Issues In Diagnosis & Classification

The medical model of abnormality treats psychological disorders in the same way as a broken arm, i.e. there is thought to be a physical cause. Supporters of the medical model consequently consider symptoms to be outward signs of the inner physical disorder and believe that if symptoms are grouped together and classified into a 'syndrome' the true cause can eventually be discovered and appropriate physical treatment administered. However, there are several major problems with this approach…

Reliability

The diagnostic classification systems are notoriously unreliable. Using the same diagnostic manual two psychiatrists could easily diagnose the same patient with two different disorders. Some famous studies on the unreliability of diagnosis are:

Rosenhan (1973)

Procedure: Eight 'sane' people (3 women & 5 men from a variety of occupational backgrounds) arranged appointments at various hospitals and complained that they had been hearing voices. The voices were unclear, unfamiliar, of the same sex and said single words like empty, hollow and thud. The pseudo-patients did not change any aspect of their behaviour, personal history or circumstances (apart from their names). On admission to the hospital ward every pseudo-patient immediately stopped simulating any symptoms and responded normally to all instructions (except that they did not swallow any medication) and said they were fine, experiencing no more symptoms and would like to be released.

Results: All but one pseudo-patients were admitted to a hospital with a diagnosis of schizophrenia and their 'sanity' was never detected by staff although many other patients did become suspicious! Length of stay ranged from 7 days to 52 days with an average of 19 days. All except one were released with a diagnosis of 'Schizophrenia in remission' supporting the view that they had never been detected as 'sane' at all.

A follow up study was conducted to check the poor reliability of diagnosis, whereby a teaching hospital was told to expect pseudo-patients over a three month period. Not a single pseudo-patient ventured near the hospital, but 41 genuine patients were suspected of being fakes, 19 of these were suspected by a psychiatrist and another member of staff.

Beck et al (1962)

Found that agreement on diagnosis for 153 patients between two psychiatrists was only 54%. This was often due to vague criteria for diagnosis.

Cooper et al (1972)
Found New York psychiatrists were twice as likely to diagnose schizophrenia than London psychiatrists, who in turn were twice as likely to diagnose mania or depression when shown the same videotaped clinical interviews.

Di Nardo et al (1993)
Studied the reliability of DSM-III for anxiety disorders. Two clinicians seperately diagnosed each of 267 people seeking treatment for anxiety and stress disorders (the nearer the value of 1, the closer the agreement). They found high reliability for obsessive-compulsive disorder (.80) but very low reliability for assessing generalised anxiety disorder (.57) mainly due to problems with interpreting how excessive a persons worries were.

Lipton and Simon (1985)
Randomly selected 131 patients in a hospital in New York and conducted various assessment procedure to arrive at a diagnosis for each patient. This diagnosis was then compared with the original diagnosis. Of the original 89 diagnoses of schizophrenia, only 16 received this diagnosis on re-evaluation. Fifty were diagnosed with a mood disorder, even though only 15 had been diagnosed as such in the first place. (You could argue that being misdiagnosed *caused* the mood disorder to develop during their time in hospital, however!)

Labelling

In the Rosenhan (1973) study the label 'schizophrenia in remission' travelled with the pseudo-patients long after they had left the hospital. Had they applied for jobs, mortgages etc this information would have been available. Unlike a physical illness where the label of 'broken leg' is dropped once the leg has healed, mental illnesses are labels for life. Even if a patient is apparently 'cured' the label '(disorder) in remission' still remains.

Scheff (1966) highlights some of the adverse effects of labels:

✪ ***Self-fulfilling prophecy***: Patients may begin to act as they think they are expected to act. They may internalise the role of 'mentally ill patient' and this could worsen their disorder. Doherty (1975) points out that those who reject the mental illness label tend to improve more quickly than those who accept it.

✪***Distortion of behaviour***: Diagnosis of mental disorder tends to label the whole person- once the label of diagnosis is attached, then all the individual's actions become interpreted in the light of the label.

✪***Oversimplification***: Labelling can lead to reification- making the classification a real, physical disorder, rather than just a descriptive term to help diagnosticians talk about patients.

