Each operational definition generates different values for the incidence of a disorder, its heritability, its responsiveness to therapeutic agents, and its prognosis. The concordance between the different sets of operational criteria for conditions such as schizophrenia is "not impressive; in other words the different criteria tend to diagnose different people as schizophrenic."<sup>44</sup> Consequently, it is important to realise that a patient who meets the somewhat inclusive criteria for a diagnosis of schizophrenia in the ICD-10 classification may not satisfy the more tightly-drawn operational criteria of another classification. These observations similarly apply to other kinds of mental disorder.

<sup>43</sup> R.E. Kendell, "Schizophrenia: A Medical View of a Medical Concept" in *What is Schizophrenia?* (ed. W.F. Flack *et al.*, Springer-Verlag, 1990), p.63.

<sup>44</sup> R.P. Benall, "The classification of schizophrenia" in *Schizophrenia — An overview and practical handbook* (ed. D.J. Kavanagh, Chapman & Hall, 1992), p.25; I.F. Brockington, *et al.*, "Definitions of schizophrenia: Concordance and prediction of outcome" *Psychol. Med.* (1978) 8, 399-412.

## DIAGNOSIS

Diagnosis forms part of the assessment process and, in general usage, the term refers to the process of identifying the specific mental disorder from which the patient suffers.<sup>45</sup> For example, the diagnosis may be that the patient suffers from schizophrenia or, more specifically, from a form of schizophrenia known by the label "hebephrenic schizophrenia." A diagnosis is therefore a "short-hand way of describing what is wrong with the patient"<sup>46</sup> and reaching a diagnosis involves recognising a particular disorder from its signs and symptoms so that, having identified it, conclusions can be reached about its causes, probable course, and treatment. The diagnostic process thus consists of categorising problems in order to solve or ameliorate them using appropriate techniques and skills. The aim of the process is to reduce clinical uncertainty because the diagnosis indicates what the individual patient holds in common with previous patients and so "suggests that a successful treatment plan used for somebody else with the same diagnosis may well lead to benefit."<sup>47</sup> Nevertheless, the diagnostic methods used by different clinicians are not always comparable so that a patient's diagnosis but not his condition may change over time. This is because diagnoses are subject to therapeutic fashions and innovations and depend upon the classification and operational criteria being used.<sup>48</sup> While diagnosing a condition has benefits in terms of communication and research, there is "no very great value in attaching a label to a patient's complaint if exactly the same course of treatment would have been carried out whatever the label,"<sup>49</sup> unless it has a predictive value. The importance of making a diagnosis lies in the fact that it is a recipe for action and a predictor of outcome, rational treatment and prognosis requiring a firm working diagnosis.<sup>50</sup> Inappropriate reassurance, unnecessary treatment and compulsion, and the dissemination of gloom are penalties to be paid for taking too lax an approach to the diagnostic process.<sup>51</sup>

#### VALIDITY AND RELIABILITY OF THE DIAGNOSIS

The validity of a diagnosis depends on the validity of the classification and operational criteria upon which it is founded and the reliability of the diagnostic process itself. It has already been noted that the validity of diagnoses such as schizophrenia cannot be conclusively demonstrated. Such disorders are hypothetical constructs. While different diagnoses may arise because examiners have different concepts and use different operational definitions, "most psychiatric diagnoses can never be confirmed or refuted, for there is no external criterion to appeal to."<sup>52</sup> Providing a classification is used appropriately, it must ultimately be conceded that it embraces a different population of patients than do other competing operational criteria. Reliability refers to the consistency with which subjects are discriminated from one another; in this context, the extent to which different diagnosticians will agree on a

<sup>45</sup> Some psychiatrists, however, use the term more broadly to refer to a comprehensive evaluation that is not limited to identification of specific disorders.

<sup>46</sup> I.M. Pfeffer and G. Waldron, *Psychiatric Differential Diagnoses* (Churchill Livingstone, 1987).

<sup>47</sup> A. Sims and D. Owens, *Psychiatry* (Baillière Tindall, 6th ed., 1993), p.8.

<sup>48</sup> These operational criteria may be implicit rather than explicit, as where a doctor applies the diagnostic methods imbued in him during his training or makes diagnostic decisions based on personal experience but without ever analysing the basis of the distinctions on which his practice is based.

<sup>49</sup> A. Sims, *Symptoms in the Mind* (Baillière Tindall, 1988).

<sup>50</sup> G.W. Bradney, *Disease, Diagnosis and Decisions* (John Wiley & Sons, 1993), p.50.

<sup>51</sup> *Ibid.*

<sup>52</sup> R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.279.



diagnosis for a given patient. Reliability is therefore a means to an end, rather than an end in itself, and its importance lies in the fact that it establishes a ceiling for validity. The lower it is the lower the validity necessarily becomes.<sup>53</sup> However, the converse is not also true. If the operational criteria applied do not constitute a valid delineation of the disease or disorder in question, reliability can be high while validity remains trivial — in which case, high reliability is of little value.

