KING'S College LONDON

INSTITUTE OF PSYCHIATRY,
PSYCHOLOGY & NEUROSCIENCE

Module:
Mental Health in the Community

Week 1:
A history of 'madness': Deinstitutionalisation to community care

Dr Frank Holloway

Topic 3:
Diagnosis in psychiatry

Part 2 of 2

Part 2

What is schizophrenia?

Types of criteria

Question

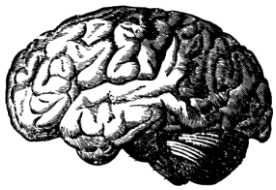
Do you meet diagnostic criteria?

- Symptoms
- Illness
- Behaviours

Yes

Result (Diagnostic label)

Schizophrenic



The label helps me define:

Interventions that will be helpful

*But it doesn't tell me about **you***

- Successful psychologist?
- Your biology?
- Living in a high secure hospital?
- Hereditability?

Schizophrenia is a useful label but there is no Platonic ideal.

DSM-5 definition of schizophrenia

DSM-5 Schizophrenia Checklist

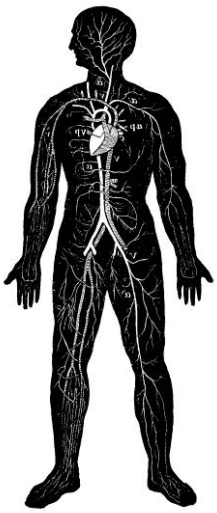
At least **two** of the following symptoms

- Delusions
- Hallucinations
- Disorganised speech
- Disorganised /catatonic behaviour
- Negative symptoms

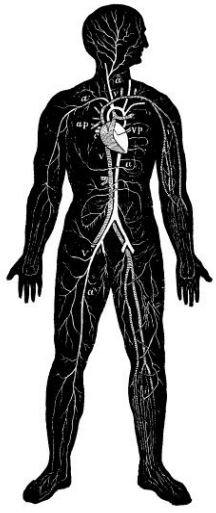
At least **one** of the **core** symptoms

- continuous signs of two symptoms must persist for at least 6 months
- experience at least one month of active symptoms
- social or occupational deterioration problems occurring over a significant amount of time
- these problems must not be attributed to another condition

Problems with schizophrenia (1)



Patient One	***Patient Two***
Delusions	Delusions
✓ Hallucinations	✓ Hallucinations
Disorganised speech	Disorganised speech
Disorganised/catatonic behaviour	Disorganised/catatonic behaviour
✓ Negative symptoms	✓ Negative symptoms
↓ Intervention	↓ Intervention
↓ Improvement	↓ No improvement
↓ *Returns to a normal life*	↓ *Remains in hospital forever*



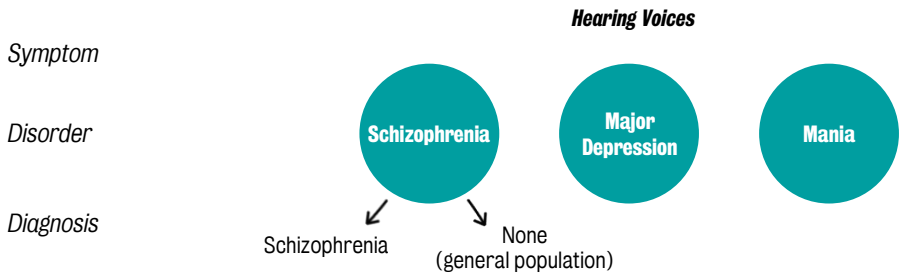
Problems with schizophrenia (2)

Question: Is there a point of rarity?

Between: **Schizophrenia + Bipolar disorder**

in terms of:
- phenomenology
- genetics

Answer: Not really!



Depression

We know depression occurs

But the nosology is a mess

How do we validate diagnosis without clear pathological mechanisms?

How do we sub-categorise depressive disorders?

How do we deal with depression and anxiety occurring together?

A moment of adversity or a problem in my life → I feel depressed about it

Understandable reaction or an 'illness'?

Categorical and dimensional approaches have their places

Severity of a disorder may determine the treatment approach

Categorical difference between unipolar and bipolar disorder

Psychotic depression responds to specific treatments

Criticisms

'Novel' diagnostic categories

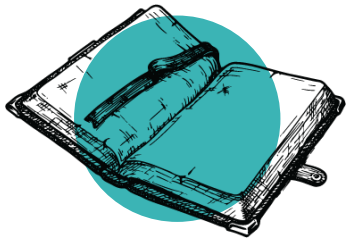
Diagnostic creep

e.g. ADHD diagnosis

Pre DSM IV

Post DSM IV

Overdiagnosis in psychiatry



Over Diagnosis in Psychiatry
Joel Paris, (2013)

Paris (2013)

