Clinical Case Example Based Viewpoint

When DSM does not help in clinical practice

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The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders is often referred to as the 'psychiatric bible', being used extensively by clinicians to make psychiatric diagnosis. However, since DSM is a set of constructs, many current criteria sets fail to capture real illnesses. While diagnostic systems seem to help understand how to categorise and respond to mental illnesses, this isn't the case always. At times, this becomes a purely academic exercise divorced from clinical reality. Also, in some patients, using psychiatric diagnosis does not aid treatment decisions. Here, we are presenting three cases to debate about the place, role and impact of diagnosis using DSM in managing psychiatric patients in clinical practice.

CASE 1

Ms K, a 20 year old female, right handed, Hindu, Marathi speaking, a 12th drop out, single, unemployed, resident of Chembur, was brought by her parents to the casualty in October 2015, with a history of altered behavior since the past seven months (March 2015) exacerbated since one week (this being the fourth exacerbation) in the form of increased irritability, mood swings, anger outbursts, being abusive towards her family, threatening to harm self with a knife, walking around in a disinhibited manner at home and blackmailing parents by refusing food /water and medications if demands not met.

She was apparently alright till December 2014 when she first noticed a swelling in the left inguinal region. Investigations revealed left inguinal tuberculosis and she was started on AKT-4 regimen {INH+ Ethambutol +Pyrazinamide +Rifampicin} in a private setup.

In January 2015 she started complaining of severe persisting backache which was of spontaneous onset, involving entire back and relieved temporarily with hot water fomentation. In February 2015, in view of her backache along with complaints of generalized abdominal pain and irregular menses, she was investigated at KEM Hospital. CT abdomen pelvis was advised which showed "Acute exacerbation of non specificaortoarteritis involving predominantly the proximal aorta". 2D ECHO was also done which suggested trivial MR and trivial TR.

In March 2015, in view of these findings, she was first admitted under Medicine department at our hospital. In the ward, she had a history of spontaneous onset of abnormal writhing like movements involving her hand and body, at times rolling on the floor, making her eyes wide and staring. Patient was fully conscious during the episode, was able to communicate and also able to recollect the entire episode. Each episode would last about half an hour and occur daily without a precipitating stressor.

A psychiatric reference was hence advised in view of the atypical presentation. During her psychiatric interview, she complained of increased irritability, mood swings, sleep disturbances over 8-10 days along with conflicts involving her sister and a history suggestive of sibling rivalry was elicited.

A provisional diagnosis of Conversion disorder with depressive disorder was made. She was started on Amitryptiline, Haloperidol, Clonazepam and Duloxetine. As regards medical management, she was on T. Prednisolone, along with AKT-3 (HRE) and hematinics which were given for her anemia (Hb 9.8). Abnormal movements decreased in intensity and frequency and she claimed 60% improvement at time of discharge.

Post discharge, there was a history of irregular compliance and around 2 months later, in May 2015, she was off all treatment when she had her 2nd exacerbation. This time, she complained of crying spells, low mood, threatening self harm and also gave ideas of reference. She also complained of persistent backache, laughing and crying in pain and used the heating bag frequently for temporary relief. This time she was started on Trifluoperazine and Trihexiphenydyl, Clonazepam and Gabapentin. With these medications, she had some relief in psychiatric symptoms but backache persisted with occasional irritability.

In June 2015, she first consulted a neurologist in view of her persitent backache. An EEG was advised and it showed "abnormal awake state with intermittent delta and slow sharp wave activity". The patient was started on Amitryptiline, Oxcarbazepine and Quetiapine in addition to AKT and pain killers (Tolperisone +Paracetamol) for backache. At this time, records indicate that INH was discontinued.

In July 2015, she had her 3rd exacerbation since 8-10 days and was brought to the casualty with complaints of staying withdrawn, increased irritability, frequent crying spells, threatening to harm herself, stubborn behaviour, refusing to take medications, clinging to mother and throwing temper tantrums. She had her first psychiatric admission in view of these symptoms. On examination, her entire back showed extensive discoloration due to superficial burns caused by repeated use of heating bag for relief from her backache. The relatives gave a history that she insisted on using the bag inspite of the lesions to obtain relief. Her diagnosis was revised and a differential diagnosis of Organicity and Psychoses NOS was considered. She was discharged on Quetiapine, Oxcarbazepine, Haloperidol, Trifuoperazine, Trihexyphenidyl, Clonazepam in addition to AKT and painkillers. She was maintained behaviourally on treatment with 80% improvement overall post discharge. However, her backache persisted.

