Indian Journal of Psychiatry, January 1988, **30**(1), pp. 73–77

CHANGING DIAGNOSIS IN PSYCHIATRY

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SUMMARY

The present study was conducted to find out changes in the diagnosis of hospitalized patients. Out of 421 hospitalized psychiatric patients from 1974 to 1976, the diagnosis was changed in 54 (12.8%) patients. The change in diagnosis occured once in 51 and twice in 3 cases. Finally reasons for change and its implementations are discussed.

Introduction

Psychiatry is the field in which subjective bias come frequently in diagnosis of the patients, unlike that of medical field where objectivity is the key for diagnosis. We frequently come across patients whose diagnosis was schizophrenia at first admission but diagnosis was changed in subsequent admission to affective disorders and vice versa.

Spitzer et al. (1963) reviewed nine major studies of interjudge reliability where presentation of the raw data permitted the calculation of chance–corrected agreement, K. Although the different studies used slightly different classification schemes, the definitions of the major categories were similar. In only three categories did the level of agreement reach satisfactory values: mental deficiency, organic brain syndrome and alcoholism. Only fair agreement was reached for psychoses and schizophrenia. For the remaining categories the agreement was poor. Ward et al. (1962) found disagreement in diagnosis and these were grouped into three major categories: inconsistency on the part of the patient (5%), inconsistency on the part of diagnostician (32.5%) and inadequacy of the nosology (62.5%). In 2.5% cases an appreciable change in the clinical picture as a result of the diagnostic interview was considered crucial.

Another important study was the U.S. – United Kingdom study (Gurland et al. 1970) where diagnostic discrepancies were present. Rope and Lipinsky (1978) have estimated that about 40% of persons diagnosed as schizophrenia in U.S. are really mis–diagnosed manic depressives. Khanna and Channabasavanna (1984) found the diagnosis changed in 2.35% of their out door patients. In re–admission cases 25% cases had change in diagnosis from index admission (Ray & Chowdhury 1984).

In view of the above findings, we have attempted to find out the frequency of change of diagnosis in our center.

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Material and Methods

The files of the patients admitted to the Psychiatry Ward of Institute of Medical Sciences, Varanasi, from January 1974 to December, 1976 were scrutinized for the present study. During this period 23417 patients attended the out–patient department. Among these 23417 patients, 421 patients were hospitalized for management. The diagnostic criteria used during those periods was I.C.D. 8th Revision. The patients who were readmitted to the same unit prior to the present (index) admission form the study group. We have analysed the records of the patients to find out changes in diagnosis in subsequent admissions and reasons for it. We have kept diagnostic criteria as above, so that diagnostic criteria will remain constant.

Results

Four hundred and twenty one adults were admitted to the Psychiatry Ward, during the study period, of which 101 cases had been admitted to the same unit earlier also; which forms the readmission group.

Total Admission	– 421
First Admission (Admitted for first time)	– 320 (76%)
Re-admissions	– 101 (23.9%)

Of the re-admissions, the number of earlier admissions is as follows:

Re-admission	– 101
1 previous admission	– 78 (77.2%)
2 previous admissions	– 18 (17.8%)
3 previous admissions	– 5 (4.9%)

Out of four hundred and twentyone hospitalized diagnosis was changed as follows:

Diagnosis changed	– 54
Diagnosis changed once	– 51 (94.4%)
Diagnosis changed twice	– 3 (5.6%)

Thus out of 421 admitted patients diagnosis was changed in 54 (12.8%) cases. Out of 101 readmitted patients diagnosis was changed in 54 (53.46%) patients. Details of change in pattern of diagnosis is given in Table–1. Regarding reasons for change, out of 12 initial diagnosed schizophrenia patients 4 developed grandiosity, pressure of speech, 5 patients had preoccupations with reactive factor, and quick recovery with treatment, 3 had fits of hysterical nature. Out of 12 MDP patients 10 showed persecutory delusion, blunt affect, 2 patients had poor memory, incontinence of urine and epileptic fits. Out of 9 reactive depression patients, 6 showed incongruity of affect, auditory hallucinations, 3 demostrated pressure of speech and grandiosity. Out of 6 hysterical patients all developed grandiosity and pressure of speech, elation but subsequently 3 patients demonstrated auditory hallucination and incongruity of affect. Out of 6 initially diagnosed OBS patients 3 showed catatonic features, and 3 showed depressive features.

