Diagnosis, Classification, and the DSM Part II

David Cohen PhD, LCSW

HBSE II – Psychopathology – SP 2010

1

Critiques of the DSM

Ever-increasing number of behaviors classified as "mental disorders" (medicalization)

2

DSM definition of "mental disorder"

- "… a clinically significant behavioral or psychological syndrome or pattern…"
- "associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom."
- "must not be merely an expectable and culturally sanctioned response to a particular event"
- "must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction"

DSM-IV, p. xxi

3

Critique #2

Lack of, or tautological, definition of the key concepts used to separate *disorder* from *non-disorder*:

- "clinically significant"
- "psychological dysfunction"
- "not culturally sanctioned response"

Jacobs, D., & Cohen, D. (2010). What does "psychological dysfunction" mean? *Journal of Humanistic Psychology*.

4

Critique #3: Limitations to the Categorical Approach (p. xxxi in DSM-IV-TR)

- States that categories are *not* discrete (p. xxii)—then goes on to define 300 categories of mental disorder
- States there are unclear boundaries amongst disorders, and between disorder and no disorder
  - If there is no recognizable boundary between "disorder" and "non-disorder", the same way we understand normal behavior should be used to understand abnormal: based on agent's own view and on contextual cues

5

Critique #3—cont'd

- According to DSM, *even the defining features of a disorder* may not be shared amongst patients (DSM-IV, p. xxii)
  - This means that patients diagnosed with the same disorder may have no symptoms in common
- Appeals to "tradition" of categorical approach in medicine, and "vividness" of categories, as sole justifications for its use in DSM (p. xxii)

6

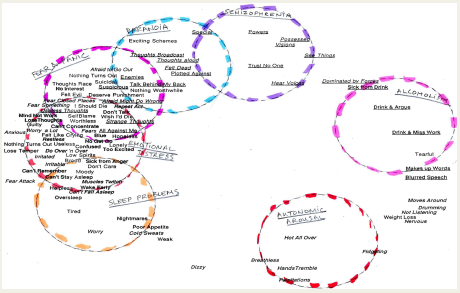
Critique #4

There is an **overlap between categories** supposed to be distinct. Because of DSM's insistence on categories, **artifactual** result is "co-morbidity" (in-between, just short of, left over, etc.)

There is a lack of fit between traditional DSM categories and empirically observed clusters of distress—No neat boundaries at all, depends on observer

7

Critique #4—cont'd: No neat distinctions between problems: Correlations among 91 symptoms



Adapted from: Mirowsky, J. (1990). Subjective boundaries and combinations in psychiatric diagnoses. *Journal of Mind and Behavior, 11*, 407-424.

8

Critique #5

Political lobbying determines how categories are included or excluded from the manual

- Resembles process of adopting a bill in a legislature (back-room deals, amendments, alliances, etc.) rather than "evidence-based"—same with deciding to remove categories from DSM (e.g., homosexuality)

Caplan, P. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal.* Boston: Perseus.

9

Critique #6

Persistent problems of **unreliability** (GAF scale) or **fair reliability** (*k*s rarely >.70), especially for personality disorders, psychotic disorders, ADHD, most substance dependence disorders

10

Critique #7

- The diagnosis, not the patient, gets treated:
  - Professionals look for symptoms to match a diagnosis
- The patient and his/her story (narrative) is lost
  - Professionals must remember they are evaluating subjective experiences reported by a client, which cannot be evaluated effectively without context
    - Lacking any etiological signs for diagnosis, all we have are the subjective stories of the patient
  - The patient's story is paramount to understanding their problem in the context of their life

Turner (1998) reading for this week

11

Critique #8

Possible **conflicts of interest** because of financial support from pharmaceutical industry to DSM-IV Task Force members
(Cosgrove et al. reading)

12

Critique #9

The continuing absence of any biological marker that may confirm any diagnosis, or predict response to treatment, leading to a **lack of "gold standard" validity**

- *Not one biological test in DSM after 40 years of neuroscience advances*

"The incredible recent advances in neuroscience, molecular biology, and brain imaging . . . are still not relevant to the clinical practicalities of everyday psychiatric diagnosis. The clearest evidence supporting this disappointing fact is that not even one biological test is ready for inclusion in the criteria sets for DSM-V." (p. 1)