✪***Prejudice***: Langer & Abelson (1974) found that prejudice against those labelled with mental disorders exists. They showed a videotape of a younger man telling an older man about his job experience. If the viewers were told the man was a job applicant he was judged to be attractive and conventional looking, whereas if they were told he was a patient he was described as tight, defensive, dependent, and frightened of his own aggressive impulses.

(Farina et al 1980)
This experiment conducted in a naturalistic setting illustrates stigma and prejudice towards those labelled as mentally ill. When one member of a pair of male college students was (falsely) led to believe the other had been a mental patient, he perceived the pseudo ex-patient to be inadequate, incompetent and not likeable. In another experiment the same authors made one of a pair of interacting males falsely believe he was perceived as stigmatised by the other naïve participant. Just believing this was sufficient to lead him to behave in ways which caused the naïve participant to reject him, i.e. he behaved in a manner typical of the mentally ill because he felt the other person had him labelled as mentally ill.

Other Labelling Problems:

✪ It can give the impression that a cure is just around the corner.
✪ Because diagnosis and classification are a communication shorthand they could lead to simplification of what can be a very complex problem.
✪ Labels in mental illness involve whole person assumptions. We would never say somebody is 'cancerous' if they suffer from cancer, but we will call somebody with schizophrenia, 'schizophrenic'.

Institutionalisation

Once the pseudo-patients in Rosenhan's (1973) study were admitted to mental wards it was very difficult for them to get out; one participant took 52 days to convince his captors he was well and the whole thing was an experiment. The problem is that once admitted, all behaviour is perceived as being a symptom of the illness and therefore a good reason why the patient should not be released! The behaviours exhibited by Rosenhan's participants was all regarded as being symptomatic of schizophrenia, eg:

1) A normal case history became distorted to emphasise the ambivalence and emotional instability thought to be shown by those with schizophrenia.
2) Pseudo patients were never asked why they were taking notes, but it was recorded by nurses as 'patient engages in writing behaviour', implying it was a symptom of the disorder.
3) Pacing the corridors out of boredom was seen as nervousness, again taken to be a sign of the disorder.
4) Waiting outside the cafeteria before lunch time was interpreted as showing the 'oral acquisitive nature of the syndrome' by a psychiatrist.

Other aspects of institutionalisation noted in the study included:

Lack of normal interaction: for example, pseudo patients politely asked a member of staff when they would be discharged. They found mostly a brief, not always relevant answer was given, on the move, without even a normal turn of the head or eye contact (psychiatrists moved on with their head averted 71% of the time and only stopped and talked normally on 4% of occasions.

Powerlessness and depersonalisation: Was produced in the institution through the lack of rights, constructive activity, choice, and privacy, plus frequent verbal and even physical abuse from the attendants. All of these examples of powerlessness and depersonalisation are illustrated brilliantly in the film 'One flew over the cuckoos nest'.

Dependency: Because it is so difficult to be released from a psychiatric ward once admitted, some residents become totally dependent upon the doctors and nurses for their survival. They never cook, iron their clothes, work, interact with other humans. They literally lose the ability to function in the real world. The Chief in the film has nothing at all wrong with him but feels dependent and unable to live independently. Likewise, when he escapes with them for the day Mac shows the other residents that there is a world outside the hospital and they could in many cases really enjoy that world!

Treatment

Because of the problems of reliability and validity of diagnosis according to the medical model, unsuitable treatment may be administered, often on an involuntary basis especially when institutionalised. Because the medical model believes mental illness to have a biological cause, the majority of treatments tend to be of a physical nature. The treatments fall into three main categories:

Drugs: Again the film One flew over the cuckoos nest demonstrates the way in which drugs are handed out like smarties merely to keep the patients subdued. Note also in the film that the same type of drug is given to every patient with no regard for the individual's case history or symptoms; the aim is merely to drug them up to the eye balls to shut them up! Note that drugs do not deal with the cause of the problem, they only reduce the symptoms.

