ESSENTIAL DIAGNOSTIC STRATEGIES

Presented by:
John C. Simoneaux, Ph.D.
OBJECTIVES

- Describe the history of the development of diagnostic schemes, from the first attempts to current and proposed models

- Explain how to formulate a diagnosis through the use of hypothesis formulation and testing, flow charts, etc.

- List and describe recent relevant peer-reviewed research regarding diagnostic conundrums and difficulties

- Discuss proposed formulations outlined in the peer-reviewed journals for present and alternative diagnostic considerations.
The initial impetus for developing a classification of mental disorders in the United States was the need to collect statistical information. The first official attempt was the 1840 census which used a single category, "idiocy/insanity". The 1880 census distinguished among seven categories: mania, melancholia, monomania, and epilepsy.

In 1917, a "Committee on Statistics" from what is now known as the American Psychiatric Association (APA), together with the National Commission on Mental Hygiene, developed a new guide for mental hospitals called the "Statistical Manual for the Use of Institutions for the Insane", which included 22 diagnoses.
This was subsequently revised several times by APA over the years. APA, along with the New York Academy of Medicine, also provided the psychiatric nomenclature subsection of the US medical guide, the "Standard Classified Nomenclature of Disease", referred to as the "Standard".

World War II saw the large-scale involvement of US psychiatrists in the selection, processing, assessment and treatment of soldiers. This moved the focus away from mental institutions and traditional clinical perspectives.
A committee headed by psychiatrist and Brigadier General William Menninger developed a new classification scheme called Medical 203, issued in 1943 as a "War Department Technical Bulletin" under the auspices of the Office of the Surgeon General.

The foreword to the DSM – I states the US Navy had itself made some minor revisions but "the Army established a much more sweeping revision, abandoning the basic outline of the Standard and attempting to express present day concepts of mental disturbance."
In 1949, the World Health Organization published the sixth revision of the International Classification of Diseases (ICD) which included a section on mental disorders for the first time. The foreword to DSM-1 states this "categorized mental disorders in rubrics similar to those of the Armed Forces nomenclature."

An APA Committee on Nomenclature and Statistics was empowered to develop a version specifically for use in the United States, to standardize the diverse and confused usage of different documents.
HISTORY OF DSM

In 1950 the APA committee undertook a review and consultation. It circulated an adaptation of Medical 203, the VA system and the Standard's Nomenclature, to approximately 10% of APA members. 46% replied, of which 93% approved, and after some further revisions (resulting in it being called DSM-I), the Diagnostic and Statistical Manual of Mental Disorders was approved in 1951 and published in 1952.

The structure and conceptual framework were the same as in Medical 203, and many passages of text identical. The manual was 130 pages long and listed 106 mental disorders.
Although the APA was closely involved in the next significant revision of the mental disorder section of the ICD (version 8 in 1968), it decided to also go ahead with a revision of the DSM. It was also published in 1968, listed 182 disorders, & was 134 pages long. It was similar to the DSM-I. The term “reaction” was dropped but the term “neurosis” was retained.

Both the DSM-I and the DSM-II reflected the predominant psychodynamic psychiatry, although they also included biological perspectives and concepts from Kraeplin's system of classification. Symptoms were not specified in detail for specific disorders.
Many were seen as reflections of broad underlying conflicts or maladaptive reactions to life problems, rooted in a distinction between neurosis and psychosis. Sociological and biological knowledge was also incorporated, in a model that did not emphasize a clear boundary between normality and abnormality.

