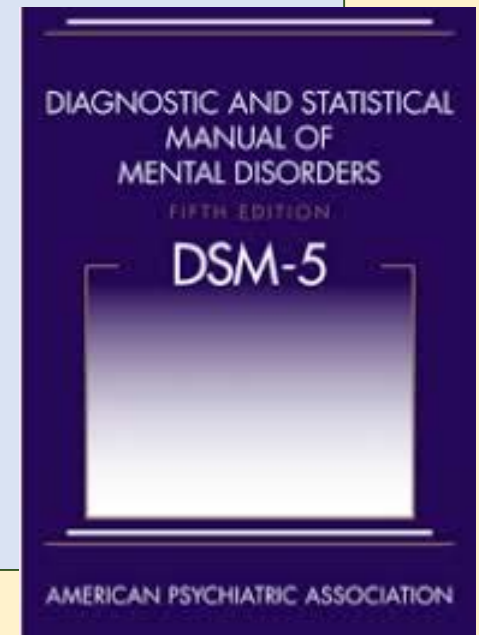
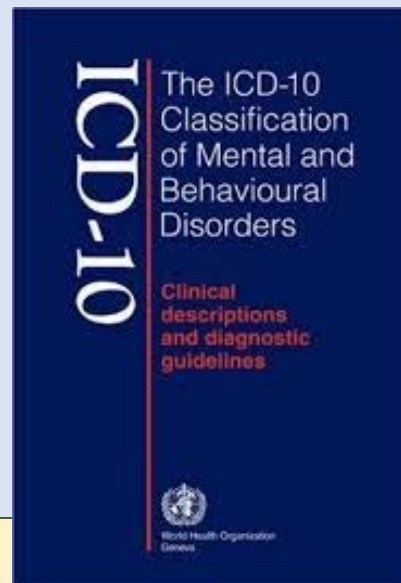


Lecture 1:Defining and classifying mental illness

- Historical and contemporary diagnostic processes
- The use of classification systems; DSM5 and ICD10
- Reliability, validity and utility
- Bias in diagnosis
 - Gender
 - Culture
 - Expert role



Current state of play: The Medical Model



- This is the best known model of abnormal behaviour in our culture. Mental disorders are regarded as `illnesses` and have a physical cause such as disease, infection, brain damage, brain chemistry or genetics.
- The type of illness which has a clear physical cause is referred to as **organic**.
- When the physical origin of a disorder is unclear, we call these illnesses **functional**.
- Many patients take comfort from the fact that their illness is down to factors outside their control, and the model sees the patient as not being held responsible for their abnormal behaviour.

How did diagnosis begin?

- It began with the work of Kraepelin- He claimed certain groups of symptoms occur together sufficiently often for them to be called a disease or syndrome...an underlying physical cause.
- He regarded each mental illness as distinct from all others with it's own origins, symptoms course and outcome.
- Kraepelin classified two major groups-
- Dementia praecox (Chemical imbalance) and manic depressive psychosis (faulty metabolism).

- This helped to establish possible organic causes and formed the basis of the **DSM Diagnostic statistical Manual (APA)** & the **ICD International Classification of Diseases (WHO)**.
- His work is still embedded in the Mental Health Act (1983, 2007) and is still used today.
- The ICD 10 and DSM-5 are based largely upon the experiences and beliefs reported by patients because there is no other objective biological markers for psychotic or neurotic disorders (Frith & Cahill, 1995).

General back ground to ICD & DSM

- WHO added psychopathologies to the ICD as a cause of death in 1939 but at first, was not widely accepted, therefore DSM was created in 1952 by APA.
- The 2nd edition was published in 1968, followed by the 3rd edition in 1980. As you know, both the current DSM-5 and ICD10 are much more co-ordinated in current times.

Diagnosing abnormal behaviour

- ICD 10 is the British system, and DSM-5 is the American system.
- These systems aim to enable a suitable form of treatment for the illness. Psychiatrists use these when diagnosing mental illness. Both ICD10 and DSM5 group symptoms together in categories, therefore they have the same limitations as closed questionnaires-
- A yes or no decision must be made, but...
- Pilgrim (2000) argues that the difference between mental health and mental illness is a matter of **degree**, and the severity of an illness is a more important indicator of mental disorder.