### The reliability of diagnoses

Reliability is usually measured in one of two ways. Either a diagnostic interview is watched by a passive observer who makes his own independent diagnosis at the end (observer method) or a second diagnostician conducts an independent interview with the patient a few hours or days later (reinterview method). The observer method over-estimates reliability because all variation in the conduct of the interview is eliminated. The reinterview method, which in essence is the method used by the tribunal's medical member or a psychiatrist instructed on the patient's behalf, may underestimate reliability because of the time lag and the fact that the patient has practised or thought about his answers. Thus, in one study, there was less than a 50 per cent chance of a psychiatrist who interviewed a patient some days after a colleague agreeing that a symptom was present.<sup>54</sup> A considerable amount of research has been conducted into the reliability of patients' diagnoses and the findings have generally not been encouraging. Necessarily, a correct diagnosis may not be made when clinical findings are inaccurate. Most studies suggest that agreement about the presence or absence of physical signs is not very good, much of the agreement being due simply to chance. While a study by Beck showed that only 54 per cent of specialists agreed about diagnosis, Kendell notes that organic and psychotic disorders generally have higher reliability than neuroses and personality disorders. That being so, reliability studies based on in-patients tend to produce higher overall reliability than those based on out-patients. In the latter case, the frequency of neurotic symptoms and maladaptive personality traits in the general population means that quantitative as well as merely qualitative judgements are involved.<sup>55</sup>

### Factors affecting the reliability of the diagnosis

There are various reasons for the low reliability of the diagnostic process, some of which reflect the imperfect operation of the assumption that symptoms elicited are present and those not elicited are absent. Bradley and Kendell have summarised the main research findings and the main areas of weakness relate to the collection, interpretation and judging of information<sup>56</sup>:

- Different diagnoses may simply reflect that fact that clinicians have different concepts and use different operational criteria. Because few psychiatric illnesses have pathognomonic symptoms, most conditions have to be defined by the presence of some or most of a group of symptoms rather than by the presence of one key symptom. This "invites ambiguity and lowers reliability still further unless operational definitions are adopted."<sup>57</sup>

<sup>53</sup> R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.290.

<sup>54</sup> N. Kreitman, et al., "The reliability of psychiatric assessment: an analysis" *Journal of Mental Science* (1961) 107: 887-908.

<sup>55</sup> R.E. Kendell, "Diagnosis and classification," *supra*, p.290.

<sup>56</sup> G.W. Bradley, *Disease, Diagnosis and Decisions* (John Wiley & Sons, 1993).

<sup>57</sup> R.E. Kendell, "Diagnosis and classification," *supra*, p.279.

- In other cases, the patient's condition may not conform to the tidy, stereotyped descriptions found in textbooks. When patients possess some but not all of the characteristic features of two or three different diagnostic categories, disagreements and the use of hybrid terms will necessarily be quite common. Although the use of operational definitions increases reliability and makes clear the concepts underpinning the diagnosis, their use varies in practice. The diagnostic criteria applied are often implicit rather than explicit and the clinician may fail to scrutinise or specify the assumed relationship between the symptoms and diagnosis.

- Although structured interviews are generally unsuitable for ordinary clinical purposes, because they do not permit a rapid focusing on the patient's main difficulties, the free-ranging, unstructured, interviews used by clinicians are nevertheless less reliable — and, in consequence, they are no longer used for research purposes.<sup>58</sup> While many of the principles involved in conducting a non-structured interview are "simple enough, even self-evident, ... this does not stop them being flouted even by experienced clinicians who ought to know better."<sup>59</sup>

- Unstructured interviews being relatively subjective, behavioural differences between interviewers account for much of the observed unreliability. A patient may give different accounts to different interviewers, partly because of the way questions are asked. Different interviewers pose different questions, show interest and probe in different places and establish different kinds of relationships with patients. The doctor's perception of the likelihood of a certain diagnosis in his practice (the "prior probability") may affect the information sought so that other information of crucial importance is overlooked. Such preconceptions, in terms of their expectations of finding different symptoms, are reflected both in the wording of questions and the interpretation of ambiguous replies. Fixing on a diagnosis at an early stage may similarly lead to a premature closure of options. Conceptual differences, involving the different usage of words such as anxiety or delusion and the extent to which a graded characteristic had to be evident to be recorded as present, can also affect the symptoms recorded and hence the diagnosis reached.<sup>60</sup>

- The importance attached to information may be inappropriate in several circumstances with a failure to attach correct weights to cues. Cues discovered early on in an interview have been found to be given more emphasis in coming to a diagnosis than the same cues given later on in the examination.

- There is also a natural tendency to overemphasise positive findings when a negative finding may contain just as much information. This reflects a natural human preference for evidence that proves rather than disproves a hypothesis. Similarly, normal findings tend to be ignored when judging the effect of a test on the likelihood of disease. Although a negative test should

<sup>58</sup> R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.281.

<sup>59</sup> *Ibid.*, p.280.

