1 The Road to Diagnosis

Carson

Years ago I evaluated Carson, a 29-year-old graduate student in psychology. He had always lived in the town where he was born, among numerous relatives and friends. Through a long history of repeated depressive episodes, he had taken antidepressant medications on and off for a decade. At one time or another he had complained of trouble concentrating on his studies, of worries that he wouldn't be able to find a job, and of fears that he would become chronically depressed like his maternal grandmother.

When Carson was at his worst (usually in the late fall), he had trouble sleeping and eating, so he was pretty thin by the time Christmas rolled around. Each spring his mood picked up, and he invariably felt well the entire summer and early fall, though he admitted that he was prone to be "sensitive to the minor vicissitudes of life." What he meant, his wife told me, was that he sometimes felt down when things weren't going well.

A typical teenager, Carson had experimented with both alcohol and drugs. Once, when withdrawing from a 3-day run of amphetamine use, he had briefly become depressed, but his mood had lifted spontaneously within a few days. His girlfriend had agreed to marry him only on the condition that he "clean up his act"; now he swore he had been completely clean and sober for the 4 years they had been together. He had never had symptoms of mania, and he thought his physical health was excellent.

Medication had helped Carson get through college, after which he had spent the summer searching for a graduate fellowship. Finally, though the economy was depressed and few positions were available in the social sciences, he was offered a graduate fellowship with a generous stipend in a good department. Despite the triumph, his celebration was muted: His new university was nearly 2,500 miles away, in a part of the country where he'd never lived before.

On a Friday afternoon in late June, at his regular clinician's request, Carson appeared for an emergency evaluation. He sat slumped

uneasily in his chair, with one knee jumping up and down, and his gaze drooping. He complained of terrible anxiety: His wife was pregnant with their first child; the following day they would start driving across the country to the site of his new job, in a city he'd never even visited. The previous afternoon he had become "almost panicky" when he was asked to sign a routine extension of his student loan.

As Carson described his fears for the future, his eyes reddened and he brushed away tears. Though he didn't think he felt depressed, he confessed that he "couldn't go through with it"—that he felt abandoned and alone. "I'm falling apart," he said, and broke down in sobs.

A Roadmap for Diagnosis

As you can imagine, a lot rides on an evaluation like Carson's. If you were his clinician, you would need to answer a lot of questions. What's wrong? Is it the same as his previous problems with depression? Does he need treatment at all? If so, what's most likely to help? Should he have more medicine, or a different antidepressant, or psychotherapy? What should you tell Carson and his wife—should they postpone their move? What should Carson tell his new boss? The answer to each of these important questions would depend on your assessment of his condition. To be helpful, it must be based on information that will assist you in finding a road to the future. Reaching an initial destination on that road—we can call it a diagnosis—is what this book is all about.

The ancient Greek term *diagnosis* means "distinguishing" or "discerning." Beyond the word itself, the concept of distinguishing one disease from another is crucially important to patients and medical scientists alike. As British psychiatrist R. E. Kendell wrote a generation ago, without diagnosis our journals would print only case reports and opinions.

When a person goes to a medical doctor with a physical complaint, in most cases the diagnosis conveys three sorts of information: the nature of the problem (symptoms, signs, and history), its cause, and the physical changes that consistently occur as a result. Any disorder that clearly meets these criteria can be called a *disease*. Take pneumonia, for example. This term tells us that the patient feels weak and tired, and that the person suffers from the symptoms of shortness of breath, fever, and a cough that produces sputum. But only after we learn the results of sputum cultures and other tests do we learn that the cause of the pneumonia is bacteria growing in the patient's lungs, causing the air sacs to fill with fluid and cells, producing shortness of breath. Then we can say that the patient has the disease of pneumococcal pneumonia.

The clinical symptoms and other information establish coordinates on the roadmap a doctor follows in prescribing treatment and predicting outcome. I'm somewhat geographically challenged, so whether I visit the automobile club or log onto Google maps, I like to have both driving directions and a graphic depiction of the route for my trip. Having both verbal and pictorial guidance is a belt-and-suspenders approach that helps me believe I'll arrive on time at the right place. In the list below, we'll take a brief overview of the "driving directions" for mental health diagnosis. I've indicated the page numbers where you can find discussions of these parts of the evaluation. (In Figure 1.1, I've drawn them as a map so you can see just where we're going. For convenience, you'll find the same graphic inside the front cover.) Don't worry if some of the terms seem unfamiliar—we'll define them as we go.