The current perspective:

- DSM-5: Last major update (May 2013).
- The manual is non-theoretical and focused mostly on describing symptoms as well as statistics concerning which gender is most affected by the illness, the typical age of onset, the effects of treatment, and common treatment approaches.
- The **DSM** was based on five different dimensions. This multi-axial approach allowed clinicians and psychiatrists to make a more comprehensive evaluation of a client's level of functioning, because mental illnesses often impact many different life areas. However, important changes have been made within DSM-5. It is no longer multi-axial for example.

DSM-IV-TR – pre-2013 update

- **Axis I: Clinical Syndromes**

This axis described clinical symptoms causing significant impairment. Disorders were grouped into different categories, including adjustment disorders, anxiety disorders, and pervasive developmental disorders.

- **Axis II: Personality and Mental Retardation**

This axis described long-term problems that were overlooked in the presence of Axis I disorders. Personality disorders cause significant problems in how a patient relates to the world and include antisocial personality disorder and histrionic personality disorder. Mental retardation is characterized by intellectual impairment and deficits in other areas such as self-care and interpersonal skills.

- Axis III: Medical Conditions
These included physical and medical conditions that may influence or worsen Axis I and Axis II disorders. Some examples may include HIV/AIDS and brain injuries.
- Axis IV: Psychosocial and Environmental Problems
Any social or environmental problems that may impact Axis I or Axis II disorders were accounted for in this assessment. These included things such as unemployment, relocation, divorce, or the death of a loved one.
- Axis V: Global Assessment of Functioning
This axis allowed the clinician to rate the client's overall level of functioning. Based on this assessment, clinicians could better understand how the other four axes interacted and affected the individual's life.

- Rather than grouping disorders categorically as previous versions of the DSM had done, related disorders and chapters are now grouped together based on underlying vulnerabilities and symptom characteristics. Ultimately, the purpose is to improve diagnostic and treatment approaches, and signal shared commonalities in aetiology within larger disorder groups.
- The changes also align the DSM-5 with the World Health Organization's (WHO) International Classification of Diseases, eleventh edition (ICD-11). These changes are expected to help improve communication and the common use of diagnoses across disorders within chapters. The eleventh version is due out in 2018.

The New Sections of DSM-5

- DSM-5 is now comprised of only three sections:
- 1. Section 1: An introduction to DSM-5 with information on how to use the updated manual
- 2. Section 2: An outline of the categorical diagnoses according to a revised chapter organization
- 3. Section 3:
 - Conditions that require further research before their consideration as formal disorders
 - Cultural formulations
 - Glossary
 - Names of individuals involved in DSM-5's development
 - Other information

ICD 10-CM: (WHO)
Last updated 2012.

- As of the end of 2008, there were 68,064 ICD-10-CM codes. The World Health Organization developed the basic ICD-10. ICD-10-CM was developed through collaboration with physician specialty groups who reviewed the basic ICD-10 and identified areas where greater detail was needed.
- Most of the world is using ICD-10 or a clinical modification of ICD-10.

Why have two classification systems?

How do they differ?

- The ICD is produced by a global health agency with a constitutional public health mission, while the DSM is produced by a single national professional association (APA).
- WHO's focus (mental and behavioural disorders) is to help countries to reduce the burden of mental disorders. ICD's development is global, multidisciplinary and multilingual; the primary constituency of the DSM is U.S. psychiatrists.
- The ICD is approved by the World Health Assembly and the health ministers of all 193 WHO countries; the DSM is approved by the assembly of the American Psychiatric Association.
- The ICD is distributed broadly at a very low cost and available free on the Internet; the DSM generates a very substantial portion of the APA's revenue, from sales, related products and copyright permissions for books and scientific articles.
- The DSM contains more detailed information than the ICD regarding mental and behavioural disorders.

Why is it important to know about DSM and ICD?