In 1974, the decision to create a new revision of the DSM was made, and Robert Spitzer was selected as chairman of the task force. The initial impetus was to make the DSM nomenclature consistent with the International Classification of Diseases, published by the World Health Organization. The revision took on a far wider mandate under the influence and control of Spitzer and his chosen committee members.
One goal was to improve the uniformity of psychiatric diagnosis in the wake of a number of critiques, including the famous Rosenhan experiment. There was also a perceived need to standardize diagnostic practices within the US and with other countries. The establishment of these criteria was also an attempt to facilitate the pharmaceutical regulatory process.
The criteria adopted for many of the mental disorders were taken from the Research Diagnostic Criteria (RDC) and Feighner Criteria, which had just been developed by a group of research-orientated psychiatrists based primarily at Washington University and the New York State Psychiatric Institute. Other criteria, and potential new categories of disorder, were established by a consensus during meetings of the committee, as chaired by Spitzer.

A key aim was to base categorization on colloquial English descriptive language (which would be easier to use by Federal administrative offices), rather than assumptions of etiology, although its categorical approach assumed each particular pattern of symptoms in a category reflected a particular underlying pathology.
The psychiatric or physiological view was abandoned, in favor of a regulatory model. A new "multiaxial" system attempted to yield a picture more amenable to a statistical population census, rather than just a simple diagnosis. Spitzer argued, “mental disorders are a subset of medical disorders” but the task force decided on the DSM statement: “Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome.”
HISTORY OF DSM

The first draft of the DSM – III was prepared within a year. Many new categories of disorder were introduced; a number of the unpublished documents that aim to justify them have recently come to light. Field trials sponsored by the U.S. National Institute of Mental Health (NIMH) were conducted between 1977 and 1979 to test the reliability of the new diagnoses. A controversy emerged regarding deletion of the concept of neurosis, a mainstream of psychoanalytic theory and therapy but seen as vague and unscientific by the DSM task force.
HISTORY OF DSM

In 1980, the DSM-III was published, at 494 pages long and listing 265 diagnostic categories. The DSM-III rapidly came into widespread international use and has been termed a revolution or transformation in psychiatry.

In 1987 the DSM – IIIR was published as a revision of DSM-III, under the direction of Spitzer. Categories were renamed, reorganized, and significant changes in criteria were made. Six categories were deleted while others were added. Controversial diagnoses such as pre-menstrual dysphoric disorder and Masochistic Personality Disorder were considered and discarded. Altogether, DSM-III-R contained 292 diagnoses and was 567 pages long.
HISTORY OF DSM

In 1994, DSM – IV was published, listing 297 disorders in 886 pages.

A major change from previous versions was the inclusion of a clinical significance criterion to almost half of all the categories, which required symptoms cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning”.

A "Text Revision" of the DSM-IV, known as the DSM – IV TR was published in 2000. The diagnostic categories and the vast majority of the specific criteria for diagnosis were unchanged. The text sections giving extra information on each diagnosis were updated, as were some of the diagnostic codes in order to maintain consistency with the ICD.
Why “5” and Not “V”? 

- Technology allows immediate electronic dissemination of information
- Roman numerals are limiting
- After DSM-5 is published, future changes prior to the next complete revision will be designated as DSM-5.1, DSM-5.2, and so on.
History of DSM

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History of DSM

The number of specific diagnoses has increased by more than 300% in just over 40 years.
How to Understand Mental Disorders

“There are balls and there are strikes – I call them as they are”

- Mental disorders are real things that will eventually reveal their existence through scientific study.
- Predominant view until about ten years ago
- The more we learn about the brain, the more complicated it proves to be.

How to Understand Mental Disorders

“There are balls and there are strikes – I call what I see”

- A nominalist position – mental disorders are no more than useful heuristic constructs
- This is now the consensus of most serious students of mental illness – even fervent biological psychiatrists
- Example – there is no one prototype “schizophrenia”

How to Understand Mental Disorders

“There are no balls and no strikes until I call them”

- This strategy suggests that mental disorders are social constructs that are subject to arbitrariness and misuses

- The power to label can be the power to destroy

How to Understand Mental Disorders

“I call balls and strikes according to how I need to use them”

- Pragmatist view – “mental disorder” should be influenced by the useful purposes it is meant to serve.
- Disorders are not real and independent illnesses, just useful constructs
- The diagnostic pie is split into many small pieces.