Majority of the patients 45 (83.3%) showed change in presenting symptomatology at readmission. 6 (11.11%) patients diagnoses were deferred and thus 2 possible diagnoses were kept and final diagnosis was made on follow up and readmission. Three patients (5.5%) of Involutional Melancholia changed into affective disorders, here it seems that nosological difficulties must be the reasons.

Discussion

We found that in 12.8% of hospitalized patient diagnosis was changed. Kreitman et al. (1961) reported that the agreement in the diagnosis of schizophrenia among psychiatrists in British is only about 60%, the rate varying according to the theoretical background of the

Table I
Change in Diagnosis

Previous Diagnosis	Total No. of cases N = 101	Diagnosis change N = 54	Re-admission Diagnosis				
			Schizophrenia	MDP	Reactive	Dep. Hyst. Neur.	OBS
Schizophrenia	32	12		6(50%)	3(25%)	3(25%)	
MDP	28	12	10(83.3%)				2(6.6%)
Reactive Depression	12	9	6(66.6%)	3(Mania)			
Hysteria	8	6	3*(50)	6(100)			
OBS	9	6	3(50)	3(50)			
Involutional Melancholia	4	3		3(100)			
Diagnosis deferred	7	6	3(50)	3(50)			

* These 3 patients who were diagnosed as Mania subsequently changed into Schizophrenia (so diagnosis in these cases changed twice)

psychiatrists. There is no Indian study in this area. However, Malhotra et al. (1982) reported that an unintended observation of academic interest was than in one third of readmission cases the diagnosis changed, and change from schizophrenia to MDP was seen equally common. In our study change from schizophrenia to MDP was 50 per cent while MDP to schizophrenia 83.3 per cent. Pope and Lipinski (1978) have estimated that about 40% of persons diagnosed as schizophrenia in United States are misdiagnosed manic–depressive. On other hand Kazanets (1979) found a very low stability of diagnosis of schizophrenia in a 20 years follow up study of 312 schizophrenics. It gives the evidence that reliance on schizophrenia and under diagnosis of Manic depressive illness, especially in good prognosis cases, it is of interest to ask how frequently such possible misdiagnosis actually occur in current American Practice. The data of Taylor and Abraham, are alarming in this respect as 39% of consecutive patients diagnosed as schizophrenia satisfied multiple validating criteria for mania. Change also seem to be more when in-patients alone are studied, with rates ranging from 16.5% (Amara 1978)) to 24.92% (Ray and Roy Chowdhury 1984). Other recent studies show rates varying from 0.1% (Ibe and Berton 1980, Andreassen et al. 1981) to 50% in a one year follow up in the Comberwell Catchment area (Jakubaschk and Hurry 1977).

However, there is no doubt regarding changes in diagnosis of psychiatric patients. Similarly classification of functional psychoses has traditionally been dichotomous with schizophrenia and manic depressive disorders, which are considered separate entities. However, psychiatric literature is replete with descriptions of psychoses with mixed features. A variety of names have been applied to these psychoses, including the term "Schizo – affective". The reason of change may be diagnosis of Schizo affective, because it

presents with plethora of symptoms of Schizophrenia and affective disorder. In such cases there are more likelihood of misdiagnosis of either schizophrenia or afective disorder (Warren 1976). The reasons may be multiple. Firstly classical schizophrenia symptoms including many types of hallucinations, delusions, catatonic symptoms and Schneiderian First rank symptoms are reported in 20-50% of cases of manic depressive illness. Secondly misdiagnosis or overdiagnosis of schizophrenia over manic depressive illness. The American Psychiatric Association's diagnostic and statistical mannual of mental disorder (DSM III) have changed the diagnostic criteria of schizophrenia by adding symptoms present for atleast 6 months duration (to avoid over diagnosis of schizophrenia). Cooper (1977) hypothesised that a change in diagnosis could occur due to (i) different illness in same patient (ii) a part of the course of the same illness and (iii) a part of artifact as a result of differences between clinicians, terminology and classificatory nomenclature.

