How Do You Diagnose Abnormality?
Psychology 3303
Professor June Gruber
Logistics

Reading Responses Due Today
Respond to all required readings, 1 prompt per reading
10% grade depreciation each day turned in late after Th 9:30am

Office Hours
Email note 24 hrs in advance if planning to attend
Logistics

QUESTIONS?
Roadmap

Logistics

Diagnosis & Assessment

Take-Away Questions
Definitions: Let’s Get Clear

**Diagnosis:** refers to the identification and recognition of a disorder on the basis of its characteristic symptoms.

**Assessment:** refers to the process of gathering information in order to come up with a useful diagnosis for a specific person.
What are the Pros and Cons of DIAGNOSING?
PROS

1. To define clinical entities
   Typical symptom cluster
   Natural history
   Causes
2. To determine focused treatment
3. Normalizes behavior
4. Consistency among professionals; common language
5. Effective for research to further the foundation of evidence-based practice
CONS

1. Diagnosis is subjectively and externally imposed by an expert.
2. Diagnostic categories minimize the uniqueness of each patient.
3. Focuses on symptoms and dysfunction
5. Ignores individual strengths
6. Pathology is identified to an individual
7. Current classification system generally ignores culture, age, gender
How is Diagnostic Information gathered?

**SOURCES**
- Individual
- Professionals
- Family
- Friends
- Teachers
- History, Records, Reports

**TOOLS**
- Questionnaires
- Interviews
- Paper or electronically admin
- Biological tests
Possible Barriers?

**Patient factors**
- Inability to provide information
  - Age, cognitive disability
- Self-presentation biases
- Resistance, Poor Insight, Poor Motivation, Incapable of specific changes

**Therapist factors**
- Bias, presumptions, Lack skills, Varying levels of training

**Patient and Therapist factors**
- Language/cultural/racial barriers
How do We Make a Diagnosis?

1952 & 1968

1980

1994

2013
What are 5 Underlying Principles of DSM?

1. Classification system is descriptive
2. Disorders defined primarily in terms of behavioral signs and symptoms
3. Disorders are grouped into categories (prototypes) based on shared characteristics
4. Encourages consideration of patient variables (gender, age, culture) in diagnosis
5. Qualifiers are used to rate severity of diagnosis for some disorders
What are the Steps for Diagnosing?

1. Collect data
2. Evaluate reliability of data
3. Identify pathology
4. Determine the distinctive feature
5. Arrive at a diagnosis
6. Review diagnostic criteria
7. Resolve diagnostic uncertainty
DSM Multi-Axial Format

Axis I: Clinical Disorders (including major mental disorders, Learning Disorders)
Axis II: Personality Disorders, Intellectual Disorders
Axis III: Acute medical conditions and physical disorders
Axis IV: Psychosocial and environmental factors contributing to the disorder
Axis V: Global Assessment of Functioning
AXIS-IV: Psychosocial Factors

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system
- Other psychosocial/environmental problems
AXIS-V: Global Assessment of Functioning

91 - 100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81 - 90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71 - 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily failing behind in schoolwork).

61 - 70 Some mild symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51 - 60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41 - 50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

31 - 40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21 - 30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends)

11 - 20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1 - 10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
### DSM Multi-Axial Format: EXAMPLE 1

<table>
<thead>
<tr>
<th>Axis</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Axis I:</strong></td>
<td>296.32 Major Depressive Disorder, Recurrent, Moderate</td>
</tr>
<tr>
<td></td>
<td>312.39 Trichotillomania</td>
</tr>
<tr>
<td><strong>Axis II:</strong></td>
<td>301.83 Borderline Personality Disorder</td>
</tr>
<tr>
<td><strong>Axis III:</strong></td>
<td>Chronic Pneumonia, Hyperlipidemia, Hypertension</td>
</tr>
<tr>
<td><strong>Axis IV:</strong></td>
<td>Occupational problems (unemployed), Economic problems (disability payment), Problems with legal system (pending DUI charge)</td>
</tr>
<tr>
<td><strong>Axis V:</strong></td>
<td>63</td>
</tr>
<tr>
<td>Axis</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>I</td>
<td>300.23 Social Anxiety Disorder</td>
</tr>
<tr>
<td>II</td>
<td>V71.09 No Diagnosis</td>
</tr>
<tr>
<td>III</td>
<td>None</td>
</tr>
<tr>
<td>IV</td>
<td>Problems related to the social environment</td>
</tr>
<tr>
<td>V</td>
<td>63</td>
</tr>
</tbody>
</table>
CASE STUDY: JESSICA