Critics of contemporary classifications (1)

Antipsychiatry
- Szasz
- Laing

Critical psychiatry

Critics of contemporary classifications

Psychological critique
- Kinderman and his 'formulation-based' approaches

Mental illness establishment
- National Institute of Mental Health, Thomas R. Insel

Anti-psychiatry: Ronald David Laing

Laing, R. (1960)
The Divided Self

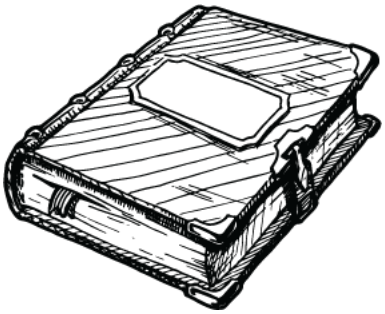
Core argument

> **...psychosis is not a medical condition, but an outcome of the 'divided self', or the tension between the two personas within us: one our authentic, private identity, and the other the false, 'sane' self that we present to the world.**

- Is Laing saying that 'mad' people are more sane than the rest of us?
- Ties in with uncommon trends in thought, which have often seen madness as something to aspire to
- Such trends flourished during the 1960s

Laing (1960)

Anti-psychiatry: Thomas Stephen Szasz



Szasz, T. (1961) The Myth of Mental Illness

Core argument

- Mental illness doesn't exist
- 'Proper illnesses' have a clear-cut pathophysiological basis
- Only a small proportion of mental disorders demonstrate this
  - General paralysis of the insane
  - Huntington's Chorea
  - Myxodematous madness
- Mental illness language is metaphorical

Szasz (1961)

Critics of contemporary classifications (2)

Antipsychiatry
- Szasz
- Laing

Critical psychiatry

Critics of contemporary classifications

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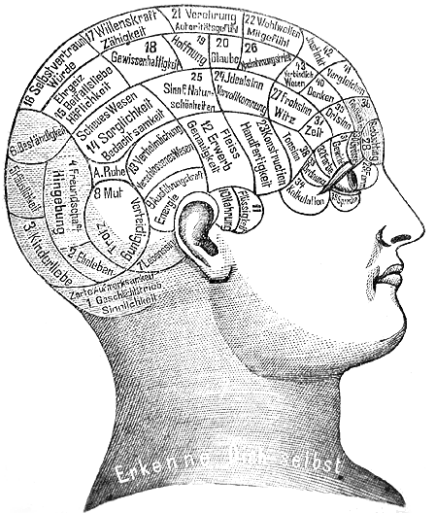
Critical psychiatry



The problems with psychiatry

Core arguments

- Psychiatric practice should not be dependent on
  - diagnostic classification
  - psychopharmacology
- There is poor construct validity amongst psychiatric diagnoses
- Sceptical about the effectiveness of pharmacological treatments
- Psychiatric diagnosis should not be used to justify civil detention
- Diagnostic constructs do not add much to scientific knowledge in psychiatry

Critics of contemporary classifications (3)

Antipsychiatry
- Szasz
- Laing

Critical psychiatry

Critics of contemporary classifications

Psychological critique
- Kinderman and his 'formulation-based' approaches

Mental illness establishment
- National Institute of Mental Health, Thomas R. Insel

Click **Next** to continue

Psychological critique: Kinderman and 'formulation-based' approaches (1)

Core arguments

- Distress is a normal part of human life
- Humans respond to difficult circumstances by becoming distressed
  - any system should reflect this position
- Psychiatric symptoms lie on continua with less unusual and distressing mental states
- There is no easy 'cut-off' between 'normal' experience and 'disorder'
- Psychosocial factors are the most strongly-evidenced causal factors for psychological distress
- Genetics and developmental factors influence the magnitude of an individual's reaction

What is the answer?

- Develop individual formulations, consisting of an individual's:
  - problems
  - circumstances
  - origins
  - therapeutic solutions
- A 'problem definition formulation' rather than a 'diagnosis treatment' approach would yield all the benefits without the dangers
- New ways of thinking must be adopted
- Rewrite most of the standard psychopathology textbooks

Kinderman et al. (2013)

Psychological critique: Kinderman and "formulation-based" approaches (2)

Quote in full

"

We need a wholesale revision of the way we think about psychological distress. We should start by acknowledging that such distress is a normal, not abnormal, part of human life—that humans respond to difficult circumstances by becoming distressed. Any system for identifying, describing and responding to distress should use language and processes that reflect this position. We should then recognise the overwhelming evidence that psychiatric symptoms lie on continua with less unusual and distressing mental states. There is no easy 'cut-off' between 'normal' experience and 'disorder'. We should also recognize that psychosocial factors such as poverty, unemployment and trauma are the most strongly evidenced causal factors for psychological distress.

