

Psychodiagnosis: Origins & Current Trends

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(Disclosure: I worked fulltime in a clinical psychological practice for 20 years and formed my legal nurse consulting practice in 2006. As a patient advocate interfacing with physicians, case managers and attorneys, insurance reimbursement was once 5% of one day a week; now it is closer to 20% of any given day. Personal experience flavors objectivity in all of us.)

During the past month, the news has informed the public of what mental health professionals have long been aware: the diagnosis of mental disorders is inexact, and treatment often proceeds without a known etiology. In the real world of patient care, clinicians measure success in terms of empirical progress; has my patient improved, plateaued, or worsened? The answer is derived by objective observation and the patient's self-reporting. But even objective observation contains an element of subjectivity, accounting for the diagnostic variability among clinicians examining the same patient.

Attempting to define a common standard by which to measure psychopathology, clinicians have relied upon the DSM-IV TR manual to find the disorder(s) that most closely match not just one, but a cluster of symptoms. Diagnosis proceeds along a continuum of severity and never does a diagnosis completely fit all criteria. The clinical diagnosis is based upon observable behavior; later, psychotherapy addresses causation. In a medical setting, treating a symptom without diagnostic clarity can result in a medical malpractice claim. A headache is not a diagnosis; it is a symptom.

The ambiguity in psychodiagnosis and the lack of progress in understanding disorders like schizophrenia has led to a fundamental chasm in the mental health field. The gap between biochemical and biopsychosocial derivations of mental disorder is wider than at any time in recent history. One factor driving the division is that of financial reimbursement of ICD codes and funding of drug research.

Insurance and Pharmaceutical Influences in Diagnosis

The International Classification of Diseases' (ICD) diagnostic codes govern the reimbursement of all care. Insurance companies require ICD-9 (and 10) codes from the DSM-IV-TR before they will authorize the evaluation or treatment of any mental disorder. Psychologists and psychiatrists must choose a code that most closely matches the symptoms. A depressive episode is coded and further refined by duration, intensity of symptoms, single episode vs recurrent, and weighed against alternative diagnoses. The accuracy of diagnosis is largely dependent upon honest and complete disclosure from the patient.

But diagnoses fall in and out of favor; in favor they are overly utilized and can result in excessive labeling. Such labels facilitate insurance reimbursement and garner the attention of pharmaceutical companies. Recall when Ritalin was the only drug for ADHD replete with side effects and adverse reactions. Pharmaceutical companies took notice and funded extensive studies and trials that resulted in more targeted drug regimens. More funding and medication options in turn resulted in more ADHD diagnoses. And so on.

While several mental disorders do benefit from appropriate medication, there is increasing concern for the polypharmacy of patients who would better benefit from fewer agents. The correlation between pharmaceutical funding and clinical research/recommendation has not gone unnoticed.

(Note: this excerpt refers to the DSM-IV-TR but the same accusations are directed at the DSM-V)

“Of the 170 DSM panel members 95 (56%) had one or more financial associations with companies in the pharmaceutical industry. One hundred percent of the members of the panels on ‘Mood Disorders’ and ‘Schizophrenia and Other Psychotic Disorders’ had financial ties to drug companies...there are strong financial ties between the industry and those who are responsible for developing and modifying the diagnostic criteria for mental illness. The connections are especially strong in those diagnostic areas where drugs are the first line of treatment for mental disorders.”¹

The Diagnostic and Statistical Manual

Mental health’s version of the Standard Nomenclature of Disease is the Diagnostic and Statistical Manual, and in 1952, the first DSM was published:

- 1952 DSM-I; medical disorders were “reactions” and psychoanalytic terminology prevailed with recognition of 60 diagnoses
- 1968 DSM-II; the term “reaction” was removed and the number of diagnoses had grown to 145
- 1980 DSM-III; a shift to a theoretical medical model with 230 diagnoses and multiple axes
- 1987 DSM-III-R; >230 diagnoses and modifications
- 1994 DSM-IV; 361 diagnoses, more empirically based with revisions in Axes II (personality) and IV (psychosocial stressors)²
- 2000 DSM-IV-TR (text revision) to update to ICD-9 codes, clarify ambiguities and reflect new information about biopsychosocial influences
- 2013 DSM-V; ICD-10 codification

The DSM considers psychopathology, personality and environment in its classification system and is often referred to as the “bible” of mental disorders. By 1994, what began as a thin little book was a reference manual suitable for wielding as a weapon. The purpose of the DSM is to classify mental disorders and provide the criteria by which diagnoses can be made.