It is very important to give correct diagnostic label to patients firstly because the label of 'Schizophrenia' in and of itself, appears to have damaging effects for patients and their relatives (Scheff 1966). Furthermore, it is likely to create a more pessimistic attitude among treatment personnel than the label of 'Mania' or 'Depression' as attitude that may profoundly affect treatment or planning and rehabilitation. Secondly, the advent of Lithium Carbonate re-doubled the need for diagnostic accuracy. Thirdly possibility of misdiagnosis exposes large number of patients to increased social stigma, inferior treatment, and potentially irreversible neurological damage due to over use of neuroleptic drugs.

There is growing need for conducting such studies in larger samples in different centres, so that it may contribute towards understanding the phenomenology and the natural course of the psychiatric illnesses.

References

AMARA, I.B. (1978), Consistency in the diagnosis of functional psychosis. *Canadian Psychiatric Association Journal*, 3, 23, 329-332.

ANDREASEN, N.C., GROVE, W.M., SHAPIRO, R.W., KELLER, M.B., HIRACHFIELD, M.A., Mc DONALD, S.P. (1981), Reliability of life time diagnosis a multicentered colloborative perspective, *Archives of General Psychaitry*, 38, 400-403.

COOPER, J.E., (1967), Diagnostic change in a longitudinal study of psychiatric patients. *British Journal of Psychiatry*, 113, 129-135.

GURLAND, B.J., FLEISS, J.L., COOPER, J.E. et.al. (1970), Cross national study of diagnosis of mental disorder: Hospital diagnosis and hospital patients in New York and London, *Comprehensive Psychiatry*, 11, 18-22.

IBE, E.O., BORTON, J.L. (1980), Schizophrenia to manic depression: mutation or misdiagnosis, *American Journal of Psychiatry*, 137, 742-745.

JAKUBASCHK, J. AND HURRY, J. (1977), Diagnosis in the Camberwell register a cumulative psychiatric case register, Schweiz. *Archives of Neurology, Neurosurg, Psychiatry*, 120, 243-247.

KAZANETZ, E.P. (1979), Differentiating exogenous Psychiatric illness from schizophrenia, *Archives of General Psychiatry*, 36, 740-744.

KHANNA, S. & CHANNABASAVANNA, S.M. (1984), Diagnostic stability over five years: Aretrospective study, *Indian Journal of Psychological medicine*, 7, 82-86.

KREITMAN, N., SAINBURG, P. et.al. (1961), The reliability of psychiatric Assessment, *Journal of Mental Science*, 107, 887-890.

MALHOTRA, S., SRINIVAS MURTHY, R., VARMA, V.K. et.al. (1982), Readmission in general hospital psychiatric unit-socio-economic and clinical correlates, *Indian Journal of Psychiatry*, 24, 37-40.

POPE, H.C., LIPINSKI, J.P. (1978), Diagnosis in Schizophrenia and Manic Depressive Illness – Reassessment of the specificity of Schizophrenic symptoms the light of current research, *Archives of General Psychiatry*, 35, 811-817.

RAY, R. & ROY CHOWDHURY, J. (1984), Stability of Psychiatric diagnosis, *Indian Journal of Psychiatry*, 26, 164-168.

SCHEFF, T.J. (1966), Being mentally ill: A Sociological Theory, Chicago Aldina Publishing Co. 1966.

SPITZER, R.L. & FLEISS, J.K., BURDOCK, E.I. & HARDESTY, A.S. (1963), Mental Status schedule.Rationale, reliability and validity, *Comprehensive Psychiatry*, 5, 384-388.

WARD, C.H., BECK, A.T., MENDELSON, ME. et.al. (1962), The Psychiatric Nomenclature: Reasons for diagnostic disagreement, *Archives of General Psychaitry*, 7, 198–201.

WARREN, R.P. (1976), Schizo Affective Psychosis: Fact or Fiction, *Archives General Psychiatry*, 33, 1167–1178.