WHAT DO WE CALL PEOPLE WHO HAVE HAD BREAKDOWNS?

The diagnostic dilemma of long-term psychiatric disability?

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People have varying levels of resilience. We are battered by life and become bruised, some are broken, their resilience gone. They have a chronic psychological disability, many become claimants of various state and commonwealth schemes. This “broken” group are not well recognised by our current diagnostic systems nor well treated, managed or adequately compensated. This paper explores this situation and highlights the inadequacy of our diagnostic systems, DSM5 and ICD-10 in understanding this group.

I have been doing medicolegal assessment for more than 30 years. During this time I have seen more than 25,000 claimants. Amongst this multitude has emerged a particular group who I struggle to diagnose. These are men and women who have had no pre-existing mental health issues and have been effective in middle management or equivalent positions.

People like Tom, a middle-aged teacher who crumbled over a period of years as his department was destroyed by bureaucratic indifference and student vandalism, or Margaret, a proud resourceful woman whose daughter was murdered, by a close family friend who had grieved with her; or George, a police sergeant who never recovered from an horrific siege.

George was diagnosed with post-traumatic stress disorder, major depressive disorder with suicidal ideation, panic disorder, agoraphobia and alcohol abuse.

These three represent the group I am describing, I will call them the X Group. They have encountered stressors, some acutely severe and some long-term that have led to them ceasing work. Initially they have had a variety of symptom profiles leading to different diagnoses. They have had appropriate treatment but years later remain significantly dysfunctional. Some say they have had a “breakdown” some describe themselves as “broken”.

Their symptom profiles have converged to such an extent that they could be described as suffering from the same “syndrome”. The prime characteristic of this “syndrome” is an ability to cope. Symptoms include emotional lability, cognitive changes especially memory, social impairment, fatigue and withdrawal. Many have alcohol abuse, excessive cigarette consumption, cannabis abuse. Most continue to take medication but have ceased mental health treatment and live very isolated lives.
However current diagnostic systems make it difficult to conceptualise people in this group as having the same diagnosis. Consider George who has had five different diagnoses with different implications for treatment.

Contrast this situation with a patient who has the following symptoms:

- shortness of breath
- weakness or fatigue
- increased nocturnal urination
- swelling or bloating
- coughing and wheezing
- irregular heartbeat
- loss of appetite
- dizziness
- weight gain
- reduced memory, alertness and concentration

These diverse symptoms have a common cause - congestive heart failure. Treatment of these individual symptoms is of little value if the underlying cause is not dealt with.

Are we dealing with a similar situation in psychiatry? Is each diagnosis the manifestation of a symptom or similar groups of symptoms but the underlying issue is not recognised or treated?

A nosology for the classification of mental disorders into diagnostic categories is a fundamental and practical tool.

A nosology is useful for research - to integrate and guide empirical studies. For healthcare delivery to guide treatment and to make prognoses. In the context of medico legal assessment nosology is also important and leads to:

- acceptance of claims,
- funding for treatment, rehabilitation
- a supported return to work.
- long term benefits, if appropriate

The people in the X Group have emotional liability, cognitive impairment, in particular with regard to working memory and organisation, fear of socialising, physical symptoms including fatigue, sleep and appetite disturbance and for many reduced coordination. They lead a very limited, isolated life and have mostly ceased all their former recreational and social activities.
People in the X Group have had a myriad of advice with little benefit. All have, by trial and error, found strategies that help them to get through the day. These include:

- alcohol
- staying home
- avoidance:
  - answering the door
  - answering phone calls from strangers
  - social events
  - shopping
  - family and friends
  - reminders of stressors
- distraction techniques to stop ruminations
- techniques for dealing with panic
- resting

The initial diagnoses no longer seem an accurate reflection of their current symptoms. Their symptoms have converged to a common "syndrome" characterised by their failure to cope.

DSM5 and the ICD-10 and their precursors have no diagnostic categories that adequately encompass this group.

Many claimants tell me that they have experienced a “breakdown”. A term worth examining.

**Breakdown**

Breakdown is a term that is not recognized in the professional literature. An extensive search for “nervous breakdown”, “stress breakdown”, “breakdown” has found only one citation referring to breakdown.

A 2010 study (Rapport) investigated views about nervous breakdown in two lay groups.

*Both groups described a time-limited condition that presented with anxious and depressed features, associated with a series of external precipitating stressors (e.g., interpersonal, employment, and financial losses). Dimensions excluded included psychoticism, somatization, phobic anxiety, and mania. Respondents held a relatively unitary view of nervous breakdown:*

An Internet search for “breakdown” and its synonyms, stress breakdown, mental breakdown, nervous breakdown reveals many non-medical references to the term with descriptions, symptom lists, treatment suggestions and so forth.