Conducting the Interview

Gathering Information:

Basic information desired for effective diagnosis and treatment planning include assessment of:

1. Intellectual, academic, and occupational functioning
2. Developmental level
3. Personality functioning
4. Family functioning
5. Social functioning
6. Temperament and affect
Gathering Information:

The diagnostic interview may be particularly useful for assessing the person’s:

1. Perceptions of his/her environment and self
2. Gaining knowledge about preferences, likes, dislikes, and expectations
3. Assessing the person’s social and emotional skills
4. Obtaining specific and sensitive types of information
Gathering Information:

The interviewer must select topic areas carefully.

A thorough review of all background information and presenting problem(s) of the particular person can guide the choice of areas.

Review the professional literature relevant to the problem, any associated physical or cognitive deficits, and possible treatments.
Conducting the Interview

It is sometimes helpful to prepare a brief checklist of information to be obtained during the interview.

Remain flexible and do not follow the outline rigidly. Periodic reference to the checklist can provide reassurance and help ensure that important topics are not forgotten.
Gathering Information:

An organizational format can be helpful. Proceed through the individual’s perceptions about his/her:

1. Environment
   A. Peer relations
   B. Work
   C. School
   D. Family
2. Self
   A. Wishes
   B. Interests
   C. Fears
3. Presenting problems
   A. The specific complaint that led to the referral
   B. May stem from environment or self
   C. Allows the interviewer to have the chance to establish rapport and trust
Gathering Information:
Selective Reflection – Helps structure the conversation during the interview

Involves listening to the total content, but reflecting only that portion of the verbalization that the interviewer wishes to explore further.

Child: Sometimes I get really mad at my sister, but Mom always takes her side.

Interviewer: Your sister does some things that make you mad.

Interviewer: Your mother doesn’t always seem to understand how you feel.
Gathering Information:

- Within each of the content areas, it is best to move from the positive, non-threatening topics to the more threatening topics.
- The problem topic is not addressed until the broader context is understood.
- Begin with subjects that the person knows and likes to talk about.
- Safe topics are age, work, school, birthday, pets, favorite games and TV shows, etc.
- Ask about what they like best about self – what they are most proud of.
- Ask to list 3 positive things, then 3 things they would like to change.
Warning Signs of Emotional Disturbance

- Sadness with no good reason
- Persistent anger
- Worthlessness or guilt
- Anxiety or worry
- Extended grief
- Fearful
- Worried about going crazy
- Does worse in school or at work
Warning Signs of Emotional Disturbance

- Loss of interest
- Changes in sleep or appetite
- Daydreams
- Hallucinations
- Poor concentration
- Obsessive behaviors
- Use of alcohol/drugs
- Violates the rights of others
The Mental Status Examination (MSE) is a standardized procedure used to evaluate the client’s mental and emotional functioning at the time the child is seen by the mental health professional. It involves a precise series of observations as well as some specific questions.
Mental Status Examination

The items included in the MSE are:

- Appearance, behavior, and attitude
- Characteristics of speech
- Affect and mood
- Thought content, thought form, and concentration
- Orientation
- Memory
- General intellectual level
- Insight and judgment
Mental Status Examination

Appearance:
A person suffering from serious mental impairment may lose interest in grooming and personal hygiene or may be unable to perform these normal functions.
Mental Status Examination

Behavior:

Psychomotor behavior is described to give some further indication about a person’s ability to maintain normal control.
Mental Status Examination

Attitude:
Typically refers to the individual’s motivation, cooperation, and ability to respond validly and reliably.
Mental Status Examination

The quality and quantity of the client’s speech provide information about thought processes.
Mental Status Examination

Quality:
Quality refers to relevance, appropriateness to topic, coherence, clarity, and voice volume.
Mental Status Examination

Quantity:

Quantity describes the amount and rate of speech, and any sense of pressure. Typically, the following items are identified, if present:

- Mutism, or no verbal response
- Circumstantiality, or excessively irrelevant detail
- Perseveration, or the repetition of the same words or phrases
- Flight of ideas or rapid, loose association of content, including:
  - Quick topic changes
  - Minimal or unusual connection between ideas
  - Simple rhymes
  - Clang associations (associations linked by sound)
  - Puns
Mental Status Examination

Other Characteristics of Thoughts: Evidence that client exhibits consistent disturbances in form of thinking.