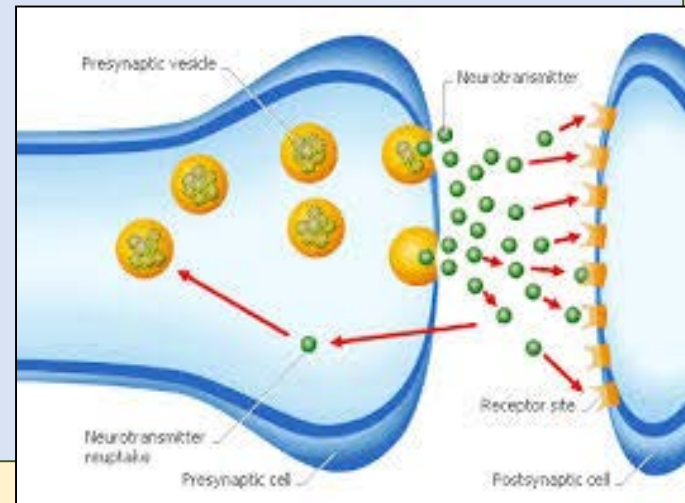
- Without these classification systems it is difficult to define what we mean by mental illness or psychopathology.
- These manuals help clinicians rule out `normal but socially deviant` behaviours from psychopathology.
- The emphasis is on `distress` and `disability` as defining features of a mental illness.
- There are 4 main objectives with DSM:
 - (i) provide necessary and sufficient criteria for correct differential diagnosis
 - (ii) to distinguish true psychopathology from problems with everyday living.
 - (iii) to apply diagnostic criteria that can be systematically be used by clinicians in a variety of settings.
 - (iv) to develop theoretically neutral diagnostic criteria.

Back to: The Medical Model

- The medical model views mental illness much as it views physical illness and hence refer to psychological problems as 'illness.' Of all the models it is the most scientific and hence the most well respected.
- **1. Assumptions**
- Psychological illnesses have a physical cause (genetic, chemical, anatomical etc.)
- Treatment of psychological illness will require a physical intervention (surgery or drug treatment for example).
- The medical model believes that psychological illness can be caused by one of the following physical causes:

Neurotransmitters:

- E.g. adrenalin, serotonin and dopamine.
- Imbalances in these chemicals can lead to psychological disorders.
- We know that LSD can cause similar symptoms to schizophrenia and that LSD is chemically similar to the brain chemical dopamine.
- It also seems reasonable to assume that an abnormal brain chemistry is an inherited characteristic.
- E.g. The Dopamine Hypothesis of schizophrenia
- E.g. Prozac, for treating depression appears to work by increasing the brain's levels of serotonin.



- Infections can cause physical illness, e.g. colds, flu, meningitis etc., but can they cause psychological illness?
- In the 19th century it was found that the syphilis bacterium was responsible for a disorder known as general paresis which resulted in delusions and forgetfulness.
- Today- the viral theory of schizophrenia has suggested that influenza during the middle section of pregnancy, can lead to an increased incidence of schizophrenia when the child reaches maturity...

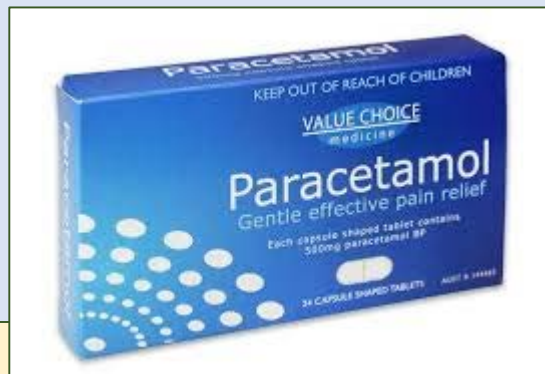


Evaluation of The Medical Model

- The model has lead to a number of widely used and effective treatments for various disorders. Drugs have the added bonus of being quick and easy to take compared to psychological treatments that can take months and be very costly. But, there are many problems with psychopharmacology...
- With much of the research there is the problem of cause and effect. For example if we carry out a post mortem on a schizophrenic and find enlarged ventricles, can we be certain that these caused the schizophrenia? Perhaps the schizophrenia has caused enlargement of the ventricles.
- No psychological disorder has a 100% concordance rate when MZ twins are compared. There are many cases of one twin having a psychological disorder and their identical twin showing no symptoms.

'Treatment aetiology fallacy'

- You have a headache so you take aspirin- the headache disappears.
- Conclusion- lack of aspirin must have caused the headache!
- Unlikely, but that is what the medical model suggests.
- Prozac increases the levels of serotonin therefore lack of serotonin must have been the cause of the depression.
- What are the problems associated with this?



