THE PROBLEM OF DIAGNOSIS IN PSYCHIATRY—FROM A PSYCHOLOGIST'S STANDPOINT

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It is an interesting experience to watch through one of those clinical conferences, where important decisions are made regarding the patient. Subsequent to the presentation from the psychiatric and the psychodiagnostic angles, ensues the discussion period, which brings forth a variety of alternative diagnoses, (often incompatible) along with justifications for the same. Many a times the confusion does not facilitate to reach a good diagnosis. All this leaves a mind scientifically trained, with a depressive feeling and a reasonable degree of confusion.

The author remembers of an young case recently presented and diagnosed by different Psychiatrists as (1) Pseudoneurotic Schizophrenia, (2) Mixed Neurosis with hysterical features, and (3) Neurotic Depression. As there were few Psychiatrists of countable experience, the alternative diagnoses suggested were also few. Longitudinally, (as was evident from history), the same case had been diagnosed as (1) Anxiety Neurosis, (2) Obsessive-Compulsive Neurosis with agitation and depression. Drugs of various combinations, Largactil, Librium, Eskazene, Tofranil, Melleril, etc. had been tried. A course of E.C.T. had been tried, followed by two Leucotomy operations. None of the treatments had done any good. Interestingly the patient had never received the benefit of Psychotherapy. This case is just one example of many, seen in everyday practice.

Apparently the procedures of diagnostic appraisal need some rethinking and restructuring. Something should be done in this regard to alleviate the less fortunate patient from taking the role of a guinea pig on whom all sorts of things could be tried. The golden concepts like, Positive Mental Health, Therapeutic Community, etc., look devoid of meaning till the more basic issues are not settled.

The point that our diagnostic procedures are in general inadequate is beyond debate. There may be many reasons for this. Psychiatrists try to diagnose Hysteria or Schizophrenia in much the same way as the medical man does with peptic ulcer or Tuberculosis, probably being bound by traditions and training (Eysenck 1960). In the latter case the causal relation of the illness with the noxious agent is fairly established. Moreover the overlap of symptoms in the case of physical disorders is not so pronounced as in the case of mental disorders so that delineation of symptoms and identification of the syndrome becomes easier and accurate. Our knowledge about causal factors is still inadequate.

Another difficulty is that till now we have not been able to know the degree of importance of each symptom to a syndrome. If this had been worked out we

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could have had a measured pattern against which we can match the symptoms observed in a particular case (Cattell 1950). Another obstacle peculiar to our field is that the same patient may simultaneously show symptoms of two or more distinct types of disorder. There is scope for finding remedy for the former but not for the latter.

A third difficulty arises out of the weakness in method adopted for diagnosing. The 'time-honoured' clinical method although could be a potential tool in the hands of skilled clinicians, places an extraordinary premium on unbiased observation and good memory.

A fourth difficulty is that the current classifications of psychiatric disorders itself is not convincing and satisfactory. As Cameron (1944) observes '.. .they are children of practical necessities' and further 'Decisions as to the group in which a given behaviour disorder shall fall depend upon schemata that actually were adopted ... by a majority vote of the practising members of large associations. In some very fundamental respects these systems of classification represent frank compromises between dissident factions, as one can readily observe by reading the successive committee reports'. Such being the case it is not surprising if any two Psychiatrists disagree about a diagnosis. A few studies are worth citing to illustrate the disagreements even among experienced Psychiatrists. Cattell (1957) reports as low a correlation as 0.25 between experienced Psychiatrists on their ratings of the symptom, 'anxiety' in 20 psychiatric patients. An interesting study comes from Page, Landis and Katz (1934), where the agreements of 12 Psychiatrists helped to prepare a list of 50 potential symptoms characteristic of the syndrome schizophrenia. The list when administered to 3 groups, Schizophrenics, Manic Depressives and Normals (matched in other respects) who answered them, the results showed that the average number of symptoms ascribed to themselves were approximately 18, 14 and 18 for the Schizophrenic, Manic Depressive and the Normal groups respectively. All the 3 groups ascribed to themselves 17 of the symptoms about equally often. Surprisingly on II of the items the Normals gave more Schizophrenic responses than the Schizophrenics themselves. The reasons for the above findings may be that the 12 Psychiatrists did not have a common view of what Schizophrenia is or that the patients may not have recognised their own symptoms, etc.