<sup>60</sup> *Ibid.*, pp.278-279.

have the effect of making the diagnosis less likely, the clinician often ignores this evidence.<sup>61</sup>

- Even if no inappropriate emphasis is placed on particular clinical findings, a clinician's inexperience may nevertheless result in failure to consider the correct diagnosis in the first place.
- Conversely, clinical experience may occasionally be disadvantageous. While analytical methods are slower but potentially more accurate, particularly for the complicated cases, the doctor who is experienced in the task in hand is more likely to use intuitive methods with a resulting advantage in speed. Nevertheless, "it is as well to remember that whilst experience can be the mainstay of diagnostic skill, overreliance on it can lead to nothing more than making the same mistake with increasing confidence."<sup>62</sup>

### DISADVANTAGES OF DIAGNOSIS

Kendell has summarised some of the main disadvantages involved in giving a patient a diagnosis.<sup>63</sup> In the first place, most psychiatric diagnoses have pejorative connotations. A diagnosis of schizophrenia or psychopathic disorder may have a particularly harmful effect on the patient's self-esteem and the attitude and behaviour of others towards him. Secondly, attaching a name to a condition may create a spurious impression of understanding. However, to say that a person has schizophrenia "actually says little more than that he has some puzzling but familiar symptoms which have often been encountered before in other patients."<sup>64</sup> Thirdly, all too often doctors reify the diagnostic concept and treat the "disease" instead of trying to relieve their patient's symptoms, anxieties and disabilities.

### DIAGNOSTIC FORMULATIONS

A diagnostic formulation is not the same thing as a diagnosis. For the reasons given, a diagnosis may be an inadequate means of conveying what the clinician regards as the essence of the patient's predicament — why he broke down, in that particular way, at that particular time. A diagnostic formulation involves considering and then specifying these important elements of the case in a short account. Formulation and diagnosis are equally necessary, but for quite different purposes — "... the idea that a diagnosis can, or should, be replaced by a formulation is based on a fundamental misunderstanding of the nature of both. A formulation which takes account of the unique features of the patient and his environment, and the interaction between them, is often essential for any real understanding of his predicament, and for planning effective treatment, but it is unusable in any situation in which populations or groups of patients need to be considered."<sup>65</sup>

<sup>61</sup> G.A. Gorry, *et al.*, "The diagnostic importance of the normal finding" *New England Journal of Medicine* (1978) 298: 486-489; G.W. Bradley, *Disease, Diagnosis and Decisions* (John Wiley & Sons, 1993), p.55. Indeed, it is of fundamental importance in tribunal proceedings to establish and list all of the operational criteria which are not present in the particular case. All too often, a long interview is summarised in two lines stating that features *a* and *b* were elicited during examination, while the fact that features *c* to *m* were not elicited is implied but goes unrecorded.

<sup>62</sup> G.W. Bradley, *Disease, Diagnosis and Decisions* (*supra*), p.68.

<sup>63</sup> R.E. Kendell, "Diagnosis and classification" in *Companion to psychiatric studies* (ed. R.E. Kendell & A.K. Zealley, Churchill Livingstone, 1993), p.278.

<sup>64</sup> *Ibid.*

<sup>65</sup> *Ibid.*, p.277.

## 20. Treatment and outcome

### INTRODUCTION

It has been noted that assessment is the process of collecting information relevant to the diagnosis, management, and treatment of a patient's clinical condition. The recording of a patient's symptoms, and the conduct of any special investigations, is initially undertaken to identify the type of disorder from which the patient suffers. A diagnosis is a short-hand way of describing what is wrong with a patient and it involves assigning the patient's case to a particular known class, such as schizophrenia, by reference to an accepted classification of mental disorders. Conclusions can then be reached about the causes, probable course, and treatment of the condition in question. All diagnostic concepts ultimately stand or fall by the strength of the prognostic and therapeutic implications they embody. However, while a diagnosis should provide therapeutic and prognostic indicators, in psychiatry these are often relatively weak.

Aetiology Pathology Symptoms Diagnosis Prognosis Treatment Outcome →

It is therefore assumed that each disease has a certain natural course although this can sometimes be interfered with by treatment. Consequently, the diagnosis of a particular disease enables the clinician to choose an appropriate form of treatment and to make an assessment of the likely outcome (a prognosis). The actual outcome may differ from that prognosed. Various terms are used to describe the consequences of an illness in terms of the individual's ability to carry out his normal activities (*e.g.* disability and handicap) and the effect which treatment, including the body's own treatments, has on the underlying disease process (*e.g.* remission).

### PREDICTING THE COURSE AND OUTCOME

A prognosis is a medical assessment of the probable course and outcome of a patient's condition. Certain disorders have been found to have a natural course and outcome and to respond best to certain treatments. By noting the timing of critical events for each patient with a particular disease — for example, dates of diagnosis, the development of further manifestations, and death — its progression can be subdivided into phases. When summarised over many patients, estimates of the typical sequence of events, the "natural history" of the illness, can be constructed.<sup>1</sup>

<sup>1</sup> R.S. Greenberg, *Medical Epidemiology* (Appleton and Lange, 1993), p.7.