In 1994 in an attempt at specificity, the DSM-IV included the addition of ~130 new diagnoses that many clinicians felt added to the confusion. In 2000, the DSM-IV-TR introduced a biopsychosocial approach to diagnosis with five specific axes. The pattern of symptoms, signs and behaviors determined the diagnosis and its severity but not the etiology. The purpose of multiple axes was to differentiate

¹Cosgrove, Krinsky, Vijayaraghavan & Schneider, *Financial Ties between DSM-IV Panel Members and the Pharmaceutical Industry*, *Psychotherapy and psychosomatics* 2006;75:154-160

² <http://facstaff.gpc.edu/~bbrown/psyc2621/ch3/dsmhistory.htm>

between types of disorders and to assess the cumulative impact of the medical, social and environmental factors upon an individual.

- Axis I relates to Clinical Disorders, which include all forms of depression (severity and recurrence), anxiety and mood disorders, PTSD, schizophrenia and psychoses. Think of these as disorders that can be acute or chronic, biologic or reactive, but generally responsive to psychotherapy alone or in combination with medication.
- Axis II reflects Personality Disorders, or features and traits that are lifelong characteristics that often interfere with daily functioning, relationships, and adaptability. Depending upon the patient's insight and motivation, these traits are addressed via a range of psychotherapeutic approaches, either alone or in combination. Examples include Dependent, Avoidant, Obsessive-Compulsive and Narcissistic Personality Disorders. The most commonly used diagnosis is 301.9 – Personality Disorder NOS with (fill in the blank) Features when more than one trait is problematic. An IQ that falls below a certain threshold is also listed under Axis II.
- Axis III lists the physical conditions present in the individual, and these are particularly pertinent to patients with chronic pain, injury or serious illness.
- Axis IV outlines the psychosocial factors such as family dynamics, housing, occupation and finance that are affecting, or affected by, the individual.
- Axis V measures the Global Assessment of Functioning (GAF), a numerical scale that assesses an individual's ability to function in all areas of life, based upon the combination of Axes I-IV.

The DSM-IV-TR vs the DSM-V

Since its inception in 1952 and throughout its revisions, the accuracy and validity of the Diagnostic Statistical Manual (DSM) for classification of psychological symptoms has been challenged. Dr. Allen J. Frances, Professor Emeritus at Duke University, chaired the DSM-IV-TR task force (year 2000 Text Revision) and publicly objects to the impending release of the DSM-V.

An active blogger for the Huffington Post, he urges clinicians to ignore it's changes altogether, asserting that the new version is vaguer than ever and will lead to labeling healthy individuals with its lowered threshold for criteria. In one of his blogs he states that the DSM-V is "offering its untested new diagnoses that will mislabel millions of the worried well as mentally ill".³ Parents of autistic children have the opposite concern, that their child will no longer fit in that diagnostic category and be denied access to medication and therapy.

Frances states that the DSM-V offers no leeway in differentiating, for instance, alcohol addiction vs dependence vs social use. The manual's authors counter that early recognition will result in early intervention, but many practicing clinicians fear that the endpoint will be over-diagnosis that misidentifies normal variations in behavior.

³ http://www.huffingtonpost.com/allen-frances/dsm-5-mental-health_b_3262458.html

The National Institute of Mental Health (NIMH)

On July 3, 1946, President Harry Truman signed the National Mental Health Act, which called for the establishment of a National Institute of Mental Health (NIMH). The process of diagnosing without etiology is the fundamental distinction between the DSM's function and the conceptual model now proposed by the National Institute of Mental Health.

NIMH rejects all DSM versions and is devoting its considerable financial and scientific resources to the premise that all psychological conditions are biologic or chemical in nature, originating in specific regions of the brain, and thus amenable to medical intervention. The stakes are significant - for insurance reimbursement, financial grants for research, pharmaceutical financing, and one hopes, the well-being of patients.

Citing the difficulty in properly diagnosing mental health disorders when forced to choose an ICD code, in 2008 NIMH implemented its Strategic Plan, a diagnostic process using Research Domain Criteria (RDoc).

This plan utilizes a matrix of Constructs (rows) that are grouped into five Domains of Functioning, and seven classes of Variables (columns) with an eighth column for paradigms. The goal is to classify mental disorders along a continuum of biologic and genetic markers, neurological circuitry and specific regions of the brain. The attempt is not to diagnose a mental disorder by looking at the overall patient presentation, but to find one symptom that is present across a variety of disorders, eventually pinpointing the physical location of the symptom. This intersection would identify the origins of disease, and science (psychopharmacology) would intervene to avert mental disorder. This theory ignores the empirical research on the greater efficacy of "talking therapies" either alone or in combination with psychopharmacology, and even NIMH agrees that this lengthy research offers no immediate relief to patients.

Opponents to RDoc fear that severe illness (schizophrenia, bipolar disorder) may go untreated if the affected individual does not express a specific gene. They question the validity of research that is conducted solely in laboratories and does not involve practitioners in the field. NIMH counters that RDoc is an open document for which they have sought input from the medical community.