- There is a danger that concentrating on physical definitions and treatments that we ignore the root causes of psychological illness such as poverty, stress and inequality (Szasz 1961).
- Szasz questions the medical model's use of the term 'psychological disorder.' If a disorder has a physical cause then surely it should be classed as a physical illness.
- Epilepsy has a clear physical cause but irrational or negative beliefs, hallucinations and low mood have no such obvious physical cause and, according to Szasz should be viewed as 'disorders of the mind' ruling out the medical model.

- If mental illness such as schizophrenia is a physical disorder caused by genetics or brain structure, can we hold them responsible for their illness or their behaviour?
- Also, if you know that a particular disorder is partly genetic and there is a family history of it, will you start to look for signs of it in yourself or in others?
- We then have the self-fulfilling prophecy and stereotyping.

The Biopsychosocial Model

- As an alternative to the Medical Model, the biopsychosocial model of health and illness was developed by George L. Engel (1977), stating that interactions between biological, psychological, and social factors determine the cause, manifestation, and outcome of wellness and disease.
- He argued that the bio-medical perspective was too reductionist and that a holistic perspective grounded in general systems theory was necessary to address health related issues.
- Within psychology, some have argued that the biopsychosocial framework provides the central pathway to unify clinical psychology.

The Biopsychosocial Model

- However not all agree. Some argue that psychological and social explanations can be reduced to the physical for instance.
- One of the most widely cited criticisms is that its inclusiveness results in an unscientific, “fluffy”, pluralistic approach where “anything goes” in medicine and health.
- Nassir Ghaemi has offered one of the most systematic critiques of the BPS model and it is in your reading folder for this weeks lecture.

The classic study: Rosenhan (1973) On being sane in insane places.

- [David Rosenhan](#)
- [Psychiatry`s deadliest scam](#)
- [Who decides who is crazy?](#)



The facts of the matter are that we have known for a long time that diagnoses are often not useful or reliable, but we have nevertheless continued to use them. We now know that we cannot distinguish insanity from sanity.

— David Rosenhan —

AZ QUOTES

Practical and Ethical problems:

- There is a practical difficulty in diagnosing mental health problems, because identification is largely down to **interpretation** of the patient's symptoms.
- With traditional physical illnesses, they can be seen, described and objectively measured with tests, but often mental illness there is often no visible or measurable signs.
- If we are to believe that mental illness brings with it a loss of responsibility, the **Mental Health Act (1983, 2007)** allows for an individual to be compulsorily detained and treated, if believed to be a danger to themselves or others.
- Critics from the anti-psychiatry movement argue that this loss of rights is unethical and can lead to discrimination.

Reliability and Validity of diagnosis

- When reliability is good, validity can be poor or good. When reliability is poor then validity is always poor.
- **Reliability- consistency in diagnosis.**
- Inter-rater reliability about 0.67-0.86 (Brown, DiNardo, Lehman and Campbell, 2001).
- Reliability of self report tests/scales-
- Test retest reliability-
- **Validity- accuracy in diagnosis.**

Evidence:

- Brown et al., (2001) looked at the DSM-IV diagnosis of anxiety and mood disorder in 362 outpatients in Boston , USA.
- Two independent interviews using anxiety disorders interview schedule for DSM-IV.
- There was much agreement across the two interviewers.
- However, disagreement tended to focus on not whether a symptom fitted criteria but whether the person had enough symptoms, whether they were severe enough or had lasted long enough to gain a diagnosis.
- They concluded that it was difficult to classify people who were on the 'boundaries' particularly with regard to depression and generalised anxiety disorder.

- Goldstein (1988) looked at the effect of gender on diagnosis of schizophrenia.
- She re-diagnosed 199 patients, originally diagnosed using DSM-II; and found that there were some differences.
- She asked two other experts to re-diagnoses (single blind) a random sample of 8 of the patients using the case histories with all indication of previous diagnoses removed.
- There was a high level of agreement/consistency of diagnosis.
- Stinchfield, (2003) Looked at the diagnosis of pathological gambling in 803 men and women from general population of Minnesota and 259 men and women on a gambling treatment programme.
- They were given a questionnaire using 19 items from DSM IV criteria for pathological gambling.
- The questionnaire results were able to help researches to correctly sort the gamblers from the non-gamblers.