- *Level I*. Gather a complete database, including history of the current illness, previous mental health history, personal and social background, family history, medical history, and mental status examination (MSE). Obviously, you must first have material that describes your patient as fully as possible. Most of it will come from interviews with the patient and, very often, with other informants. You'll discover a lot about these building blocks in the Part II database quarry. Pages 89–126.
- *Level II*. Identify syndromes. *Syndromes* are collections of symptoms that go together to produce an identifiable illness. Major depression is a syndrome; so is alcoholism. Page 9.
- *Level III*. Construct a differential diagnosis. *Differential diagnosis* is just a term for all of the disorders you think that a patient could have. You don't want to overlook any possibilities, however unlikely, so at first you must cast a very wide net. Page 14.
- *Level IV*. Using a decision tree, select the most likely provisional diagnosis for further evaluation and treatment. Page 19.
- *Level V*. Identify other diagnoses that might be comorbid (coexist) with your principal diagnosis. Arrange multiple diagnoses according to the urgency of their need for treatment. Page 57.
- *Level VI*. Write a formulation as a check on your evaluation. This brief statement of your patient summarizes your findings and conclusions. Page 80.
- *Level VII*. Reevaluate your diagnoses as new data become available. Page 81.

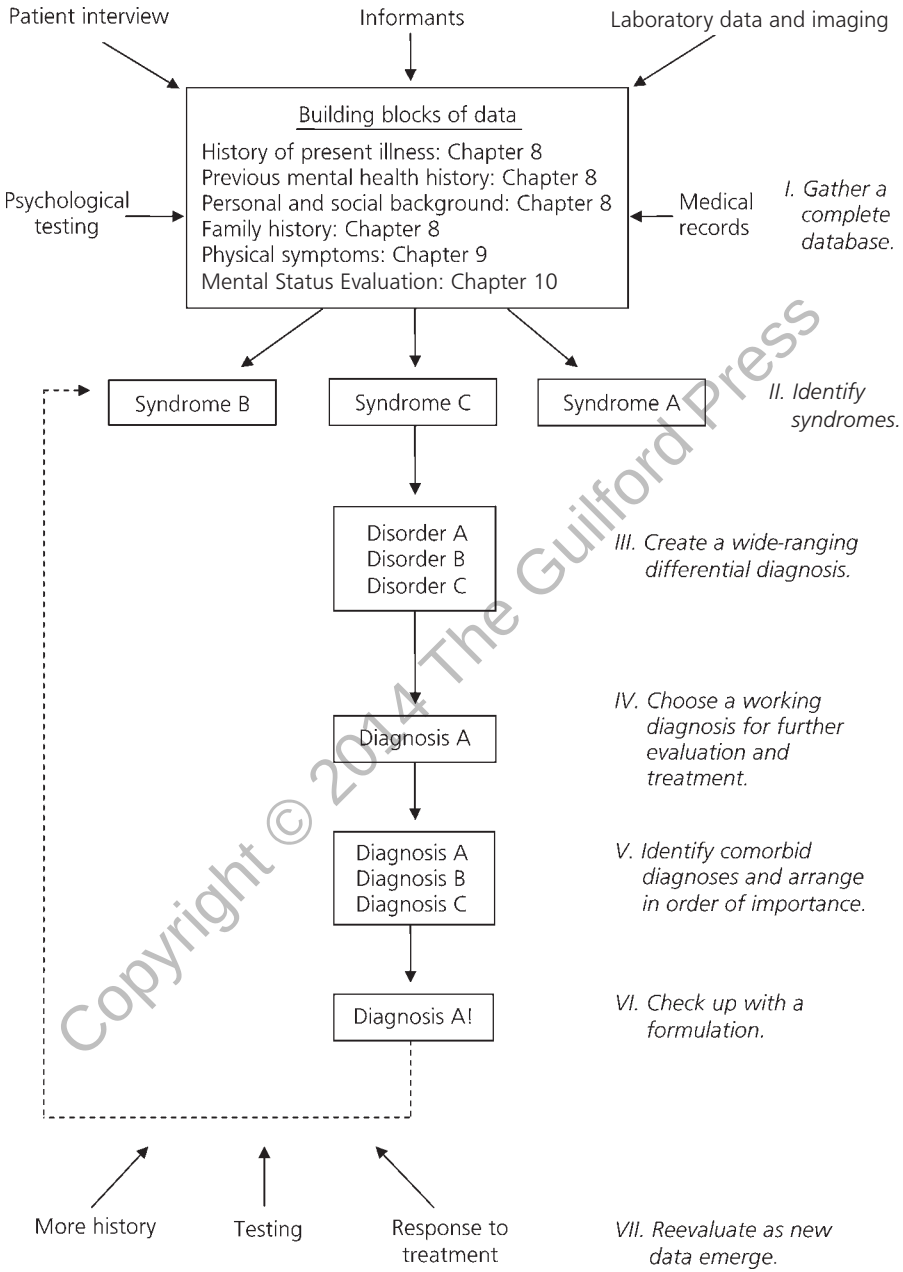

FIGURE 1.1. The roadmap for diagnosis.