Although, of course, we must also acknowledge that other factors —for example, genetic and developmental—may influence the magnitude of the individual's reaction to these kinds of circumstances …

For clinicians, working in multidisciplinary teams, the most useful approach would be to develop individual formulations; consisting of a summary of an individual's problems and circumstances, hypothesis about their origins and possible therapeutic solutions.

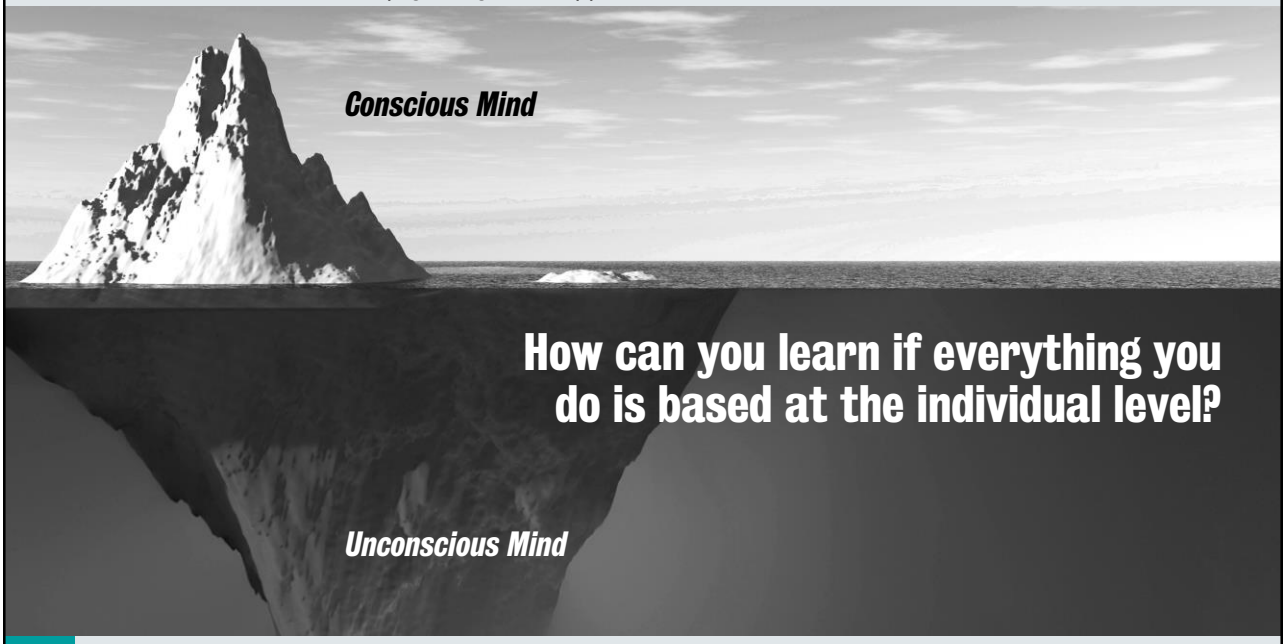
This 'problem definition, formulation' approach rather than a 'diagnosis, treatment' approach would yield all the benefits of the current approach without its many inadequacies and dangers. It would require all clinicians— doctors, nurses and other professionals—to adopt new ways of thinking. It would also require the rewriting of most standard textbooks in psychopathology (which typically use DSM diagnoses as chapter headings).

"

Click **Next** to continue

Kinderman et al. (2013)

Problem with Kinderman and psychodynamic approaches



Critics of contemporary classifications (4)

Antipsychiatry
- Szasz
- Laing

Critical psychiatry

Critics of contemporary classifications

Psychological critique
- Kinderman and his 'formulation-based' approaches

Mental illness establishment
- National Institute of Mental Health, Thomas R. Insel

Click **Next** to continue

Insel and the Research Domain Criteria (RDoC) Matrix

A different way of assessing mental disorder → *Psychiatric Establishment Research domain criteria matrix (RDoC)* → *Thomas Insel (Director of NIMH at the time)*

Construct/Subconstruct	Genes	Molecules	Cells	Circuits	Physiology	Behaviour	Self-Report
Acute Threat ("Fear")	Elements	Elements	Elements	Elements	Elements	Elements	Elements
Potential Threat ("Anxiety")	Elements	Elements	Elements	Elements	Elements		

5

Negative valence systems
- fear
- anxiety

Positive valence systems
- initial responsiveness to reward attainment

Cognitive systems
- perception
- working memory

Social systems
- social communication
- understanding of self

Arousal and regulatory systems
- arousal
- circadian rhythms

NIMH – We will fund research that uses this matrix as opposed to those using traditional diagnostics

National Institute of Mental Health (n.d.)