- Kirk and Kutchins (1992) critique much of the research supporting the reliability of DSM for:
 - Methodological problems of questionnaires and interviews;
 - Training and supervision of interviewers being insufficient.
 - Studies taking place in research settings.
-
- However Brains, (2009) makes the following comments:
 - Goldstein did not use interviewing to test reliability.
 - The gamblers from Stinchfields study were not in a research institution but on a gambling treatment programme.
 - Browns patients were outpatients.
 - She also notes that the work of both Brown and Stinchfields were conducted after the K & K critique and have suggested that diagnosis can be reliable.
 - Remember if DSM were not reliable it would not be valid either but just because it is reliable (if we accept it is) does not mean it is valid.

Type 1 and Type 2 errors in diagnosis

- In the words of Dr Guy Sutton (neuroscientist):
 - A "type one" error exists when a disorder is diagnosed when in fact none exists (i.e. the false positive is the (incorrect) diagnosis of schizophrenia in a sane person).
 - "Type two" error is when a disorder exists but is not diagnosed (false negative - negative being not diagnosing an ill person).

More problems with the diagnostic process

A number of issues pose threats to the reliability, validity and utility of the diagnostic process. Some of these are historical and resolutions have been achieved, whereas others are ongoing and still present a multitude of problems.

The Medical Model & social norms

- In the 1960`s the anti-psychiatry movement formed, with Thomas Szasz as one of its supporters. He claimed that the absence of physical symptoms in many illnesses led to inaccurate diagnosis and a `**culturally accepted**` way of labelling the mentally ill.
- He argued that the medical model and its treatments were a form of punishment for those individuals who did not conform to social norms. Some treatments in the 1960`s were given to aggressive people who violated social norms.
- Taylor (1992) reports that 38,000 leucotomies were conducted in 1968. These procedures resulted in permanent changes in behaviour and even death.
- The main advantage of psychosurgery is that it made patients easier to control, but often these procedures were given without the patient`s consent.

The medical model and cultural differences

- Stirling & Hellewell (1999) suggest that the majority of psychiatrists in the UK are middle class, male and white. Therefore they are subject to their own **cultural bias**, perceiving others' behaviour as abnormal if it differs from their own.
- Sabin (1975) found cultural bias when clinicians used assessment techniques with non English speaking patients: their problems and symptoms were often misunderstood. This may explain why there is a higher reported incidence of schizophrenia in the UK in Ethnic minorities.
- This contrasts with physical illness, where culture would not affect diagnosis.

Culture and mental illness

- Depression is very rarely reported in Asian culture. Does this mean that they are happy and contented or are there other explanations?
- Rack (1982) reports that Asians rarely consult their doctor with emotional problems, preferring to sort these out within the extended family unit. When they do visit the doctor they only report the physical symptoms of stress such as tiredness, lack of sleep and appetite etc.
- Because mental illness carries such a stigma it is very unusual for Chinese doctors to diagnose such disorders in their patients (Rack 1982).

- More recently:
- Ingleby (2014) points out that psychiatry continues to be dominated by Westernised health ideals, the pharmaceutical companies and that by and large both low and middle-income countries are under-represented.
- He argues that current psychiatric diagnostic procedures, explanatory models and treatments are only to a limited extent 'evidence-based' and neglect research outside of the mainstream countries.
- This suggests that the current system remains biased in its approach to diagnosing mental illness world wide.
- In addition he believes that biases operate reflecting professional and corporate interests, as well as other social pressures, meaning that diagnosis will not be beneficial to all people equally.

Social class and mental illness

- In the UK the middle classes are far more likely to be diagnosed with depression and eating disorders whereas the lower classes are more likely to be diagnosed with schizophrenia.

Possible explanations for schizophrenia:

- **Diagnosis:** Johnstone (1989) found that doctors were far more likely to diagnose psychotic illnesses such as schizophrenia in the lower classes even when they reported similar symptoms to those from higher social groups.
- What are the implications?

- **Social causation hypothesis:** the higher levels of stress due to poverty, poor housing etc., experienced by the poor is more likely to lead them to psychiatric illness.
- **Social drift hypothesis:** Perhaps mental illness such as schizophrenia causes people to become poorer since they may be unable to maintain suitable employment.