—Allen Frances, Chair of DSM-IV Task Force (2009)

A warning sign on the road to DSM-V. *Psychiatric Times.* www.psychiatrictimes.com/display/article/10168/1425378

13

Why then does DSM continue to be widely used? Several interacting/overlapping factors:

1. The DSM fits within the dominant school of thought—"mental disorder as conventional medical disease"
2. Acceptance of DSM by all major third party payers and institutional players (insurance industry, drug industry, gov't, journals, professional associations)
3. Usefulness of DSM approach (distinct disorders, target symptoms) for conventional drug treatment studies (most frequent & best-funded).

14

Why is it used? — cont'd

4. Slow-to-change professional licensure exam/ requirements which require familiarity or use of DSM
   - **Interesting development**: since 2005, a clause in the *Code of Ethics of the ACA* allows counselors to "refrain from making or reporting a psychiatric diagnosis" if they believe it may harm a client
5. Psychiatry's vital interest in maintaining its position of leadership by regularly issuing new DSMs—dovetails with institutional acceptance of psychiatry as legitimate "owner/definer" of mental health problems.

15

Why is it used? — cont'd

6. Misguided belief in the importance of a "common language" for practitioners/clients
7. The familiarity of many DSM categories to laypersons, media, and uninformed mental health professionals, (unaware that DSM categories are social constructions)
8. The belief that, although an imperfect system, it's among the best "scientific" classifications of "psychopathology" we have, and that psychopathology is a "natural, objective phenomenon" that requires a science-based classification

16

DSM in Social Work Practice

Only 3 surveys of the use of DSM in social work practice

1. Kutchins & Kirk (1988, *Social Work, 33*, 215-220): random sample (n=884) from NASW list of clinical social workers
   - Billing insurance most highly rated reason to use DSM (81%)
   - DSM "very important" for treatment planning (31%)
2. Dziegielewski et al. (2002, *Social Work in Mental Health*, *1*, 27-41): 160 social workers queried before a DSM training
   - 67%: DSM important for treatment planning
   - 57% "always or often," 33% "sometimes," 10% "rarely or never" comfortable to diagnose using DSM

17

DSM in social work — cont'd

3. Frazer et al. (2009, *Social Work in Mental Health*, *7*, 325-329): random sample (n=558) from NASW list of 7,000 clinical social workers in 1999 register
   - Billing insurance most common reason to use (93% rated "often to always")
   - 86% gave a DSM diagnosis "often to always"
   - 78% used it to assess clients "often to always"
   - 50% would use if not required

- **Questions for research**: 1) What specific pressures do employers put on practitioners to use DSM? 2) How exactly is DSM used in assessment? 3) How to move beyond DSM for eligibility?

18

Two classification alternatives to DSM:
1. *Person-In-Environment System* (PIE)

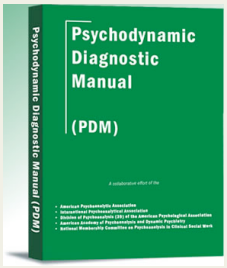
- PIE developed by social work researchers in mid-1980s, published by NASW, as complement to DSM, focuses on interpersonal and social functioning.
- Rarely used today, probably because not tied to funding.

Karls, J.M., & Wandrei, K.E. (Eds.) (1994). *Person-in-Environment system.* Washington, DC: NASW Press.

19

2. *Psychodynamic Diagnostic Manual* (PDM)

- Published in **2006** by a coalition of organizations representing **psycho-dynamic** clinicians and researchers
- Unlike the DSM, has references…



20

PDM—cont'd

- Urges that clinicians understand, before diagnosing:

A. "healthy" and "disordered" personality functioning

B. Individual profiles of mental/emotional functioning, including relationship patterns, comprehending and expressing feelings, coping with stress, observing one's own emotions and behavior, & forming moral judgments

C. Symptom patterns (modeled after the major DSM groupings), including differences in each individual's personal, subjective experience of symptoms