Common disturbances include:

- **circumstantial thinking**: persistent story-telling, gets to point eventually
- **tangential thinking**: responses that do not pertain to question
- **black-white thinking**: thinking in extremes
- **impoverished thinking**: minimal responses in terms of speech production or content
- **obsessive thinking**: repetitive, ritualistic, intrusive thoughts
- **pressured speech**: rapid speech that client seems compelled to produce
Mental Status Examination

These are less common:

- **perseverative thinking**: persistent focus on a single idea, often irrelevant to topic
- **echolalia**: repetition (echoing) of interviewers words
- **blocking**: inability to recall, of which client is aware
- **confabulation**: generating material to replace gaps in memory
- **neologisms**: words and phrases repeatedly used to replace gaps in memory
- **magical thinking**: beliefs that events occur through magical processes
- **gross perceptual disturbances** (i.e., hallucinations, delusions, paranoid ideation that is not delusional)
Affect:

Affect is described by such terms as:

- Constricted
- Normal range
- Appropriate to context
- Flat
- Shallow
Affect and Mood:
Affect is the visible reaction a person displays toward events. Mood is the underlying feeling state.
Affect: Areas to Assess

- Awareness of feeling states and own feelings
- Predominant emotions
- Range of emotions
- Emotional stability and depth:
  - labile emotions?
  - absence of strong emotion?
  - degree of emotional reactivity
- Appropriateness and maturity of emotions in various situations (e.g., when confronted, teased, encouraged)
Mental Status Examination

Mood:

Mood refers to the feeling tone and is described by such terms as:

- Anxious
- Depressed
- Dysphoric
- Euphoric
- Angry
- Irritable
Mental Status Examination

Important Patterns to Look For Include:

- Incongruent affect, in which the client’s expression is of feelings opposite the ones appropriate for the context
- Lack of affect, in which emotional subjects are described in a detached manner
- Overreactions, in which a client may display an emotional response that is excessive in relation to the situation
Mental Status Examination

Thought Content:

- Delusions
- Illusions
- Hallucinations
Mental Status Examination

Thought Content:

Areas to assess include:

- negativistic thinking
- defense mechanisms
- empathic skills
- identity formation and interpersonal boundaries
- narcissistic thoughts
- paranoid thoughts
Thought Content:

Areas to assess include:

- antisocial, homicidal thoughts
- number and quality of coping mechanisms
- presence of suicidal thinking
- presence of morbid thinking
- other frequently occurring ideas in client's thinking
### Delusions:

Delusions are fixed, false beliefs that are contrary to reality. Rational evidence will not influence a person to change such a belief. Common delusions include:

- Persecution
- Special attention
- Grandeur
- Nihilism
- Alien control
- Self-deprecation
- Somatic delusions
Illusions:

Illusions are false perceptions in response to an external object that other people can also see. For example, a person may perceive a cord lying on the floor as a coiled snake.
Mental Status Examination

Hallucinations:
Hallucinations are false sensory perceptions. Auditory or visual distortions are the most common.
Mental Status Examination

Hallucinations:

Visual -- these may include simple patterns or fully formed shapes, such as animals. Colors are often bright and there may be a bizarre quality to the hallucination.