In September 2015, she consulted the Orthopedics department at J.J hospital for treatment of backache. The dose of painkillers was adjusted, and a neurology opinion was taken, the repeat EEG advised was normal. MRI brain also did not reveal any abnormality. In addition to ongoing antipsychotics, Phenobarbitone was added by the neurologist at J.J. Hospital

In October 2015 she came back to KJSMC with 4th exacerbation of altered behavior in the form of irritable, abusive behaviour, hostility towards parents and refusing treatment. There was a history of sudden preoccupation with respect to getting married to a boy who was a past acquaintance to an extent that she threatened using a knife to get her married. Her parents did not approve of him. During this period, history of patient wearing scanty clothes and walking in the house in a disinhibited manner, telling neighbours she was being tortured by her parents. However, she claimed relief in backache for the first time then.

In view of her psychiatric symptoms, she had her2nd psychiatric admission in October 2015. Her repeat EEG was normal, her Hb was low (9.3), ESR was high (120), with mild decrease in TSH (0.3). Medicine review reference was done and she was started on hemantinics and asked to repeat her thyroid function tests in a month. Her treatment this time comprised of AKT (not on INH or Cycloserine), Oxcarbazepine, Haloperidol, Trihexyphenydyl with Phenobarbitone and Chlordiazepoxide and showed 50-60% improvement within first two days of admission. She was discharged on these doses in a week.

She stopped AKT in December 2015 as advised after completing her course. On follow up, she had a history of 1-2 episodes of abnormal body movements associated with making eyes wide and rolling on the floor secondary to demand not being met, and on her last follow up in January 2016 she had near total improvement, functionally maintained on medications mentioned above.

She had no history of other psychotic symptoms or mania, no OC symptoms/ overt panic attacks or phobias were reported and there was no history of head injuries/ loss of consciousness or generalised seizures. There was no history of major medical or surgical illnesses prior to current pathology as mentioned. Patient was the youngest of 5 children, 3 elder sisters and 1 older brother. There was a family history suggestive of psychoses in maternal uncle, with Koch's and death secondary to the same 2 years back.

She was born of a full term normal delivery, and cried immediately after birth. Her developmental milestones were appropriate to age. She studied in a regular school and was an average student. She pursued her 12th in commerce stream, unable to clear one subject in 12th in view of her health problems and subsequently did not reappear. She is Single, has few close friends. There is no history of substance abuse. There is a history of irregular menses with oligomenorrhea prior to taking psychiatric treatment.

As described by her mother, patient is stubborn, impulsive, quick tempered, she would love dressing up, buying new clothes, and spending on shopping.
Positive examination findings included presence of feeble peripheral pulses with regular heart rate of 84 beats per minute.Pallor was present. Her entire back showed extensive healed scars of previous burns.
Systemic examination did not reveal any significant abnormalities.

MENTAL STATUS EXAMINATION

a) At time of first admission

An averagely built young girl, restless, threatening to leave, pleading before parents and doctors, crying, clinging to mother, and showing manipulative behaviour, she was conscious but only partly cooperative, initiating but not maintaining eye contact. Rapport was difficult to establish and attention was aroused but ill-sustained. Her mood was conveyed to be sad and affect was anxious, tearful, congruent to mood but inappropriate to surroundings. Her speech was continuous coherent and relevant, threatening if she was not given her way. She was not cooperative for details on thought testing. Her personal and social judgement was impaired and a detailed MSE could not be carried out as she was not cooperative.

b) At the time of last follow up

She was neatly groomed, conscious, cooperative and communicative, and her mental status examination was unremarkable. Mood conveyed was euthymic and affect though slightly restricted was MC, stable and appropriate to surroundings. Her judgement was intact and her insight was grade 4/6.
Her psychological testing with Rorschach revealed: "Unsatisfactory reality testing along with signs of impulsivity and immaturity". It also reflected patient's "difficulty in forming an integrated view of her surroundings."

