The science of the mind: investigating mental health
Diagnosis in mental health

Narrator
Professor Neil Frude is a chartered clinical psychologist and a Fellow of the British Psychological Society. His work in clinical practice involves working with patients diagnosed with a variety of mental health problems.

Professor Neil Frude
Obviously one of the things that happens if somebody receives a diagnosis is that that label is something which can have all sorts of implications. It has, for example, a social implication. Generally speaking, to be given a label, which is often a lifetime label, of something like schizophrenia is very stigmatising. There are other diagnoses, however, where people sometimes, well what happens is that it sheds a different light. People often actually quite, are quite relieved that rather than just having an odd set of behaviours that now they have got something which is a diagnosis. An example of that would be the many people who've suffered for decades with Tourette's syndrome, thinking that they were odd themselves, thinking that their behaviour was strange, not having any explanation for it, any label for it, thinking they were unique, often being teased, often you know suffering a great deal from this, who then discover after all that they are one of many people who are, who have a condition which is fairly well understood, which is Tourette's syndrome. Another example indeed would be dyslexia where generations have felt that they're, you know that they're stupid, they can't read, they can't even read and write, they're illiterate and so on, and now the label of dyslexia is one which gives us a different understanding of people where we understand that, you know, people can be very bright indeed but they have a particular and very specific disability which is that of dyslexia, or dysgraphia if they can't draw, or dyscalculia if they can't add up, and so on, so there's a whole generation of those but the notion is that these are specific disabilities and that they certainly don't add up to what, you know, the alternative label which is a playground label rather than a DSM label which is, you know, stupid or thick or whatever it is, so a very different view if you then actually apply dyslexia, dysgraphia, and so on.

Narrator
The Diagnostic and Statistical Manual of Mental Disorders, or DSM, provides standard criteria and a common language for the classification of mental disorders. The fifth edition is due for publication in 2013. Another classification system, International Statistical Classification of Diseases and Related Health Problems or ICD, allows every health condition can be assigned to a unique category. The tenth edition was published in 1992.

Professor Neil Frude
The actual process of diagnosis has changed somewhat over the years in that what the DSM system and ICD have also done is to try and become more reliable, the notion being that if you're reliable you've got a half chance of being valid as well, and the increase in reliability has really been by making criteria more sort of measurable so that, for example, rather than say 'has trouble sleeping', it would be 'has had trouble sleeping for at least three months, at least three days out of the seven each week, on average', you know, it would be, it would be that and the notion is that that increases reliability because, you know, what you mean and I mean by 'has trouble sleeping' might be different, whereas if we counted up in terms of number of nights then we're presumably if we, with the same evidence, we would come to the same conclusion so in, so reliability has increased. I mean some have always been very reliable. If you've got, for example, a hand-washing OCD you know it doesn't really take a lot of hard evidence or reliability studies, or anything like that, you know, you're going to get agreement between people. But there are some labels like Schizoaffective Disorder which overlap with Affective Disorder but also with Schizophrenic Disorder, and it's there you get all

sorts of blurred lines, furry lines and there are difficulties there, so what DSM and so on has tried to do is to raise the reliability and indeed they've done that, because you can measure these things, you can measure you know basically how much agreement is there between clinicians in how they diagnose a hundred random cases, the same people, and we can show that over the years with each version of DSM reliability is increased, and that's not surprising because that's what, that's what gives rise to a new generation of DSM, that's what they're trying to do all the time is to make the system better, and one element of better is that it's more reliable.

Narrator
One problem that clinicians face when making in a diagnosis is personal bias.

Professor Neil Frude
There are all sorts of personal biases, what experiential differences, what you're used to, your own theories, and so on, which could influence the diagnosis that you give.

So for example if we were to take a judgement like 'has difficulty sleeping' well it depends I say guess where you're coming from, if you yourself have no difficulty sleeping and anybody with any difficulty you might be, tick that box, whereas if you were somebody who yourself had great difficulty you'd maybe would think that was the norm and so somebody who says well 'have trouble sleeping' you would sort of shrug and say don't we all, as it were, and you might not tick that box.

It's been suggested that there may be biases that reflect stereotypes, stereotypes of women versus men, for example, of if working class people versus middle class people, and so on, that in other words what you're doing is not simply judging the person but you're judging the person relative to some stereotype that you have and of course ~~people,~~ different people will have different stereotypes and it's clearly not a, as it were, a fair or neutral process to let those stereotypes influence your so-called diagnostic process.

Narrator
In diagnosing any medical condition, it's important to distinguish between signs and symptoms.