Jessica is a 28 year-old married female. She has a very demanding, high stress job as a second year medical resident in a large hospital. Jessica has always been a high achiever. She graduated with top honors in both college and medical school. She has very high standards for herself and can be very self-critical when she fails to meet them. Lately, she has struggled with significant feelings of worthlessness and shame due to her inability to perform as well as she always has in the past.

For the past few weeks Jessica has felt unusually fatigued and found it increasingly difficult to concentrate at work. Her coworkers have noticed that she is often irritable and withdrawn, which is quite different from her typically upbeat and friendly disposition. She has called in sick on several occasions, which is completely unlike her. On those days she stays in bed all day, watching TV or sleeping.
CASE STUDY: JESSICA

At home, Jessica’s husband has noticed changes as well. She’s shown little interest in sex and has had difficulties falling asleep at night. Her insomnia has been keeping him awake as she tosses and turns for an hour or two after they go to bed. He’s overheard her having frequent tearful phone conversations with her closest friend, which have him worried. When he tries to get her to open up about what’s bothering her, she pushes him away with an abrupt “everything’s fine”.

Although she hasn’t ever considered suicide, Jessica has found herself increasingly dissatisfied with her life. She’s been having frequent thoughts of wishing she was dead. She gets frustrated with herself because she feels like she has every reason to be happy, yet can’t seem to shake the sense of doom and gloom that has been clouding each day as of late.
CASE STUDY: Jessica

- What do you know?
- What do we want to know?
- How can you get information?
- What do you do with it once you have it?

- Distress — How upsetting are this person’s symptoms?
- Dysfunction — How much do symptoms interfere with this person’s functioning?
- Deviance — Is this person’s behavior well outside the normal range?
- Danger — Is this person a danger to self or others?
CASE STUDY: MARTIN

Martin is a 21 year-old business major at a large university. Over the past few weeks his family and friends have noticed increasingly bizarre behaviors. On many occasions they’ve overheard him whispering in an agitated voice, even though there is no one nearby. Lately, he has refused to answer or make calls on his cell phone, claiming that if he does it will activate a deadly chip that was implanted in his brain by evil aliens.

His parents have tried to get him to go with them to a psychiatrist for an evaluation, but he refuses. He has accused them on several occasions of conspiring with the aliens to remove his brain and put it inside one of their own. He has stopped attending classes altogether. He is now so far behind in his coursework that he will fail if something doesn’t change very soon.
CASE STUDY: MARTIN (continued…)

Although Martin occasionally has a few beers with his friends, he’s never been known to abuse alcohol or use drugs. He does, however, have an estranged aunt who has been in and out of psychiatric hospitals over the years due to erratic and bizarre behavior.
CASE STUDY: Martin

- What do you know?
- What do we want to know?
- How can you get information?
- What do you do with it once you have it?

- Distress – How upsetting are this person’s symptoms?
- Dysfunction – How much do symptoms interfere with this person’s functioning?
- Deviance – Is this person’s behavior well outside the normal range?
- Danger – Is this person a danger to self or others?
What is the process of ASSESSMENT?
LIKE A FUNNEL…

- begins broad (what’s going on here?)
- narrows toward a particular domain (e.g., depression) while getting multiple forms of information
- arrives at a specific problem area and diagnosis (or set of diagnoses)
DOMAINS OF ASSESSMENT

A. Clinical Interview
B. Mental Status Exam
C. Behavioral Assessment & Observation
D. Psychological Testing
   A. Objective Tests
   B. Projective Tests
   C. Neuropsychological Tests
E. Neuroimaging
F. Psychophysiological Assessment
G. Physical Exam
Scheff (1984): Society sets up certain norms and rules that individual must follow, and failure to adhere to these rules defines abnormal behavior.

Then, a self-fulfilling prophecy.

Potentially stigmatizing effects (Hinshaw chapter)
Roadmap

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Take-Away Questions
Thank You!

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Abnormal Psychology
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