The medical model and mal-adaptiveness

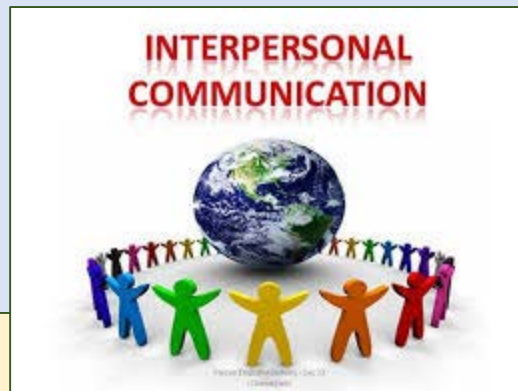
- The way mental illness affects a person's functioning has been widely accepted, and often a person's social and occupational functioning prior to the illness is taken into account in diagnosis.
- Davidson & Neale (2001) argue that this is subjective, and it assumes that there is some form of 'average' level of functioning that we should be using to compare. Also, they argue that once an individual has been diagnosed with mental illness, it can have negative consequences, because family, friends and employers act differently towards them, thus affecting their normal functioning.

The medical model and distress

- In order to be referred to a psychiatrist, the person, family or friends must have reported some **distress**. As Laing (1967) argues, this distress is more often reported by the family or friends rather than the patient, raising the ethical concern that whilst their behaviour may be unpredictable, it may not be causing them distress.
- Surely we have the right to behave as we want too?

Interpersonal issues in assessment

- The medical model and current classification systems are objective, but assessment takes place between people.
- Therefore practitioners are affected in their judgements of people.
- This is particularly important when communicating with individuals from a variety of cultures and societies.



Interpersonal issues in assessment: Stereotyping

- Scheff (1966) criticised the medical model of mental illness and particularly the diagnosis of schizophrenia. He believed that it was a label attached to unusual behaviour.
- He argued that many people act unusually, but only those who are diagnosed/labelled are perceived in a negative way.
- `Patients` are encouraged as seeing themselves suffering from something out of their control, receiving attention and settling into a new role. Once labelled it not only determines your behaviour, but also the behaviour of others around you.
- Once judged insane people look for behaviour to confirm the label. Rosenhan`s study clearly showed this.

- Faulkner & Layzell (2000) demonstrated the existence of stereotyping:
- 584pp`s completed a questionnaire about discrimination, and ways of reducing it.
- 70% of pp`s had experienced stereotyping and discrimination regarding their mental illness.
- 66% claimed that they didn't tell people about it because of the stigma.
- 44% reported stereotyping from their G.P and 32% from other healthcare professionals.
- 30% reported discrimination in the workplace, and many did not disclose their illness on their application form.

Interpersonal issues in assessment: Racism

- WHO studied the rates of serious mental illness in Europe, North America Asia and Africa, and concluded that there was little difference in the rates reported across the world. So why the difference in diagnosis?
- In the UK, black people are more likely than white people to receive a diagnosis of severe mental illness.
- The rates of serious mental illness are higher for British born black people than their migrant parents.
- Littlewood (1980) `what is judged as insane behaviour is actually a legitimate response to disadvantage and racism`.
- The psychiatric community has treated black people differently. Hospitalised black people are 2-3 times more likely to be involuntary patients and are given higher doses of drugs and more frequently given ECT, compared to white people with the same diagnosis.

Interpersonal issues in assessment: Sexism

- Sex differences in mental health have been documented since the 70`s. Women are more likely to be admitted to hospital than men for depression.
- Walker (1994) reported that in all studies of depression, women outnumber men between 2 & 6 times.
- Weissman et al., (1977) argued that women are led to believe that their bodies are problematic and that hormonal changes will be difficult. This leads to the **self fulfilling prophecy**.
- Usher (1989) only 10% of women express regret over the menopause, yet the myth of `depressed middle aged women` still exists.
- Cochrane (1995) proposed that the sex difference in mental illness is recent. Earlier in the twentieth century, men were more likely to be admitted into hospitals than women. Substantially higher rates for women have only been seen since the Second World War- why?