It has also been observed (Guilford 1959) that there is considerable agreement among Psychiatrists when they have to assign patients to very broad classes but the degree of agreement rather falls down when patients are to be classified into more limited categories. And as Guilford warns 'Agreement is only an index of inter-judge consistency and has no necessary implications of validity. Agreement does not necessarily mean that the categories are sound or that the diagnosticians are using them properly.'

A study has been reported from Schmidt and Fodna (1963), where each of 423 patients at Norwich State Hospital was diagnosed independently by a pair or Psychiatrists, employing the nomenclature, 1952 revision of APA's Diagnostic

and Statistical Manual. When classifications of diagnoses into the broad types (1) Organic, (2) Psychotic, and (3) Characterological, was the frame of reference, about four fifths of such classification by one Psychiatrist were confirmed by another. But agreement about diagnoses on the sub-categories occurred only in about half of the cases.

The above discussions substantiate some deficiencies in the area of diagnosis. They may be arising out of unsatisfactoriness of the present system of classification and unsatisfactoriness of the process by which we arrive at a diagnosis. In any case there could be no two opinions about the need for minimising these shortcomings so as to arrive at a correct diagnosis. The fact that diagnosis is related to many other aspects makes it all the more important. Bannister *et al,* (1964) summarise the functions served by Psychiatric diagnosis as (I) Predicting treatment (inclusive of aetiology), (2) Indication of Prognosis, (3) Influencing legal and quasi-legal decisions, (4) Aiding communication, (5) 'Mapping' the field for research purposes, (6) Increasing the confidence of those professionally involved.

The close affiliation of clinical Psychology to Psychiatry would go a long way in the solution of such problems. Now alone in Psychiatry many concepts like Reliability, Validity, etc., have in large measure been transplanted from clinical Psychology. The collaborative findings from the questionnaire method, Behaviour-rating method, the Projective Techniques and Objective Tests give valuable clues towards a diagnosis. This is one of many important contributions of clinical Psychology to Psychiatry.

Of great relevance here would be a brief discussion of the factor-analytic procedures as they help in structuring the pathological concepts enabling us for a more accurate diagnosis. Of late the Eysenckian and Cattellian groups of Psychologists have been putting hard labour in this direction. The novelty of these techniques lies, not only in providing us with a knowledge of the various symptoms going together in a syndrome but also in throwing light upon the degree of importance of each symptom to the syndrome (Factor saturations). This latter aspect fills up the lacuna as rightly suggested by Tsung-yi Lin and Standley (1962) that the 'quantitative aspect of morbid Psychiatric States—the degree of impairment—also requires attention, an aspect rather neglected in the past'.

There are many systems of factor analysis developed in the early part of this century, largely due to the efforts of Spearman (Two Factor Method), Holzinger (Bi-Factor Analysis), Thurstone (Multiple Factor Analysis), Hotelling (Principal Components Method), Cyril Burt (Simple Summation Method), Burt and Stephenson (Q-Technique) etc. Application of these techniques presuppose considerable knowledge of Statistics and Mathematics. Eysenck (1960) from his experience suggests that canonical analysis of discriminance is a powerful method in investigating dimensional problems of nosology.

In a typical factor analysis, measures are taken on a number of variables (symptoms) to start with, in a certain field on a population (patients) and all the possible correlation coefficients among them is worked out, to see to what extent

they co-vary. Factor analysis when worked out on these correlation co-efficients shows us how some variables can be grouped together because they behave in the same way and it brings out factors which may be responsible for these groupings. In the field of Psychopathology, these factors may be regarded as syndrome types (Guilford 1959).

Eysenck (1960) reviews a number of empirical studies on these lines and summarises his conclusions: '(1) There are two main independent factors in the psychiatric field associated with the Psychotic and the Neurotic disorders respectively, Psychoticism (P-factor) and Neuroticism (N-factor), (2) Both factors define continua which range all the way from extreme disorder to normality, there are no breaks or qualitative differences which would enable us to classify people into separate groups, (3) Introversion-Extraversion emerges as a third independent factor interacting with neuroticism and also possibly with psychoticism, (4) Intelligence is a fourth factor relatively independent of the three, but interacting with all of them in complex ways, (5) When psychoticism is studied in isolation several sub-factors are discovered which are usually non-orthogonal and roughly correspond to traditional Psychiatric groupings'.

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