Introduction, History & Scope of Clinical Psychology

Dr. Sadia Malik

What is Clinical Psychology?

According to the APA Division of Clinical Psych (Division 12):

- "Involves research, teaching, and services relevant to the applications of principles, methods, and procedures for understanding, predicting, and alleviating intellectual, emotional, biological, psychological, social, and behavioral maladjustment, disability and discomfort, applied to a wide range of client populations."

What is Clinical Psychology?

What does all that mean? In essence, we:

- Work to understand why people have psychological distress
- Work to prevent emotional disturbance/distress
- Work to relieve emotional disturbance/distress
- Promote psychological well-being
- Promote personal development and growth*

What is Clinical Psychology?

How do clinical psychologists live out these goals?

- Provide assessments to determine if there is the presence of emotional disturbance
- Provide psychotherapy to treat people with emotional distress
- Conduct research cause, prevention, and promotion of mental health
- Teach undergraduate and graduate students
- Develop prevention and treatment programs
- Engage in program administration
- Provide expert testimony

Activities

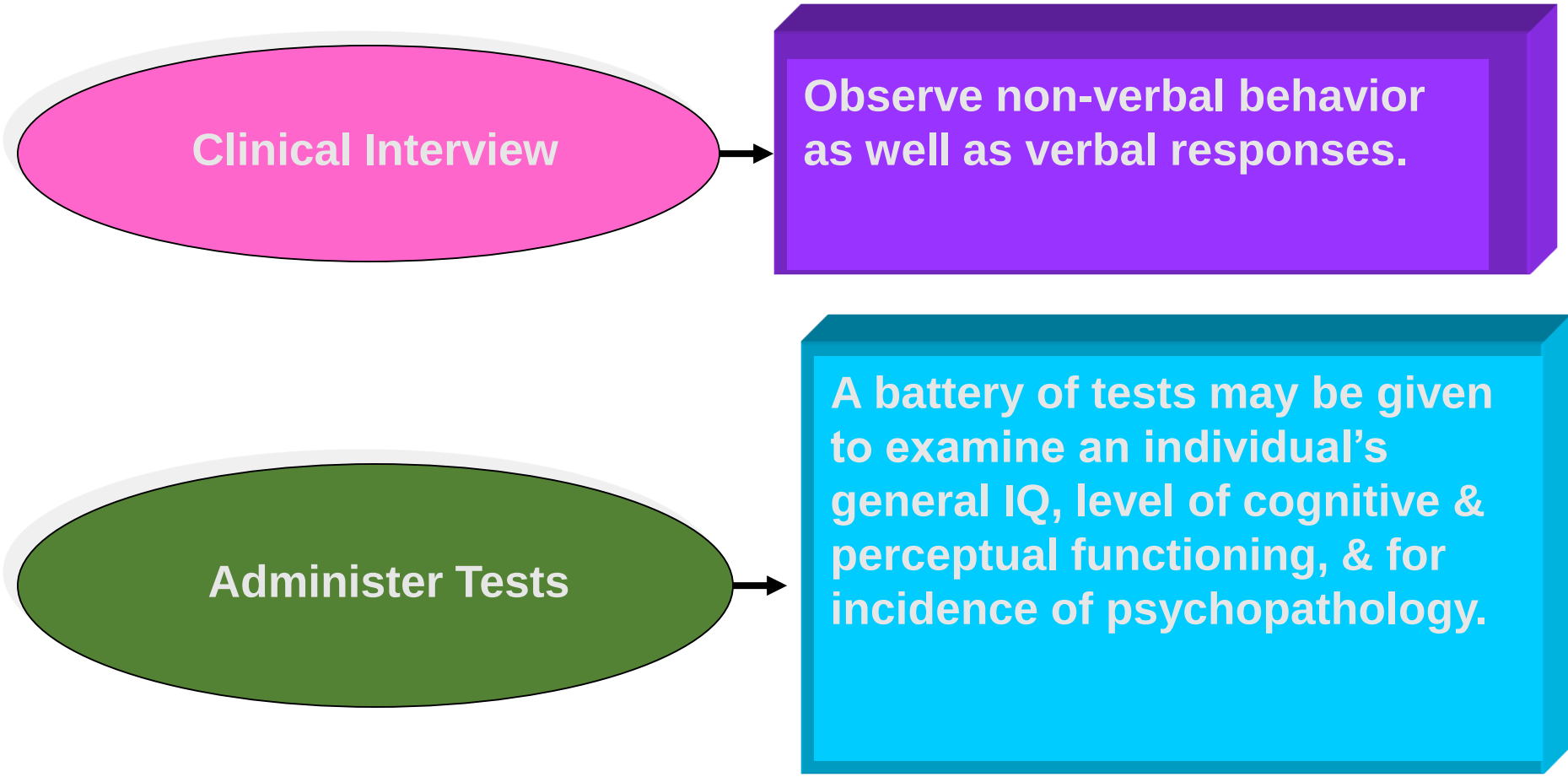
- Therapy/Intervention
- Diagnosis/Assessment
- Clinical Supervision
- Teaching
- Research
- Consultation
- Administration