Gender and diagnosis: examples

- **Anorexia nervosa:** over 90% of sufferers are women (in fact young girls)
- **Depression:**
 - Major depression is twice as common in women as it is in men
 - Bipolar disorder is equally common in both sexes, although women tend to have more bouts of depression and men more bouts of mania
- **Autism:** about 80% of sufferers are boys
- Perhaps GP's and psychiatrists have different expectations for the sexes.
- Certainly doctors seem to describe the healthy characteristics of men and women differently.
- According to Boverman et al., (1981) doctors believe that men should be assertive and decisive and women should be dependent and emotional. Perhaps their ideas on abnormal characteristics vary similarly.



Interpersonal issues in assessment: Sick role & expert role.

- In the medical model the responsibility for recovery is taken away, and the expert provides treatment. Martin (1999) helped patients accept the sick role by showing them brain scans of their brains allowing them to see that their problem is biological and out of their control. Is there a problem with this?
- It is difficult to apply the sick role to all mental illnesses. The patients may not accept that they are ill, and treatment often has to be given without their permission. Patients should not be discouraged from responsibility, adopting a sick role makes people dependent.

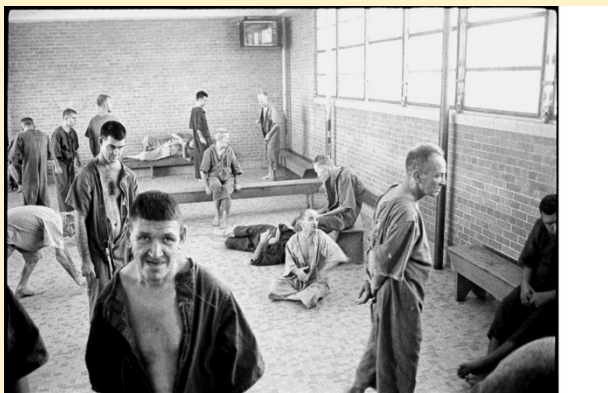
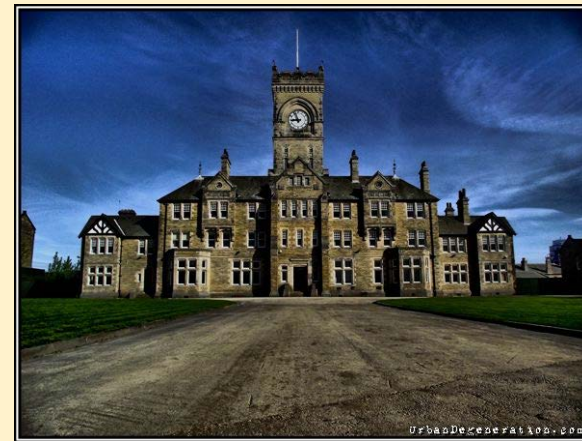
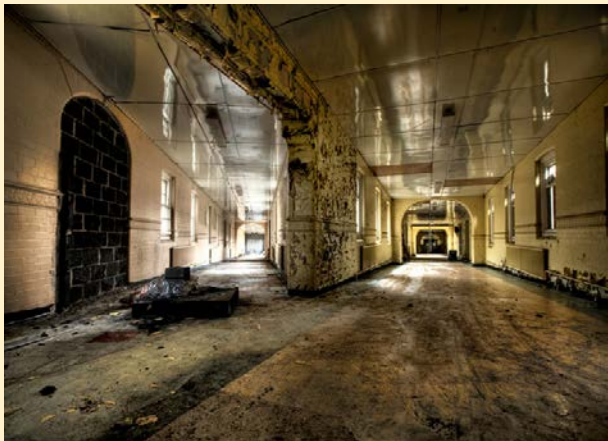
- Failure to take control interferes with the recovery process, especially as certain treatments need active involvement.
- Additionally, the sick role implies complete recovery. Sometimes this is unobtainable, and recovery should be thought of as an on-going process.
- The sick role automatically creates an expert role...



Demand characteristics of the consultation process

- Rosenhan showed the influence of expectancy. He told members of a teaching hospital that over a three month period pseudo patients would be trying to gain a diagnosis and admission. Although none were actually sent, the hospital believed that out of the 193 patients admitted, 41 were actually the `pseudo patients` thus supporting the idea that if you are looking for a particular behaviour, you are more likely to find it! Remember this is a type 2 error.

In conclusion



mental a history of the madhouse