Wikipedia states:

- "nervous breakdown" and "mental breakdown"
- *not in DSM-5 or ICD-10.*
Post-traumatic psychological disability

- nearly absent from current scientific literature regarding mental illness
- surveys of laypersons
  - refers to a specific acute time-limited reactive disorder,
  - anxiety or depression, usually precipitated by external stressors
- For some a "breakdown" refers to
- emotional and physical demands so great there is an inability to do activities of daily living or
- from performing family or occupational responsibilities

Although the various sites provide differing symptoms they consistently state that a "breakdown" is a time-limited event. This is not the situation with this group.

Edward Shorter a professor of psychiatry and the history of medicine in his book How Everyone Became Depressed: The Rise and Fall of the Nervous Breakdown (2013), differs with the orthodox view and argues for a return to the old-fashioned concept of nervous illness:

*We have a package here of five symptoms–mild depression, some anxiety, fatigue, somatic pains, and obsessive thinking. ... We have had nervous illness for centuries. When you are too nervous to function ... it is a nervous breakdown. But that term has vanished from medicine, although not from the way we speak. ... The nervous patients of yesteryear are the depressives of today. That is the bad news. ... There is a deeper illness that drives depression and the symptoms of mood. We can call this deeper illness something else, or invent a neologism, but we need to get the discussion off depression and onto this deeper disorder in the brain and body. That is the point. (my emphasis)*

Professor Shorter is referring to a similar group to the group I am describing. However, the term "breakdown" in all its associated synonyms are so tainted by the disdain of academia that they can no longer be resuscitated. The terms are also non-specific and are of little treatment value.

Another term that has come to the fore recently is the “p Factor”.

**The p factor**

There is an emerging view, with evidence, that there is one general psychopathology factor in the structure of psychiatric disorders.

Casi et al 2103 noted that a persistent challenge to the DSM and related nosology is was the very high rate of comorbidity in psychiatry. 50% of those who meet diagnostic criteria for one disorder also meet diagnostic criteria for a second disorder, 50% with two disorders meet criteria for third disorder and so forth.

This paper examined recent research on the epidemiology of mental disorders:
1. Life-course epidemiology, there is a need for longitudinal research to study the course of psychopathology, in addition to cross-sectional studies.
2. Need to take into account both concurrent and sequential comorbidity when evaluating the structure of psychopathology.
3. Efforts to model psychopathology without consideration of psychotic symptoms may not capture the true structure in the population.
4. Twin studies and risk-factor studies imply that the causes of different disorders may be similar, highlighting the potential value of a transdiagnostic approach to psychiatric disorders.
5. Diagnostic thresholds are arbitrary, there is meaningful and useful clinical information above and below diagnostic thresholds.
6. In addition to propensities to specific forms of psychopathology, there may be one underlying factor that summarizes individuals’ propensity to develop all forms of common psychopathologies.

Casi et al used data from the Dunedin Multidisciplinary Health and Development Study, a longitudinal investigation of health and behavior in a complete birth cohort. Study members ($N = 1,037$; 91% of eligible births; 52% male, 48% female) were all individuals born between April 1972 and March 1973 in Dunedin, New Zealand, who were eligible for the longitudinal study based on residence in the province at age 3 and who participated in the first follow-up assessment at age 3. The cohort represents the full range of socioeconomic status in the general population of New Zealand’s South Island and is primarily White. Assessments were carried out at ages 3, 5, 7, 9, 11, 13, 15, 18, 21, 26, 32, and at 38 years, when 95% of the 1,007 study members still alive were assessed.

They concluded that the structure of psychopathology can be explained by three main dimensions:

- Externalising (substance abuse and anti-social disorders), Internalising (depression and anxiety) and Thought Disorder (psychotic symptoms). In addition to these three dimensions, an overlying general factor (coined the ‘p factor’) was confirmed, which best explained dispositions in developing any type of mental disorder. The p factor was associated with life impairment and a family history of mental disorders. Developmental histories and compromised brain integrity from early life also showed correlations with both the three underlying factors and the p factor. The finding of a general factor of psychopathology further validates previous claims that mental disorders show to be comorbid as well as continuous throughout development.

This fascinating research is important and reinforces my view that a longitudinal research is needed in addition to cross-sectional studies. It also highlights the need to take into account both concurrent and sequential comorbidity when evaluating psychopathology.
The concept of a common factor in psychopathology has profound implications but, in my view, is not relevant with regard to the group I am describing, people in this group have reached the middle part of their life with no evidence of any psychopathologies "continuous throughout development". There may be a "q" factor!