Activities of Clinical Psychologists:

- 1. **Assessment**- Clinicians gather information on individuals regarding their behavior, problems, abilities, characteristics, intellectual functioning, and personalities.
- They may observe an individual in a clinical interview as well as administer tests to assess general intellectual abilities, memory, reaction times, & psychological & mental functioning.

- Assessment--collect information about people to
- diagnose problematic behavior,
- describe a person's personality characteristics,
- enhance personal well-being,
- determine possible career options,
- select employment candidates,
- provide legal decisions (criminal responsibility, commitment to an institution, family reunification, fitness to return to society, etc.),
- determine readiness and effectiveness of treatment

Assessment Procedures



Treatment

- offer various interventions to resolve emotional distress and psychological problems (psychotherapy);
- most commonly used therapeutic approaches are cognitive-behavioral, psychodynamic, and humanistic.
- Goals of treatment vary from person to person and are determined by clients and their therapists.
- Treatment can be performed on an in-patient basis (psychiatric hospital) or out-patient basis (community mental health center, offices, etc.)

- Clinicians provide therapeutic treatment for individuals with behavioral & psychological problems.

- **Method of treatment** is determined by:
- ***Clinician's theoretical orientation (background)***
- ***Nature of the client's problems***
- ***Is client adult or child?***
- ***Is client an outpatient or in a facility?***
- ***Does client need medication in conjunction with therapy?***

3. Research

- Clinical psychologists employ research paradigms to examine psychopathology and efficacy of therapies used for treatment.

- The range of psychologists interested in clinical science is quite broad.

- The goal of research in psychological science is to advance our understanding of human behavior and treatment outcomes for behavioral & mental problems.

Why are Clinical Psychologists required to engage in research to earn their degrees?

- 1. Clinical psychologists need to be trained to critically evaluate published research on assessment methods & treatment options to determine which have been validated.

- 2. Research training will help Clinicians objectively evaluate their own treatment methods.

- 3. A strong research background will aid Clinicians who work with community mental health centers in assessing the effectiveness of the agency's programs.

- 4. Clinical psychologists who work as faculty members at a university need to supervise and mentor students in research programs.

4. Teaching

- Many clinical psychologists are faculty members in a college or university.

- As academics a large portion of their time is spent teaching courses in the clinical psych field to undergraduates and graduate students.

- Courses typically taught by Clinicians may include: abnormal psychology, theories of counseling, psychological testing and assessment, clinical psychology, and personality.