The term "Ivory Tower" designates an environment or atmosphere where intellectuals engage in pursuits that are disconnected from the practical concerns of everyday life"⁴. The last sentence in the first paragraph of Draft 3.1: June, 2011 states that one of RDoc's goals is "...to facilitate commentary from scientists and other interested stakeholders..." Should there be concern that patients and practicing clinicians are not mentioned in this sentence?

⁴ https://en.wikipedia.org/wiki/Ivory_Tower

Addendum – a Little History

Psychology

The inner workings of the brain have captivated mankind for thousands of years, but the formal study of psychology did not emerge until the late 1880s as an academic discipline for experimental research. In 1886, G. Stanley Hall, Ph.D. opened the first experimental psychology lab in the United States at Johns Hopkins University. The American Psychological Association formed in July 1892 with Dr. Hall as its first president. For many years, psychology was studied in the laboratory with research and experimentation.

The influence of such research cannot be overstated. (Every research student documents their sources in “APA style” but do they know they are following the documentation standards of the *Publication Manual of the American Psychological Association*?)

In 1896, the University of Pennsylvania was the first institution to establish a psychological clinic⁵ and later, the first to shift from experimental to actual patient care. Scientists developed divergent theories of personality and development including Behavioral Theory (Watson and Skinner), Trait Theory (Allport and Cattell), Humanistic Theory (Maslow and Rogers), Cognitive Theory (Kelly and Ellis) and numerous other ideologies. Freud’s Psychoanalytic Theory marked the first major split from a biological perspective and although a psychiatrist, he is often called the Father of Modern Psychology.⁶

Psychiatry

Formal psychiatry developed in the early 1800’s. A politically active physician, Benjamin Rush M.D. published the first psychiatric textbook in the United States in 1812, and is considered the Father of American Psychiatry.⁷ In 1896, Freud and Breuer proposed that deep seated conflict and repressed trauma was the origin of mental illness and “hysteria” and could be resolved using dream analysis. Prior to this there were two psychiatric diagnoses: idiocy (referring to intelligence) and lunacy (any deviation from “normal”).⁸ Freud’s evolving (and titillating for the times) concept of psychosexual theory and arrested sexual development eventually alienated many of his colleagues.

Numerous psychiatric societies formed during the early 1900’s, and the first formally organized association was known as the American-Medico Psychological Association. In 1921 the name was changed to the American Psychiatric Association (commonly known as “little APA”). In 1932, disease classifications (physical and medical) were established in the Standard Nomenclature of Disease.⁹

⁵ <http://psychology.sas.upenn.edu/graduate/resareas/cppp>

⁶ <http://allpsych.com/personalitysynopsis/learning.html>

⁷ <http://www.psychiatry.org/about-apa--psychiatry/more-about-apa/history-of-the-apa>

⁸ Highmore, Anthony, *A treatise of the law of idiocy and lunacy*, Exeter, N.H.: G. Lamson, 1822

⁹ <http://1boringoldman.com/index.php/2011/05/09/depression-1952-dsm>

Soldiers returning from World War II were drowning in the depths of their “shell shock” and research of mental disorders broadened in scope, as did federal funding. With the pursuit of diagnosis, treatment and prevention of mental health, psychiatry broke into numerous small branches.

Realizing that strong unification would allow them to influence the course of public policy, in 2000, the American Psychiatric Association became the umbrella organization for the American Psychiatric Foundation, the American Psychiatric Institute for Research and Education, American Psychiatric Publishing, Inc., and the American Psychiatric Political Action Committee. This alliance came on the heels of an increasing number of psychologists that became licensed for limited prescribing, a treatment modality formerly the sole turf of psychiatry. Additionally, “nearly 80 percent of all prescriptions for antidepressants are written by non-psychiatrist providers, and of those almost three-quarters are not accompanied by any psychiatric diagnosis.”¹⁰

Conclusion

The mind is too complex to be reduced to a series of circuits that are switched on or off with medication or neurostimulation. Neither can every patient benefit from psychotherapy. A medical history includes the health status and diseases of family members; this information is equally important in a psychological evaluation. Genetics does play a strong role in familial disorders like schizophrenia. Comprehensive care will ideally address biologic, chemical and biopsychosocial factors with the same goal: the well-being and proper care of patients.

Epilogue: My copy of the DSM-V came in the mail today. It is a foreign object to me now, but as soon as it starts making some degree of sense, I will share the changes that may have a real impact medically and legally, especially in the area of workers compensation.

¹⁰ <http://psychcentral.com/news/2011/08/08/more-antidepressants-prescribed-by-non-psychiatrists/28423.html>