Professor Neil Frude
We make a distinction between signs and symptoms, and generally speaking symptoms are what can be shown or what people report, and signs are what you see first hand, for example somebody might be looking as if they're very tired and you say how are you feeling, and they say I'm feeling fine. Now they're reporting that they're feeling fine whereas actually it looks to you as if they're not fine at all, or as if they're sleepy, and so on, so we've got to take into account really all the evidence that we have in terms of, you know doing tests, but generally speaking what we mostly do, certainly with people who are not thought to have neurological problems, is we talk to people and we talk through their clinical history and we ask them how they're feeling, and generally speaking we take at face value what they say, and we do cover biological aspects in terms of, you know, how are you sleeping these days, what's your appetite like, have you lost weight lately, things like that; we look at psychological aspects which is how are you feeling, how are you thinking, and we look at social aspects, how are you getting on at work, how are you getting on in your relationships, and so on and so forth, so we build up a very much a biopsychosocial picture, and where we see issues, problems as it were, then we would obviously drill down further so that if somebody says, for example, that they're really having trouble with their, their eating and so on, then we would go into more detail about that, and what we're trying to do of course is to get as much evidence as we can which will allow us to build up a formulation, and a formulation is an individual picture beyond a diagnosis.

A diagnosis ends with a label in a sense, or a number, a DSM number, whereas what we are doing in a formulation is actually trying to come up with an individual sort of case picture, it's a theory, it's a hypothesis, but it's about what might be important causal factors in the person's condition, what their present condition is, what the effects of various aspects of their life have been, various symptoms, and also with a prognosis about what's likely to occur following this.

Is it something that's likely to spontaneously revert to a sort of normal picture, or is it something that's likely to become ~~more,~~ more serious? And associated with that of course all the time would be a risk assessment. Is this person a risk to themselves mostly but also, you know, maybe they could be a risk to other people as well, so that's another sort of framework that we would be bearing in mind. But it's very much, is drawing upon that biopsychosocial because that really is the only way where you get a sense of completion, and of course it's a holistic picture as well because each one of those elements feeds around to the others, you know that, so that we've got all sorts of circles going on there, sometimes vicious circles that makes things worse and worse and worse, other times virtuous circles, and so on.

Obviously there are cases in which we want very specialist knowledge. An example would be that we really want to have a brain scan on somebody and so we would arrange that a specialist in that technological approach takes our patient that we're involved with in a holistic way, and they supply really just one piece of information and of course we can just look at the biological and the medical sort of aspects of this, what a psychologist would do at the very least would be to think what the impact of that damage or disability is likely to be. Typically we are concerned very much with what a condition stops somebody being able to do, that is the disability that it leads to and also the distress that it's causing, so whereas you can do a biomedical analysis and stop there, without just ignoring as it were the person's social condition, and so on, that really tends not to be very fruitful and I don't think many people would want to do that.

Let me tell you that when I was training, which was a long time ago, there was one particular finding from the local hospital where I was working, a piece of research there which, which absolutely amazed me at the time, it amazes me less now, let me tell you what it was. It was at the Institute of Psychiatry in London where there was a very famous neurosurgeon and, and this neurosurgeon carried out brain surgery at a rate of knots, as it were, and had many, many patients and did lots of research, and looked to see at one stage in one study what predicted good recovery from the brain surgery. And as you can imagine it was partly the size of the tumour that had been removed, let us say, partly it was to do with the age of the person, so it was these sorts of biological, understandable, predictable variables, and then something that came as highly, highly significant – remember this is in recovery from brain surgery – was whether the patient was married or not and that, at that time, you know I thought that's really interesting – how can something like whether you walked up the aisle and signed a piece of paper – how can that possibly affect your, you know, your recovery from brain surgery. It really was crossing that barrier. Now today that I'm a born again biopsychosocial person I have no difficulty in understanding that, but it stood out to me and we're going forty years ago now, it really struck me as very, very odd and I always think these correlations where you get something like that, something which is very social, affecting something which is very biological, like where you get people telling stories of trauma, and that telling of a story actually affects the level of their immune functioning and their immune system, and I just think that's, it's almost like magic, but that's where the biopsychosocial and what it indicates, and this is the whole fascination of the area, is how you know everything is tied to everything, it is holistic, it's like the old thigh bone connected to the knee bone, and it's really every aspect of the system that is, you know is connected to everything else.

Narrator
Even taking this biopsychosocial approach, diagnosis is not always straightforward.

Professor Neil Frude
Clearly there are some cases, some people would come in and they would say something like 'I'm finding that I'm now having to wash my hands twenty times a day, and I check on things, and so on', and I think in cases like that we would have little difficulty in diagnosing in this case OCD. In other cases people come in and we're not absolutely sure. For example, a lot of people go to their GP with aches and pains and it actually turns out, after lots of investigations, and so on, that these people are depressed and that the physical signs and symptoms here are actually signs and symptoms of a predominantly psychological situation. Now sometimes people come in and we're not sure whether maybe it's this or maybe it's that, and what we're always looking for is the sort of acid test, we're looking for the litmus test, as to whether somebody, let's say, has got some physical ailment, which are responsible for the

aches and pains, or whether it's depression, and so we would have a test ideally that would separate out one from the other.