DIAGNOSTIC DILEMMAS

At the outset, a DSM -5 diagnosis of Functional Neurological Symptom Disorder (Conversion disorder) was considered in view of her atypical presentation of abnormal body movements.
Subsequently, an organic etiology needed to be ruled out in view of her EEG abnormality. Was it a seizure, was it AKT induced psychoses or were her behavioral disturbances secondary to her aortoarteritis? Accordingly, a DSM-5 diagnosis of Psychotic disorder or Depressive disorder due to another medical condition was considered. A diagnosis of Medication (AKT) induced psychosis also had to be ruled out.
A possible diagnosis of Depressive disorder could be considered in view of her episodes of low mood, crying spells, withdrawn behavior and increased irritability as also the diagnosis category of Psychotic disorder Unspecified was yet another DSM-5 differential diagnosis in view of her good clinical response to optimum doses of antipsychotic medication.

CASE 2

Mr. S, a 40 year old Hindu, Marathi speaking, married man, a resident of Dadar, right handed, completed std XII and diploma in interior decoration, currently unemployed came to the outpatient clinic with chief complaints of Backache, heaviness in head and abdominal discomfort
Patient was apparently alright prior to 5years ago when he developed backache, which was generalised in nature. It was aggravated by movements and decreased with rest. He consulted several orthopaedic specialists but the pain did not subside.
The patient also gave history of heaviness in the head and abdominal discomfort for the past 5 yrs. He described it as a constant and generalised sense of heaviness in the head and associated with a tingling sensation. He denied history suggestive of migraine or seizures.
The abdominal pain was generalised, with no specific aggravating or relieving factors. It was not associated with nausea, vomiting or loose stools. Patient had consulted several specialists for the above complaints but had no relief from the symptoms.
He had been preoccupied with his physical complaints and had been reading up about them on the internet. He felt that he may have a variety of illnesses and also read about all the possible remedies and alternative therapies for his problems. The patient developed altered eating habits as a result of these readings. Eg: for the past several months, he had only been eating boiled sprouts i.e. he would boil the

sprouts and eat them in the form of 'panipuri'; he would eat approximately 10-15 such 'puris' for breakfast, lunch and dinner each. He had obtained this recipe off the Internet and adhered to it rigidly as he felt that it would help with his abdominal complaints.

According to the patient, his physical complaints have interfered with his professional life and hence he has been unemployed for the past 2 years. Eg: the patient said that the last place that he had worked for was at a walking distance from his home; approximately 10-15 minutes away. However, he said that he would be unable to get ready for work in time and so would have to take a shorter route which would save time, but apparently had more traffic. After 2-3 such instances (of him having to take the short route) he quit the job as he felt that "crossing a road with so much traffic was a risk to his life".

The patient's wife had a full time job. Since he was not working, the patient felt that he was doing his share by doing household chores and dropping and picking up their daughter from school. However, according to the patient's mother, he refuses to help with household chores and errands; and will only help as and when it suited him.

The patient felt that no one in his family understands him or his problems. According to him, his mother is not sympathetic enough towards him eg. he feels that she does not make any attempt to soothe him (stroking his head/ back) when he is unwell. The patient says that he realises that he may have outgrown such attentions but yet, he would like his mother to attend to him. He does not express any such feelings about his wife and in fact, appears quite indifferent towards her.

Patient complained of disturbed sleep on and off i.e. at times he apparently lies awake until 2-3 am ruminating about his problems and how his mother does not sympathise with him. Patient gave a history of pervasive sadness of mood for the past 1-2 years; associated with ideas of hopelessness and helplessness. He felt fatigued easily and finds it difficult to concentrate on tasks. He denies a lack of interest in activities and also denies death wishes or suicidal ideas.

The patient was persistently worried and preoccupied about his physical complaints. He denied hearing voices that are inaudible to others feeling that people intend to harm or him or discuss him. There is no history suggestive of mania, panic attacks or GAD. He consumed alcohol occasionally i.e. once in2-3 months. No history of head injury, loss of consciousness or seizures. He denies any other significant medical or surgical illness.