Three major types of drugs are administered in institutions:

Type of Drug	Treats	Side Effects
Anti Depressants	Obsessions, social phobias.	Kidney poisoning, brain haemorrhage.
Major Tranquillizers	Revolutionalised psychiatry in the 1950's, allowed schizophrenia sufferers to live independently.	Dry mouth, blurred vision, low blood pressure, muslce trembling.
Minor Tranquillizers	Anxiety (depress the nervous system. Valium is most famous.	G.P's can prescribe minor tranquilisers and can simply keep making repeat prescriptions which leads patients to become reliant on the drug and prevents them from facing up to their probs.

ECT: Electro Convulsive Therapy began in the 1930's after it was noticed that when cows are executed by electric shocks they appear to convulse as if they are having an epileptic shock. The idea was extrapolated to humans as a treatment for schizophrenia on the theoretical basis that nobody can have schizophrenia and epilepsy together, so if epilepsy is induced by electric shock the schizophrenic symptoms will be forced into submission! Bizzare train of thought, but it did seem to work to a certain extent on some patients and to this day is used as a last resort for treating severe depression.

There are many critics of this extreme form of treatment, especially of it's uncontrolled and unwarranted use in many large, under staffed mental institutions where it may be used simply to make patients docile and manageable or as a punishment (Breggin 1979). Side effects include impaired language and memory as well as loss of self esteem due to not being able to remember important personal facts or perform routine tasks.

The procedure for administering ECT involves giving a muscle relaxant (to minimise the violent physical reactions) followed by an anaesthetic and topped with a 80-110 volt electric shock through electrodes placed on the temples which produces an artificial Grand Mal epileptic fit (loss of consciousness and strong bodily convulsions followed by a period of coma like sleep). There is a debate on the ethics of using ECT, primarily because it often takes place without the consent of the individual and we don't know how it works!

There are three theories as to how it may work:

1) The shock literally shocks the person out of their illness as it is regarded as a punishment for the inappropriate behaviour.
2) Biochemical changes take place in the brain following the shocks which stimulate particular neurotransmitters.
4) The associated memory loss following shock allows the person to start afresh. They literally forget they were depressed or suffering from schizophrenia.

Psychosurgery: As a last result when drugs and ECT have apparently failed psychosurgery is an option. This basically involves either cutting out brain nerve fibres or burning parts of the nerves that are thought to be involved in the disorder. The most common form of psychosurgery is a prefrontal lobotomy. Unfortunately these operations have a nasty tendency to leave the patient vegetablized or 'numb' with a flat personality, shuffling movements etc due to their inaccuracy. Moniz 'discovered' the lobotomy in 1935 after successfully snatching out bits of chimps' brains. It didn't take long for him to get the message that his revolutionary treatment was not so perfect; in 1944 a rather dissatisfied patient called his name in the street and shot him in the spine, paralysing him for life! As a consolation he received the Nobel prize for his contribution to science in 1949.

There are four major types of lobotomy:

Type	Treats	Side-Effects
Prefrontal lobotomy (severs nerve fibres connecting frontal lobes to diencephalon)	Schizophrenai. Particularly successful because present functioning areas are disconnected from memories and from future concerns.	Inability to plan ahead, indifference to the opinions of others, child-like actions, intellectual and emotional flatness.
Biomedial Leucotomy	Depression, Obsessive-Compulsive Disorder	Death, serious personality changes
Orbital Leucotomy	Depression, Obsessive-Compulsive Disorder, Extreme Anxiety.	Death, serious personality changes
Bilateral Leucotomy	Severe Depression	Epileptic Fits.
Limbic Leucotomy	Abnormal Agression.	Controversial because patient isn't suffering, we just like their behaviour.

Bias in Diagnosis

Some diagnostic classification systems are not 100% objective and the diagnosis may be influenced by the attitudes and prejudices of the psychiatrist or the diagnostic test itself. For example, women and black people are more likely to be diagnosed mentally ill. This could be because psychiatrists expect them to be more prone to mental illness and are therefore keen to diagnose them as such upon presentation of symptoms which if presented white men would be interpreted as something other than a mental illness.