Tactile -- e.g. Of insects crawling over the skin, or of a sexual nature, auditory hallucinations may also occur.
Mental Status Examination

Thought Form:
The sequence of thoughts, logical connections, and the ability to provide specific information are elements of thought form.
Concentration:
Concentration inability is another indicator of thought disturbance. A good evaluation tool is the Serial 7 test, in which a person is asked to sequentially subtract 7 from 100.
Mental Status Examination

Concentration:
Complex task completion, such as generating a list of animals, within one minute. At least 12 is normal. (this tests frontal lobe function too.)
Awareness of time elapsed, such as in the interview, is said to be very sensitive.
Orientation:

Orientation in terms of time, place, person, and self is assessed to determine the presence of confusion or clouding of consciousness. This is important information for determining whether the person has organic m
Mental Status Examination

Orientation:

QUESTIONS TO ASK:

- Can you tell me today’s date?
- Do you know the day of the week?
- What month is it?
- What year is it?
- Do you know where you are?
- Do you know who I am?
- Do you remember your name?
Mental Status Examination

Memory:

Both recent and remote memory are assessed.
Mental Status Examination

Memory:

- serial counting tests (threes, sevens, forward or backward)
- digit span tests (forward, backward)
- visual memory tests
- five-minute object recall
- client's recall of well-known societal events
- richness of client's recent and remote memories
Memory:

**Testing memory**: Ask about immediate past personal history - who brought you to hospital etc.

- Ask about recent public events – eg., major news items.
- Test by giving 4 simple words, and checking recall after an intervening task.
Mental Status Examination

Memory:

Questions to Ask

Long-term memory:
- Where did you live when you were growing up?
- What was the name of the school you went to?

Short-term memory:
- What did you have for breakfast?
- What did you do yesterday?
Mental Status Examination

General Intellectual Level:

The child’s basic knowledge (often called the fund of knowledge) and awareness of social events are assessed.
Mental Status Examination

General Intellectual Level:

QUESTIONS TO ASK OLDER CHILDREN:

- Name a president of the United States?
- Who was Christopher Columbus?
- What country do you live in?
- What is the state capital?
General Intellectual Level:

QUESTIONS TO ASK OLDER CHILDREN:

- What is a thermometer?
- What do you do to make water boil?
- Name four presidents since 1946.
- From what direction does the sun rise?
- Who discovered America?
General Intellectual Level:

QUESTIONS TO ASK YOUNGER CHILDREN:

- Where are your ears?
- What is a bicycle?
- What is the name of your school's sports teams?
- What is a baby dog called?
- What color is the grass?
Mental Status Examination

Abstract Thinking:

Ability of client to think abstractly, beyond concrete data. This includes several areas, including:

- **superordinate reasoning** (similarities and differences, higher concepts)
- **social comprehension and insight**
- **social judgment** (general and personal judgment)
Mental Status Examination

Abstract Thinking:

- superordinate reasoning
  client's ability to infer meanings and higher level principles from concrete data.

- similarities and differences between common items
- opposite and similar concepts
- interpretation of proverbs
- simple numerical operations
Mental Status Examination

Social Comprehension and Insight:

Client's grasp of social concepts

- comprehension questions (e.g., why do we have laws?)
- client's level of understanding as to sources of problems
Mental Status Examination

Abstract Thinking:

Social Judgment:

client's grasp of appropriate social behaviors

- general judgment ("what if") questions (e.g., what would you do if you found someone's wallet on the street?)

- client's descriptions of recent decisions in own social situations
Mental Status Examination

Judgment:

A question commonly used is "If you were to find a stamped, addressed envelope lying on the sidewalk, what would you do?"
Mental Status Examination

Insight:

Insight is the client’s ability to identify the existence of a problem and to have an understanding of its nature.
Alternatives

- New diagnoses enter new editions by receiving the approval of the current Task Force appointed by the APA to revise the DSM.

- Draft versions are circulated for comments and suggestions.

- “Proposed mental disorders” from the previous edition, are more likely to be added then to be eliminated.

- Even the term “mental disorder” has been debated repeatedly between psychiatry and psychology.
Alternatives

Eliminating Old Labels:

Diagnoses that entered the DSM system by way of collective judgment rarely disappear.

