IB Psychology of Dysfunctional Behaviour

Diagnosis and Classification - Interpersonal Issues in Assessment

The first step in diagnosis and classification of behaviours is the clinical assessment. This is covered on another handout or in notes and includes a variety of forms (clinical interviews, clinical observations and a range of clinical tests such as projective tests, self-report inventories, psychophysiological tests, neuropsychological tests and intelligence tests). The data produced during this assessment are subject to a number of possible shortcomings with which you will be familiar such as questions about validity, reliability and standardization. Due to these factors, the data are more often gathered from a battery of tests and are then integrated to produce an overall picture of the individual's behaviour. Once the data have been integrated, their significance needs to be determined, in other words they need to be interpreted.

Clinical Interpretation and Judgement

Interpretation and diagnosis depend upon major classification systems such that when certain symptoms occur together (a cluster of symptoms is known as a *syndrome*) they are assumed to constitute a particular mental disorder. When someone shows such syndromes they are assigned to a particular category in a classification system, which is nothing more than a very detailed list of descriptions of symptoms characteristic of each syndrome together with guidelines on how to assign behaviours (and so people showing those behaviours) to categories. The World Health Organization(WHO) uses a system known as the ***International Classification of Diseases*** which is periodically revised and the current version is ***ICD - 10***. This system is used in Britain. The classification system used in USA is the ***Diagnostic and Statistical Manual of Mental Disorders*** or ***DSM*** with the latest revision being in 1994 to give ***DSM-IV***. You should read Hayes p276-8 or Gross for information on how DSM-III-R (earlier version of DSM-IV) is used, though your tutor will probably explain this in some detail.

Problems of Clinical Misinterpretation

Even if the assessment data are reliable, valid and standardised so that they can be considered trustworthy, it is still possible for the clinician to arrive at the wrong conclusion and to misinterpret signs and symptoms due to a number of biases.

☞ ***BIAS***

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 another classic in its field, a study by Rosenhan (1973). Eight people were tested prior to the field part of this study and were certified psychiatrically healthy. They were a psychology student, three psychologists, a housewife, a paediatrician, a psychiatrist and a painter-decorator. They then presented themselves to admissions at eight psychiatric hospitals in USA complaining of hearing voices saying 'empty', 'hollow' and 'thud'. These auditory delusions and the name and occupations of the pseudopatients were the only falsifications in any part of the study at any time. All eight were admitted and then immediately stopped complaining of hearing voices. They were all classified as schizophrenic on the basis of this information alone and were kept hospitalized for up to 52 days. They were eventually discharged with a diagnosis of *schizophrenia in remission*. 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. Another field experiment by Rosenhan involved telling practitioners in a teaching hospital about the above findings and asking them to try to spot pseudopatients who would turn up for admission during the next three months. Rather cruelly (to save money?) Rosenhan sent no fakes but of the 193 patients who presented for admission during the period, 41 were identified as impostors by at least one member of staff, 23 were suspected of being fakes by at least one psychiatrist and 19 were suspected by one psychiatrist and one member of staff. There were no impostors, all were real patients!

The above biases, misconceptions and expectations may result in outrageous misdiagnoses. 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!)

Φ ***LABELLING***

Some theorist suggest that our perceptions of abnormality are a reflection of diagnostic **labels** attached to people. If you label someone as something (be it *friendly, deviant* or whatever) the tendency is to see their behaviour as fitting with this label. (You have come across this idea in various labelling theories such as self-fulfilling prophecy and halo effect.) Szasz (1987, 1973) and Rosenhan (1973) suggest that when people behave in ways that are unacceptable to society, they are categorised as deviant and labelled as such. Although the initial application of the label may be totally unjustified, a vicious circle follows such that any subsequent behaviour is seen as confirming the label. For example, if someone in authority labels you as disruptive, any protest on your behalf could be interpreted as disruptive. Gradually you might acquiesce and play the role, functioning in ways that you believe are expected of you. In this sense, labels of *madness, insane* or *crazy* are seen by Szasz as means of social control, a way of manipulating and undermining the power of people who behave in any way that is seen as deviant or socially unacceptable. The danger comes about when we start to ask who it is that defines *socially acceptable*. Of course, it is not the people who are labelled but those who label that have the power in such a situation.

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.

A dilemma remains. If a diagnosis is made, it is fraught with the problems outlined above. If the limitations and negative aspects of classification and labelling lead to diagnoses being refused, it then becomes difficult to treat the person. Akiskal (1989) holds that "classification and diagnosis can yield valuable information that greatly advances the understanding and treatment of people in distress. To throw away such information would be too drastic a measure, one that would create more problems than it solves" (Comer 1995 p135).