On the Instability of Diagnoses Across Time

July 07, 2010 | Obsessive Compulsive Disorder [1], Bipolar Disorder [2], Schizophrenia [3], Major Depressive Disorder [4], Alcohol Abuse [5]
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When I was much younger, I started an inpatient adolescent service—a unit for boys and another for girls. It was one of the first such inpatient services in our part of the world and attracted a huge volume of referrals, a long waiting list for admission, and a consequent population of very disturbed adolescents. These patients had not responded to outpatient therapies and most had experienced multiple brief hospitalizations elsewhere.

Most health insurance covered long-term care in those days, and many of the patients stayed for months—even a year or more. Treatment was intensive: each patient was seen 3 times a week by a doctoral level psychotherapist and in daily group therapy. Much attention was also paid to the twice-daily unit meetings in which patients were often confronted about their behaviors by their peers. Medications were used, but many of the patients were unresponsive to the then available antipsychotics and antidepressants. Each of the 3 psychiatrists and 2 psychologists on the service were the individual therapists for a small group of patients (usually 3 to 5) and were not involved in those patients' daily administrative care.

I offer all of this as a way of describing how I became involved in intensive psychotherapeutic efforts with several adolescents who I then continued to see, often for many years following their inpatient experiences. There is much that might be said about what I learned from those severely disturbed adolescents, but for the purposes of this essay I wish to focus on the instability over time of descriptive diagnoses.

Alex, as I shall call him, was admitted to the inpatient adolescent service when he was 14. He was large and had an intimidating air of barely suppressed violence. His admission was prompted by a near-lethal suicidal attempt and followed a subsequent hospitalization in a local general hospital. He was severely depressed and, for some months before his suicidal effort, had been withdrawn, refused to go to school and, for the most part, stayed in bed.

When I first interviewed him, Alex did not say much and, as a consequence, our interaction became more and more a question-and-answer type of interview. He acknowledged that he had been depressed and had tried to kill himself—but not much more. He seemed both sad and flat, and I felt that I had not made any contact with him. In the days and weeks that followed, he remained much the same. First-generation antidepressants did not help, and on the boys' adolescent unit, he was

generally a nonparticipant, remaining a shadowy, “not there” presence. I became his therapist, and our sessions were filled with silence and aloneness. After several months and 20 or so psychotherapy sessions, he continued to behave as if I were not there. I responded by gradually sharing my sense of his unwillingness to meet me and, in doing so, rendered me into a sense of helplessness. I told him I thought that I was feeling his helplessness as well as my own. Slowly, he began to respond to a focus on the here-and-now of our relationship and began to talk about his feelings about his family. What emerged (and was validated by the psychiatric social worker’s contacts with the family) was a picture of family chaos. His mother had been immobilized for years by a refractory depression. His younger sister had schizophrenia, and his father, although successful in his business, seemed to live in a cloud of denial. He simply refused to acknowledge either the pain in his family or its chaotic structure.

To make a long and difficult story more understandable, Alex gradually emerged from his major depression and after many months was discharged to a halfway house, and I continued to see him several times a week. What became obvious as his major depression cleared was his severe obsessive-compulsive disorder (OCD). He was haunted by painful obsessional thoughts to which he responded with a number of compulsive rituals. Despite the limiting nature of these symptoms, he earned his GED and began classes at a lo-cal junior college. He remained in the halfway house for 4 years and then moved to an apartment-living situation where he received several hours a week of supervision of a concrete nature (paying bills, shopping, etc). During these years of psychotherapy, my focus was mostly supportive but included efforts to deal with his hurt and rage with his parents for their failure to provide either affection or structure. During these sessions, the only descriptive diagnosis that could be made was OCD. There was no evidence of the major depression that had ushered in his hospitalization and our ongoing psychotherapeutic relationship.

When Alex turned 25, we had been working together for 11 years. He had graduated from college and was contemplating graduate school. At that time, the only girl he had ever dated told him she no longer wished to see him. This rejection provoked a florid paranoid psychosis. He was very agitated and his delusions involved a number of persons—some real and others imaginary—who were plotting to kill him. An antipsychotic drug helped, but for the next several years, we struggled together to somehow get a handle on these thoughts. Despite his paranoid psychosis, he was able to work the nightshift at a convenience store and live independently. Gradually the paranoid delusions faded and his OCD once again became prominent.

His psychological status appeared stable (at the obsessive-compulsive level) for the next 8 years. We continued to maintain contact, although his actual visits to my office happened about once a month. Then, out of the blue, my answering service called me in the middle of the night with his emergency call. When we talked he seemed obviously in a severe manic state. Once again he fulfilled the criteria for a different psychiatric disorder—this time a bipolar disorder. After several weeks of intense negoti-ation, he agreed to be admitted to the psychiatric unit of a local public hospital, where he was appropriately medicated and discharged, and called for an appointment.

Alex was now 34 and I had been his doctor for 20 years. During these many years, and from a purely descriptive perspective, his diagnoses were major depression; OCD; paranoid psychosis; and bipolar psychosis, manic type. What I wish to emphasize here is that the major use-fulness of these descriptive diagnoses had to do with what medications to prescribe. Antidepressants for major depression and OCD, antipsychotics for paranoid psychoses, mood regulators for manic psychoses . . . the list goes on. I do not wish to minimize the efficacy of psychotropic medications—they were crucial in the management of Alex’s crises. Their helpfulness and the descriptive diagnoses that led to their use have, however, little explanatory value. They do not inform us as to who Alex is and what he was struggling with.

I will not elaborate on what I came to understand as Alex’s complex dynamic formulation, other than to say that at a fundamental level I thought that there were genetic factors involved. Whether the propensity was for major depression or any of the other diagnostic entities he experienced was hard to know because so many of his relatives had such a wide variety of serious psychopathologies. In addition, I believed Alex had been wounded early in life by both his mother’s unavailability and the chaos in the family. As a consequence, Alex was full of rage and his more or less persistent OCD and his 3 major psychotic-level episodes (major depression; paranoid psychosis; and bipolar disorder, manic type) could all be understood at one level as intense struggles to deal with his rage.

The clinical narrative does not end well. Alex began to drink excessively, often to the point of stupor. His parents died and he was left with his schizophrenic sister, a large home, and a survival-level inheritance. At length, I took a stand about his drinking. We would work together for 6 months on ways he might get it under control, but if that failed I would see him only if he cut his drinking back

to one 6-pack a day. If he did not succeed, our contacts would be restricted to one 15-minute phone call each week. This intervention (however problematic and probably influenced by my needs as I aged) did not work, and for the next several years, the 15-minute phone call each week was our only contact. These, too, finally ceased, and for the past 10 years, he only leaves a rare middle-of-the-night message on my answering machine, the gist of which is always the same, "You're the only person who ever understood me and I wish I could see you, but I can't cut back on my beer. It's the only peace I have."

There is much, much more that could be said about this 40-year experience with this bright and terribly hurt man, but the emphasis here is that over the decades of my involvement with him, Alex fulfilled the diagnostic criteria for 4 major psychiatric disorders, none of which spoke very clearly about who he was and what he struggled with. Others may argue that such is not the intent of descriptive diagnoses. If so, then perhaps they should not be accorded the centrality they currently receive.

Links:
[1] http://www.psychiatrictimes.com/obsessive-compulsive-disorder
[2] http://www.psychiatrictimes.com/bipolar-disorder
[3] http://www.psychiatrictimes.com/schizophrenia
[4] http://www.psychiatrictimes.com/major-depressive-disorder
[5] http://www.psychiatrictimes.com/alcohol-abuse
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