**DSM5 and ICD-10 (11)**

Diagnostic symptoms are based on either causation, such as Post Traumatic Stress Disorder or, in the absence of obvious causation, the predominant symptom, for example Major Depressive Disorder. This causes problems, many of us have seen people with all the symptoms of Post Traumatic Stress Disorder but who do not meet criterion A and we struggle to find an appropriate diagnosis.

Another problem with our diagnostic symptoms is that they give little guidance regarding change in symptoms over time. The more major defect, in my opinion, is the lack of any clear method for assessing levels of dysfunction. The fundamental disorder present in the group I am describing is loss of coping function and this has profound effects on their work capacity, their relationships, their recreational activities and their overall quality of life. To ignore their inability to cope is to do them a major disservice.

There are glimpses in both the DSM system and ICD that hint at a recognition of the issues being discussed. In particular DSMIV, with its little used multiaxial system including:

- Axis I: Clinical Disorders
- Axis II: Personality Disorders and Mental Retardation
- Axis III: General Medical Conditions
- Axis IV: Psychosocial and Environmental Problems
- Axis V: Global Assessment of Functioning (GAF)

The multiaxial system did provide for combining clinical disorders with psychosexual and environment mental problems and an assessment of functioning. It has been abandoned in DSM5 on the basis that Axis I, Axis II and Axis III to separately note diagnosis from psychosocial and contextual factors. Axis V, the GAF has been abandoned because it was not reliable. DSM5 has replaced the GAF with the WHO Disability Assessment Schedule (WHODAS).

The WHODHAS consists of seven categories and 36 questions. These categories include:
- understanding and communicating
- getting around
- self care
- getting along with people
- household activities
- school/work activities
- participation in society

Of the 36 questions approximately 10 questions relate directly to mental health issues.
However, in practice, the WHODAS is little used. The fundamental problem remains that of relating a diagnosis to levels of function. The authors of DSM5 have a paragraph in the section regarding Post Traumatic Stress Disorder:

*Functional Consequences of Post Traumatic Stress Disorder*

*PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high level of medical utilisation. Impaired functioning is exhibited across social, interpersonal, developmental, educational, physical health, and occupational domains. In community and veteran samples, PTSD is associated with poor social and family relationships, absenteeism from work, lower income and lower educational and occupational success.*

This paragraph is consistent with what the experience of the X Group.

However there are two problems with this.
- Many in this X Group do not meet the criteria for a post traumatic stress disorder.
- There is no method of incorporating this paragraph into the diagnosis or into the subcategories of that diagnosis.

Another entity that is included in DSM5 as a condition for further study is Persistent Complex Bereavement Disorder. The symptoms include persistent yearning for the deceased, intense sorrow and emotional pain in response to the death, preoccupation with the deceased and with the circumstances of the death with reactive distress to the death and social/identity disruption.

There are some features of this diagnosis consistent with the target group however this condition is restricted to those who have been bereaved and hence has limited scope.

**Is the ICD 10 any better?**

ICD 10 was first used in 1994. There is a diagnostic category in ICD 10 that is not present in DSM5. Enduring Personality Change after Catastrophic Experience. This diagnosis was reviewed by Beltran and Silove the initiators of the term in 2011, almost 2 decades after it was first introduced in ICD 10.

The definition of EPCACE in ICD-10 is:

*Enduring personality change, present for at least two years, following exposure to catastrophic stress. The stress must be so extreme that is not necessary to consider personal vulnerability in order to explain its profound effect on the personality. The disorder is characterised by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a*
chronic feeling of “being on edge” as if constantly threatened, and estrangement. Post traumatic stress disorder may precede this type of personality change.

Personality change after:
- concentration camp experiences
- disasters
- prolonged
  - captivity with imminent possibility of being killed
  - exposure to life-threatening situations such as being a victim of terrorism
- torture

The review noted some problems with the diagnosis including its focus on personality change leading some to questioning whether it was appropriate to categorise this diagnosis as a personality disorder.

The review discussed the literature regarding the effects of extreme trauma including Concentration Camp Syndrome and Chronic Neurotic Reactions (Eitinger 1964 and others, Bychowski (1968), Chodoff (1966), Krystal (1968);

Concentration Camp Syndrome was characterised by:
- difficulties in memory and concentration
- increase in fatigue
- dysphoria
- emotional instability
- sleep disturbances
- feelings of inadequacy
- amotivation
- irritability and nervousness

Chronic Neurotic Reactions included somatization symptoms:
- sleep disturbances
- anxiety
- depression
- hypersensitivity
- difficulties in functioning
- difficulties in relationships.