Research Domain Criteria (RDoC) Matrix (1)

Memory – Dementia – Cognitive system

- (RDoC) Matrix allows us to look at phenomena (disorders) at different levels
- We normally investigate a disorder (schizophrenia or anxiety) as defined by diagnostic formulations

Cognitive systems

	Construct/Subconstruct	Genes	Molecules	Cells	Circuits	Physiology	Behaviour	Self-Report
Working memory	Active maintenance	Elements	Elements	Elements	Elements	Elements		
	Flexible updating	Elements	Elements	Elements	Elements	Elements		
	Limited Capacity	Elements	Elements		Elements	Elements		
	Interference Control	Elements	Elements	Elements	Elements	Elements		

Perception – Schizophrenia – Cognitive system

- Hallucination – abnormal perception devoid of stimulus

Cognitive systems

	Construct/Subconstruct	Genes	Molecules	Cells	Circuits	Physiology	Behaviour	Self-Report
Attention		Elements	Elements	Elements	Elements	Elements	Elements	
Perception	Visual Perception	Elements	Elements	Elements	Elements	Elements	Elements	Elements
	Auditory Perception	Elements	Elements	Elements	Elements	Elements	Elements	Elements
	Olfactory/Somatosensory/ Multimodal/perception							

National Institute of Mental Health (n.d.)

Research Domain Criteria (RDoC) Matrix (2)

Do not fund research based on diagnostic categories

*Diagnostic and Statistical Manual **DSM-5***

Fund research based on the ability to pinpoint a particular system of interest

Research Domain Criteria (RDoC) Matrix

Social process system

Impaired in autism

Can we research though...

The lens of **genetics**?

The lens of disrupted **circuits**?

ADVANTAGE

We can draw things together that otherwise may have been missed?

National Institute of Mental Health (n.d.)

Early outputs from Research Domain Criteria (RDoC) Matrix

Using DSM-5

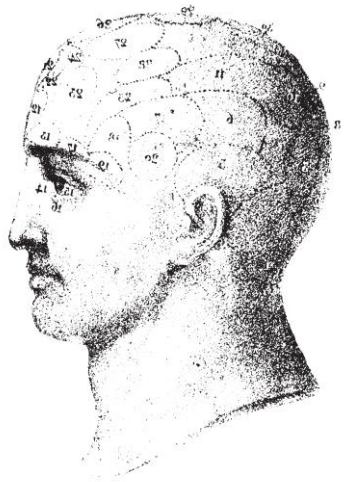
They found no phenomenological 'point of rarity' between

Bipolar **Schizoaffective** **Schizophrenia**

Symptoms are pretty evenly spread across these diagnostic categories.

Using RDoC Matrix

Significant homogeneity of biomarker-based groupings



Clementz et al. (2015)

Diagnosis in psychiatry: Conclusions

Limitations

There are limitations of contemporary diagnostic systems

- these are already well-rehearsed

Stigma

Diagnosis is associated with stigma

- do diagnostic labels stigmatise?
- do diagnostic labels help because they demystify?

Positives

There is a positive value of diagnosis

- it improves our understanding
- it allows us to improve what we can do in order to help treat the problems we face

In defence of diagnosis in psychiatry (1)

> *"If we forgo the making of a diagnosis , we also forgo all application of the extensive knowledge which has been accumulated in the past. This would be sheer folly; we cannot willfully ignore what is known, and if we wish to do so we are under the psychological necessity of proving (or believing) that the knowledge is false knowledge, or that it is irrelevant. If we refrain from diagnosis we shall be left in the individual case without the help of general concepts...*
>
> *...The wise physician never neglects the individual peculiarities of his patient; but he will first see how far he can be fitted into general patterns, and he will not mistake a quality which is characteristic of the group, such as thought disorder or auditory hallucination, as either without significance or as something to be interpreted by the life history of that one patient alone."*

Mayer-Gross, Slater & Roth (1969)

In defence of diagnosis in psychiatry (2)

> *The true value of a psychiatric diagnosis is the ability to predict course of illness, response to treatment, and, ultimately, quality of life and level of function in society. Good clinicians use diagnoses in the service of best patient care; they balance a paternalistic focus on outcomes with a respect of personal agency and encouragement for recovery.*

Heckers (2015)

In defence of diagnosis in psychiatry (3)

> *When used well, diagnosis is a key to assisting patients in making informed decisions about their care. It can ensure a patient gets effective help as quickly as possible and can benefit from the body of knowledge that has been built up from those who have had similar experiences previously.*
>
> *Most people who seek help from mental health professionals want these benefits. When a patient consults a psychiatrist they have a right to expect an expert diagnostic assessment and the psychiatrist has a professional responsibility to provide such an assessment and use it to guide available evidence-based treatments.*
>
> *This is not an issue of personal choice for a practitioner. It is a professional responsibility to the patient.*

Craddock & Mynors-Wallis (2014)

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End of topic