The patient was the younger of 2 children. The elder sister was married and well. The mother was a housewife. The father had passed away 2 years ago, of cancer (details not available)

Patient had been married for 5 years; his wife worked as ground staff in the Navy. He had a 3 year old daughter. There was no history of psychiatric illness, suicide or epilepsy in the family

Patient was born at term and developmental milestones were within normal limits. No history of perinatal complications. He had an average academic performance. After completing Std XII, he enrolled for several courses, but was unable to complete any. He would say that he was unable to cope with classes or get along with classmates or teachers. He had completed a diploma course in interior decoration.

According to the patient's mother, even after completing his education he was unable to hold on to a job for long. He would frequently cite differences with colleagues/ superiors as reasons for quitting.

According to her, at the age of about 25-26 years the patient apparently announced to the family that he wanted to get married. He blamed the parents for not finding him a suitable bride; for not being interested in his welfare. He would argue with his family members repeatedly over this issue.

He was not forthcoming regarding sexual history. The patient displayed characteristics like stubbornness, being lazy, not inclined to work for what he wanted and poor social interactions.

On examination –

General and systemic examination did not reveal any significant abnormality.

Patient is a young adult male, conscious, cooperative, average height and build, appropriately dressed, adequately groomed, initiating / maintaining eye to eye contact, rapport was established, attention was aroused and concentration was sustained. The mood was anxious and affect appropriate, congruent to mood. The speech had a normal tone and output. It was relevant and coherent. The patient had ideas of

hopelessness and helplessness, denied death wishes and perceptual abnormalities. Judgement was intact, orientation was fine, intelligence was average and memory was intact. Insight was 3/6.

CASE 3

Ms. A, a 26 years old female, Muslim, Hindi Speaking, graduate, single, unemployed, resident of Govandi was brought by her mother with complaints of two episodes of wandering away from home.

On enquiry, she complained of sadness of mood, loss of interest in work and pleasurable activities associated with headache, back pain, leg pain for the past 4 years.

Patient was apparently alright 4 years back, when her maternal cousin named Akbar whom she loved, rejected her proposal for marriage. Since then, patient started feeling sad throughout the day, staying withdrawn, having reduced interaction with family members and decreased interest in household activities as well as poor concentration in work, expressing passive death wishes. On asking by family members she would get irritated and often threaten to commit suicide. She also had reduced sleep and early awakening, lethargy and staying awake in bed for long time. She also had complaints of back pain, headache and pain in both lower limbs. This continued for 2 years and during this period, she rejected many marriage proposals without giving any valid reason. Two years ago, she went out of the house to drop the younger sister at school and went away to Vashi without informing anyone. She wandered for 5-6 hours and came back on her own and on questioning by the parents she replied that she wanted to go out so she went. After 10 days of this incident, she went out on her own from morning 10 am to 11pm at night when family members got a call from Powai saying that she had reached there in someone's wedding and she was unsure of the way home hence took help from the people at the wedding. She was aware of the whole episode but didn't give any explanation for the same.

On asking her, she said that if she had informed someone at the house, they would not have allowed her to go. She also denied any purpose of going or meeting someone. She was then brought to our hospital for evaluation. Her Mental State Examination at that time (2years back) showed sad mood, anhedonia, somatic preoccupation, hopelessness, helplessness, worthlessness and passive death wishes. Rest of the examination was unremarkable.

She was diagnosed Major Depressive Disorder and advised admission but she and her mother were not willing for the same. She was started on Escitalopram 5mg subsequently increased gradually to 25mg and Etizolam 0.25mg increased to 0.75mg with which she had hardly any improvement. On follow up, her irritability had increased and once after some interpersonal conflict, she tried to take 4-5 tablets of Escitalopram together after which Oxcarbazapine 300 mg was added. However, patient developed itching lesions over body which was found to be Drug Induced Lichenoid eruptions. So all the drugs were stopped and she was shifted to Tianeptine 37.5mg in three divided doses. On subsequent follow ups, her irritability and lethargy increased and she also started suspecting that people were talking ill about her, not maintaining eye to eye contact. Olanzapine 2.5mg was added and increased to 7.5mg over time.