These symptoms are similar to those experienced by the target group.

Beltran and Silove (1999) circulated a questionnaire to therapists regarding causes of post-traumatic personality change in adults. Causes of EPCACE were ranked, as expected torture and concentration camp experiences rated very highly, war exposure, sexual assault, hostage situations and domestic violence rated between 50-75%. Of particular interest with regard to the X Group’s was the rating of natural disasters or
motor vehicle accidents as the cause of EPCACE for about 25% of people in this category! This finding did not lead to any change in the list of severe traumatic events required for the diagnosis however.

There are three problems with the diagnosis of Enduring Personality Change after Catastrophic Experience with regard to the group I am describing.

The major problem is that they do not meet the initial criteria:

- concentration camp experiences
- disasters
- prolonged
  - captivity with imminent possibility of being killed
  - exposure to life-threatening situations such as being a victim of terrorism
- torture

The second problem is that the term “personality change” removes the focus from the underlying and more fundamental issue of global coping dysfunction. There are also concerns about using the term personality change as it implies categorisation in the group of personality disorders.

The third and more trivial problem is the clumsiness of the name. It does not trip off the tongue, it is not easy either to say EPCAPE or to remember it.

Similar syndromes include Complex Post Traumatic Stress Disorder (Complex PTSD) or Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Research on Complex Post Traumatic Stress Disorder (Complex PTSD) or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) has been mainly in the area of sexual abuse, physical abuse, childhood trauma, with combat veterans and with refugee survivors of torture and ethnic cleansing and in individuals with other histories of trauma. Three major areas of dysfunction were recognised:

- symptoms
  - somatisation
  - dissociation
  - affective changes including:
    - rage
    - depression
    - self-hatred
    - chronic suicidality
- character change
  - dependency
  - passivity
  - helplessness
post-traumatic psychological disability

- intense attachment in or extreme withdrawal from relationships
- pathological changes in identity and sense of self
  - repetition of harm
    - these phenomena make them vulnerable and at risk of repeated harm or repeated victimisation. These can be self-inflicted or at the hands of others.

ICD-11 has added Complex Post Traumatic Stress Disorder (incorporated Enduring Personality Change after Catastrophic Experience) despite DSM5 deciding not to do so because of a lack of evidence that CPTSD can be separated from PTSD. The symptom clusters of CPTSD in ICD-11 are similar to the DSM5 criteria for PTSD with the difference being causation. (Karatzias et al)

ICD-11 CPTSD causation includes:
- multiple traumatic events
- multiple incidents of child abuse
- prolonged domestic violence
- concentration camp experiences, torture, slavery, and genocide campaigns

DSM5 PTSD causation: The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):
- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Discussion:

There are a significant group of people who have functioned well but have had exposure to an acute or prolonged stressor(s) that usually does not meet the criteria for Complex Post Traumatic Stress Disorder (ICD-11) and may not meet Criterion A for Post Traumatic Stress Disorder (DSM5). This adversity has caused permanent damage leading to major dysfunction in social, occupational and recreational activities with the development of significant symptoms. Treatment has usually been appropriate in type and duration but this group have been left with enduring symptoms and high levels of disability.

Furthermore this group have had a variety of initial diagnoses depending on either the cause of the condition (leading to the diagnosis of PTSD) or the major symptom (major depressive disorder) but over time their symptoms and disabilities have merged and the target population have developed many common features. This notion of a morphing of diagnosis over time is not encompassed by our diagnostic systems nor is a suitable means of incorporating levels of dysfunction.
This group are not adequately encompassed in either the DSM5 or the ICD-10.

Diagnosis is important not only with regard to treatment but also with regard to conceptualising a suffering patient. Diagnosis is also important in a medicolegal context.

The lack of an accurate diagnosis means this target group ‘disappears’ as a group and individuals are ‘pushed’ into the category that most closely approximates their symptoms. Furthermore the focus is usually on recovery, the permanent damage is not recognized. The focus should be on ‘coping with not coping’ with symptomatic reduction rather than on a ‘cure’.

The failure of current diagnostic symptoms has disadvantaged claimants. The lay term “breakdown” is not a robust diagnosis despite Shorter’s defence of the term. For reasons described the other options are not appropriate.

It may be time for a diagnosis suitable for this group who:
- have previously functioned well
- have been exposed to significant stressors that may not meet the causation criteria required for PTSD and CPTSD
- have developed clinically significant symptoms
- have become dysfunctional in social, occupational and recreational activities
- have not responded to treatment
- are permanently damaged
- been left with long-term psychological disability

A suggestion is the term “post-traumatic psychological dysfunction - chronic”.

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