Forms of Bias:

☞**Racial**

Clinicians are often considering a vast amount of data, from the tests, from classification systems, from legal and ethical interests and so on. Meehl (1962) and Dailey (1952) suggest that they put too much emphasis on earlier information, ignoring later but significant information in their diagnosis. Similarly, they may put too much emphasis on one source of information, for example, the family's descriptions such as paying too much attention to the parents rather than to the child (McCoy 1976). Numerous studies point to personal biases in the clinician's interpretation of data (Fabrega et al 1994, Jenkins-Hall and Sacco 1991, DiNardo 1975, Broverman et al 1970). The study of the '*Effect of client race and depression on evaluations by white therapists*' by Jenkins-Hall and Sacco (1991) involved white

therapists being asked to watch a video of a clinical interview then to evaluate the female interviewee. There were four conditions representing the possible combinations of race and depression. In one condition the woman was African American and nondepressed, in another condition she was a white American and nondepressed. In the other two conditions she was each of these races but depressed. Although the therapists rated the nondepressed African American and the white American in much the same way, their ratings of the depressed women differed in that they rated the African American woman wit more negative terms and saw her as less socially competent than the depressed white American woman.

☞MISCONCEPTION

The clinician may have various preconceived ideas about the nature of mental states and behaviours which then influence their interpretation of signs and symptoms. In deciding on a diagnosis they may draw upon misconceptions about how the data were gathered and their significance (Reisman 1991). For example, they might believe that the more assessment techniques they use the more valid their interpretation will be. Kahneman and Tversky (1973) point out that this is not the case, there is not a positive correlation between the number of assessment techniques used and the accuracy of eventual diagnosis (supported also by Golden 1964). Chapman and Chapman published in 1967 a study that has become a classic illustration of misconceptions by clinicians. Their investigation of 32 therapists showed that there was a tendency to diagnose male clients as homosexual if there was a strong tendency to see in Rorschach inkblots various images such as human or animal anal images, feminine clothing, male or female genitalia. In spite of the fact that research has found no relationship between the client seeing such images and their being homosexual, clinicians still persist in assuming that there is evidence to suggest this correlation and consequently in making clinical diagnoses on the basis of such false assumptions.

☞EXPECTATION

Another form of misconception is built in to the consultation process. Clinicians may tend to have expectations about the person who consults them, assuming that if the client is here, there must be some disorder to diagnose. Since their job is to diagnose abnormality, they perhaps over-react and see abnormality wherever they look, a characteristic Phares (1979) calls 'reading-in syndrome'. This is most clearly demonstrated by the classic study in its field, Rosenhan (1973). It seems that the clinicians in all eight hospitals cannot have all been poor practitioners but rather there was something about the settings that caused them to *read-in* to the 'patients' some particular diagnosis even when the evidence was totally lacking.

Φ **SICK ROLE**

When a person is diagnosed as experiencing some mental disorder, the label is often interpreted as a statement about the person in general. Rather than saying that the person *has* schizophrenia, they are said *to be* schizophrenic. The person may be treated in a stereotyped way and expected to take on the **sick role**. According to Comer (1995) "[i]n the Rosenhan (1973) study ... staff members spent limited time interacting with those labelled as patients, gave only brief responses to their questions, tended to be authoritarian in their dealings with the patients, and often made them feel invisible. In response to such attitudes and treatment, patients may increasingly consider themselves sick and deficient and eventually come to play the role that is expected of them." (P134)

Φ **DEMAND CHARACTERISTICS**

The vicious circle may continue. A person labelled 'mentally ill' may encounter prejudices in looking for a job or starting friendships. Remaining socially isolated might lead to the person feeling socially incapable, incapable in a variety of ways and generally undesirable. This self-perception may in turn exaggerate emotional difficulties and the problem persists.

Φ **EXPERT ROLE**

Demand characteristics seem to be operating in the consultation process. If the person perceives the clinician to be fulfilling the **expert role**, then the person may behave in ways that are consistent with what he or she believes are expected of him or her. In this way, the relationship between the person and the clinician is such that is leads to the demonstration of symptoms which have no basis outside the relationship. It's as though the relationship between the patient and the clinician has created the symptoms of the mental disorder.