Despite this, she had increased aggression, fearfulness, inappropriate smiling, reduced sleep and repeated hand washing, so Tianeptine was stopped and Haloperidol 5mg with Trihexyphenidyl 2mg were added and increased to 12.5mg and 4mg respectively. The psychotic symptoms improved however, sadness of mood recurred. Divalproate Sodium 250mg was then introduced along with Tianeptine 12.5mg. However, on next visit, Divalproate had to be discontinued because of increased sleep and lethargy. With these drugs, she had complaints of tremors, stiffening of limbs, slowness in walking and robot like movements (EPS), hence Haloperidol and Olanzapine were gradually reduced and stopped.

MMPI done at this stage showed invalid profile. Because of no improvement, patient was again advised hospitalisation and ECTs but mother was not willing for the same. To know the exact stressors she was posted for Pentothal Interview. The interview did not yield any additional information hence suggestions were given during the interview. Following Pentothal interview, she perceived 60% improvement in withdrawn behavior, loss of interest in work, sadness and somatic complaints; and she started helping in household work and also started taking tuitions at home. At that time, patient was maintained on Tianeptine 37.5 mg and Etizolam 0.25mg.

Since October 2015, following stressor in the form of marriage proposal rejection, patient became more aggressive, back answering father, crying and laughing inappropriately, with lack of self care, not initiating eye to eye contact, increased sleep and decreased appetite, repeated hand washing and repeating holy phrases while performing namaz. Restlessness and depressive symptoms persisted.
Since November 2015,she started talking about going to Powai taking right on platform 4 to meet Aurangzeb and visit the places of interest, then to Kurla, taking left from platform 2 to meet Akbar, from there to Santacruz Airport to visit Mecca-Madina on 26th November but she didn't go. For this, Amisulpiride 50mg was started and increased to 200mg was added and Pentothal interview was conducted to find the cause for recent symptoms though no new information obtained, significant symptomatic improvement (>60%) was noted following Pentothal interview after which she started requesting for pentothal interview to get relief.
There is no history suggestive of head injury, seizures, loss of consciousness and substance use. Also, there is no history suggestive of hearing of voices, muttering to self, disinhibited behavior, maintaining odd postures for long time or of abusive and assaultive behaviour, no excessive grooming, spending or religious activities.
She was the 2nd amongst 7 siblings. No history of psychiatric illness in family was obtained.
Birth and developmental history was normal. She studied till BSc, B.Ed. Interpersonal relations well maintained with family members Decreased frequency of menstrual cycle was noted over the past 2 years.
Premorbid personality was stubborn, short tempered, irritable when opposed, wanting to get her own way.

On examination
General and Systemic Examination: did not reveal any significant abnormality.
Mental Status Examination (Nov 2015):
Not initiating eye to contact, occasionally smiling inappropriately, restricted affect, irrelevant talks about going to Powai and Kurla on 26th November and somatic preoccupation. Rest of the MSE was unremarkable.
Her Rorschach test was done which showed: intact reality testing, rigidity of thoughts, impulsivity.
She is currently on Amisulpiride 300mg, Tianeptine 37.5mg, Etizolam 0.5mg. On last follow up she said the date to meet the friends was 26th February 2016.

Dilemmas were

a. Initially though the patient's symptoms fulfilled the criteria for Major Depressive Disorder, there was very minimal response to antidepressants.
b. From October, in view of her psychotic symptoms, she was started on antipsychotics with which however, there was no improvement.
c. She showed more than 60% response to Pentothal Interview

CONCLUSION

There are many cases in clinical practice that may have significant psychopathology or have subthreshold symptoms but may not fulfil the diagnostic criteria laid down by DSM-5. In such cases it is warranted that a clinical approach be followed and treatment started in the light of a clinical evidence of psychopathology and treatment should not be withheld due to lack of a DSM diagnosis.
Though DSM plays an extensive role in classifying psychopathology, the above cases illustrate the lacunae in this classification system. Mental health professionals have used DSM to diagnose mental illnesses since decades but unfortunately this is fraught with problems as it is unable to encompass the wide range of individual variations seen in clinical practice.

Acknowledgements – Nil
Source of Funding – Nil
Conflict of Interest – Nil