It might be that someone comes along and they have got symptoms which are rather extreme distortions, delusions, hallucinations, and there the issue might well be whether they have got bipolar disorder where we, I mean we normally think of that as the old manic depressive disorder where there's a lot of depression and then in between bouts of depression there are phases of mania where, you know, they lose inhibitions and behave in, you know, anti social perhaps ways, and schizophrenia which comes again in lots of different forms but often there is a problem about which label or which diagnosis to apply, and that obviously is again important in terms of our understanding, in terms of treatment, in terms of care planning because we need to know, we want to know what the likely outcome is going to be and so we would apply. Basically if you look at the criteria in DSM for bipolar and for the various types of schizophrenia then you will find that there are tremendous overlaps, but also there are these differential characteristics, and it's those that you would use then to apply to make a diagnosis. Let me say anyway that all diagnoses really should be considered to be provisional so that, you know, you do sometimes get clinicians who are said to be 'wedded to their diagnosis'. That means that once they've decided that somebody is bipolar there's nothing on earth that's going to persuade them otherwise whereas, you know, there are people who are much more flexible and will take in new evidence and say, 'I guess I was wrong, it looked like bipolar, but now it seems to me the most appropriate diagnosis here would be one of let's say paranoid schizophrenia'.

Narrator
Another problem clinicians face when trying to make an appropriate diagnosis is comorbidity.

Professor Neil Frude
Sometimes people have two or even more conditions at the same time. They're obviously going to interact and sometimes it's rather difficult to disentangle, to find out whether, for example, there is both a depression, let's say, and there is anorexia, or whether maybe what's happened is that this, let's say this young woman has developed anorexia, that has had such an impact on her life and on her relationships that she's now, as a consequence of that, become depressed. Now that would be a very sort of common picture and the question now would be do we consider that to be two conditions: depression and anorexia, or do we consider it to be anorexia with a spin off effect, as it were, down the line, which is depression. Certainly it would be the case that almost anybody with a disabling, distressing condition is likely to be anxious or depressed as a result of that, but in some cases there will be people who have a, as it were, genuine, stand alone depression and also anorexia, and again the way in which we treat that person might be different, I guess, in those two cases.

Obviously when we have the burgeoning of the number of disorders which has happened with the DSM through the various versions of it, it's now DSM4, and with each version it's really the number of sort of disease entities, as it were, has increased so to an extent, because you've got that increased number of recognisable disorders, you would imagine that you're going to get greater comorbidity because somebody who's, let's say depressed, if you scan for all the other possibilities then there's in a sense almost a high chance that they're going to have at least one of the other conditions. To some extent that's offset by the fact that DSM, for example, often will say that if you've got somebody with, let's say with anorexia, who is depressed, then don't count that as stand alone depression as well as anorexia, take into account that this is actually better seen as a symptom of anorexia rather than as a stand alone depressive illness because the main things, depression and anxiety, are both symptoms but they're also types of disorder, and in some cases they're best regarded as symptoms, in other cases they're best regarded as the disorder itself.

Narrator
By taking a holistic, biopsychosocial approach to diagnosis, treatment can tailored specifically to the individual.

Professor Neil Frude
Take for example a case of somebody who had been seen for some time, we'll call him John. John has OCD and he's a checker, he checks, it probably takes him about an extra hour each evening before he goes to bed, checking, you know, the windows and the taps and the electric plugs, and everything, his checking depends entirely on how he's doing at work, whether he's stressed or not, and it's really been interesting that in terms of my treatment, there's sort of treatments for OCD which are sort of cognitive behavioural treatments, and I've been using those and he's taken to them, and he's done his homework, and so on, and we'll be getting somewhere, his checking will be going down. And then what will happen is that there'll be a stressful event at work and, and this has gone on for so long that we now have a metaphor which is, 'it's like the tide comes in and washes away the sandcastles that we've been building', so we're doing good CBT work, we're building up, and so on, we're getting success and then something at work will happen and it completely puts him back to as bad as he ever was before. So we've got to take into account both, you know, I'm sure there is a biological aspect to his OCD as there is to many, if not all, cases of OCD so I'm sure that there is a, you know, there is a chemistry issue there, why he's vulnerable, there might be a genetic vulnerability, etcetera, and so on, so we're not ignoring that, but his outlook on things is very important, what he perceives as stress and so on, and his relationships with the work environment, and particularly with his line manager, so his social relationships are absolutely vital in determining his sort of clinical picture. And in fact what's happening, and what happened for ages, was that all of my and his therapeutic efforts were being completely swamped by social kickbacks, as it were, and in the end my intervention and the one that worked, was actually to write letters to his employers to suggest that certain types of work, which he found very stressful, were in a sense almost poisonous to him in the way in which if you had an allergy to asbestos, aluminium, whatever it is, that you wouldn't be, you should be allowed not to work in those environments, and that actually showed a major improvement. So what that did was to clear the decks so that we could then do the CBT and the sandcastles, as it were, did not get blown down.