- **Too soon to evaluate impact on field**

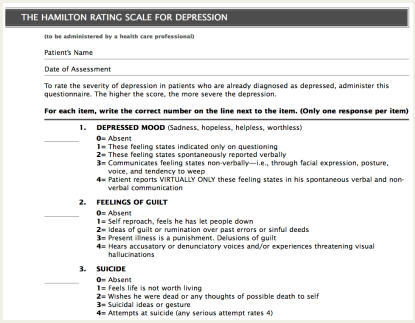
21

Assessment in Social Work

- Assessment: the process of formulating a basis for intervention
  - **Categorical (DSM, PIE)**: separates phenomena into mutually exclusive classes, emphasizing criteria to determine if a person "has" or "does not have" a disorder, emphasizes differential diagnosis
  - **Dimensional (various rapid assessment scales)**: focuses on "how much" of a problem is present, or "how serious" it is.
    - DSM-V (2012) expected to incorporate many dimensional assessment scales

22

Example of a dimensional assessment scale: HRSD



THE HAMILTON RATING SCALE FOR DEPRESSION

(to be administered by a health care professional)

Patient's Name

Date of Assessment

To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression.

For each item, write the correct number on the line next to the item. (Only one response per item)

1. **DEPRESSED MOOD** (Sadness, hopeless, helpless, worthless)
   - **0**= Absent
   - **1**= These feeling states indicated only on questioning
   - **2**= These feeling states spontaneously reported verbally
   - **3**= Communicates feeling states non-verbally—i.e., through facial expression, posture, voice, and tendency to weep
   - **4**= Patient reports VIRTUALLY ONLY these feeling states in his spontaneous verbal and non-verbal communication
2. **FEELINGS OF GUILT**
   - **0**= Absent
   - **1**= Self reproach, feels he has let people down
   - **2**= Ideas of guilt or rumination over past errors or sinful deeds
   - **3**= Present illness is a punishment. Delusions of guilt
   - **4**= Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations
3. **SUICIDE**
   - **0**= Absent
   - **1**= Feels life is not worth living
   - **2**= Wishes he were dead or any thoughts of possible death to self
   - **3**= Suicidal ideas or gesture
   - **4**= Attempts at suicide (any serious attempt rates 4)

23

Assessment in social work—cont'd

- **Contextual**: involves multiple persons and systems in interaction; more holistic and transactional view

24

Assessment in social work

Distinguished from DSM-type diagnosis by

1. An emphasis on client strengths or competency rather than deficits
2. An explicit attention to social context and interactions between individuals and their environment

- A contextual approach to assessment asks "What changes do we (client, worker, others) want to see in this web of interactions?"

Saleeby, D. (2005). Balancing act: Assessing strengths in mental health practice. In S.A. Kirk (ed.), *Mental disorders in the social environment* (pp. 23-44). NY: Columbia U Press.

25

Developing a diagnostic "formulation"

The worker uses his/her formal, informal, and relational knowledge to arrive at a statement of:

1. what the client sees as the problems,
2. how the problems may have come about,
3. how the person and his/her environment has reacted and interpreted them, and
4. What is maintaining the problems in the present

26

"Diagnostic formulation"—cont'd

- **Collaborative**—worker & client work together to develop a joint picture of the problem and what happened
- **Tentative**—Formulations change over time as worker and client learn more about the problem & each other
- **Provisional**—Formulations are "best guesses" about problems, to be tested over time
- Individualized, geared to each client/context
- *Obviously influenced by worker's "theoretical orientation/school of thought"*

27

"Diagnostic formulation"—cont'd

- Turner (1994) defines diagnosis as "the conceptual art of formulating ongoing judgments for which we take professional responsibility and upon which we base our intervention activities… It sets out in formal terms the conclusions to which we have come and by which we assess our practice."
- Obviously a complex process…

Turner, F. J. (1994). Reconsidering diagnosis. *Families in Society, 75*, 168-171 28

"Diagnostic formulation"—cont'd

- Usually requires interview(s), ongoing face-to-face interaction/observation
- Explicit focus on presenting problem, description of difficulties, their severity, their perceived causes and consequences
- Focus on biological/developmental/life-stage history of the client and his/her family
- Focus on cognitive and emotional functioning and quality of relating to others
- Focus on client's SES and social support network
- **Guided by any number of bio-psycho-social theories...**

29

"Diagnostic formulation"—cont'd

- When pressed for time and/or lacking in information sources, *worker should be careful to acknowledge limitations of his/her assessment*

30