DSM-5 contains a number of diagnostic labels that are based on expert consensus rather than on empirical studies of the reliability and validity of the diagnoses.
Alternatives

- Most psychiatric disorders as remaining in the primitive stage of development.

- Once the identification of the cause of a disorder is established, it leads to a reduction in disease labels -- a number of diseases previously defined syndromally unified into a single etiologically defined category.

- According to this analysis, progress would occur when syndromally defined disorders are reduced by etiological explanation.
Scadding proposed a ladder of taxonomic knowledge in medicine to explain changes in the naming of diseases.

- **Etiology of Causal Explanation**
- **Disorder of Function or Pathophysiology**
- **Structural Anomalies**
- **Signs & Symptoms of Syndromal Classification**
Alternatives

Obsessive-Compulsive Spectrum Disorders?

Disorders commonly considered to be in the spectrum include:

- Tourette’s Disorder
- Body Dysmorphic Disorder
- Hypochondriasis
- Impulse Control Disorders
Alternatives

Obsessive-Compulsive Spectrum Disorders?

Spectrum membership is based on similarity with OCD in a variety of domains:

- Symptoms
- Sex Ratio
- Age at Onset
- Course
- Comorbidity
- Joint Familial Loading
- Treatment Response
- Presumed etiology
There have been discussions about whether delusional and nondelusional variants of disorders should be classified as a single disorder, spanning a spectrum of insight, or should they be classified as distinct disorders?
Combining Delusional and Non-Delusional Variant?

Some believe that research will show BDD, OCD, Hypochondriasis, and Anorexia Nervosa are similar in "insight" and that a subtype model (with and without psychotic features) will be more useful than the current scheme.
Alternatives

Pragmatic Reasons for a Diagnosis an New DSM:

- Diagnosis solves social problems
- Diagnosis comforts professionals
- Diagnosis allows professional identity
- Diagnosis allows marketing
- Diagnosis makes money for the APA
How to Define Disorder:

Sociopolitical -- The condition is undesirable and health care providers can deal with it more effectively than other social entities (police, church, etc.)
Alternatives

How to Define Disorder:

**Biomedical** -- The disorder places the species at a biological disadvantage.

**Combined** -- Biological dysfunctions that are also harmful.
How to Define Disorder:

Ostensive -- General definitions are impossible -- only definitions of individual disorders.
Alternatives

Four Types of Diagnoses:

- Symptoms (Pseudoanatomical)
- Syndromes
- Anatomically Defined Conditions
- Etiological Diagnoses

Alternatives

Symptoms:

Examples include fever, headache, etc. Symptoms offer nothing in terms of information about treatment and prognosis.

Alternatives

Syndromes:

Aggregated clusters of symptoms that probabilistically coexist -- all diagnoses should be “tested” for predictive validity

Anatomical Diagnoses:

Limited utility in psychiatry --
Demonstrating that a condition is organic has little clinical utility unless there is a definable cause that can be treated.

Alternatives

Etiological Diagnoses:

Based on causes, not manifestations. Cut across syndrome boundaries and organ system boundaries.

Alternative Diagnostic Approaches:

Ideal Types

A hypothetical construct denotes a configuration of characteristics which are assumed to be interrelated. Actual cases are compared with ideal or prototypical cases.
Alternative Diagnostic Approaches:

Prototype

Organized around prototypical cases -- the best examples with a continuum from less prototypical to most prototypical -- involves a list of features
Alternatives

Higher-Order Patterns

Several factors have been proposed:

1. Emotional Dysregulation
2. Dissocial Behavior
3. Inhibitedness
4. Compulsivity

Affective lability
Anxiousness
Callousness
Cognitive Dysregulation
Compulsivity
Conduct Problems
Insecure Attachment
Intimacy Avoidance
Narcissism
Oppositionality
Rejection
Restricted Expression
Social Avoidance
Stimulus Seeking