- Clinicians who teach in universities with graduate programs also *mentor graduate students in research programs, supervise their research theses/internships, and present/publish research with their students.*

5. Consultation:

- Clinical Psychologists may work as consultants in research, academic, & clinical settings.
- Consults may:
- ***Educate individuals in a setting*** (e.g., familiarizing staff with a new procedure.)
- ***Advise***
- ***Provide direct service*** (assessment, treatment, evaluation)

Other Mental Health Professionals

- Counseling Psychologists/School Psychologists--focus primarily on normal transitions that people face; emphasis on educational, vocational, and group adjustment; obtain a Psy.D., Ph.D., or Ed.D.
- Psychiatric Social Workers -- provide direct services to clients or work to improve social conditions; provide therapy, obtain a BS, MA, or Ph.D.
- Psychiatric Nurses -- care and treat persons with psychiatric disorders; work in psychiatric hospitals or hospitals
- Marriage/Family Therapists -- focus on psychological disorders as they relate to the family, marriages, and couples
- Paraprofessionals -- provide supplemental services to mental health specialists

Employment Settings for Clinical Psychology

- Psychiatric Hospitals 4%
- General Hospitals 3%
- Outpatient Clinics 4%
- Community Mental Health Clinics 2%
- Medical School 8%
- Private Practice 39%
- University, Psychology 18%
- University, Other 4%
- VA Medical Center 3%
- Other 15%

Clients & their problems: Data based on reports from over 6,500 Clinicians

- The most commonly treated problems in clincal psychology are in order of frequency:

- *Anxiety and depression*
- *Interpersonal problems/difficulties*
- *Marital difficulties*
- *School problems*
- *Psychosomatic & physical complaints*
- *Job-related problems*
- *Alcoholism/drug use*
- *Psychosis*
- *Mental retardation*

What do you need to become a clinical psychologists?

Most important aspect: ***Personal Attributes***

- Clinical Attitude/Approach -- use of knowledge from research on human behavior and mental processes, along with individual assessment, in efforts to alleviate personal/emotional distress
- Deep interest and compassion for people
- Integrity, emotional stability, and honesty
- Sound judgment

What do you need to become a clinical psychologist?

Educational Requirements:

- Graduate degree from an APA-Approved Clinical Psychology Program (coursework that includes: Psychopathology, Assessment, Therapeutic Interventions, Ethics, Statistics, Research Methods, etc) -- Ph.D., Psy.D., and EdD (school psychologists)
- Clinical Experience -- practicum training, externship, and clinical internship
- Competence -- must pass a comprehensive examination (national and state licensing board exams), referred to as the Examination for Professional Practice in Psychology (EPPP)

Legal Requirements:

- Legally regulated profession
- Must be licensed or certified to assess, diagnose, and provide treatment for mental health disorders -- qualifications for licensure vary from state to state as well as levels of training (graduate students require supervision from licensed clinical psychologist)

Ethical Requirements:

- Understanding of the Ethical Codes (put out by the APA's Ethical Principles of Psychologists and Code of Conduct "Ethics Code") -- provides guidelines on how to carry out the goals and objectives put forth by Clinical Psychology
- Various ethical issues arise whereby the Ethics Code stipulates how to best handle such situations
- We have to abide by the ethics code as well as state and federal laws for psychologists to be effective and to avoid professional mistakes

History of Clinical Psychology

- Have tried to understand and explain behavior that is bizarre
- Explanations involved magical forces/supernatural phenomena
- Possessed by demons, spirits and treatment involved exorcisms
- Hippocrates attempted to explain bizarre behavior through use of medical model; believed that abnormal behavior stemmed from natural causes, behavior disorders are function of distribution of four bodily fluids: (blood, black bile, yellow bile, and phlegm); paved the way for the concept of mental illness

History of Clinical Psychology

Treatment of Mentally-Ill

- Socially isolated
- Demonized
- Institutionalized in sanitariums/mental hospitals often for a life-time in conditions that were in-humane (find video)
- Treatment began to gradually change by late 18th and early 19th century with movements led by Europeans and Americans Philippe Pinel, Benjamin Rush, William Tuke, and Dorothea Dix
- Pushed for more humane living conditions and treatments

History of Clinical Psychology

Empirical Tradition of Clinical Psychology as a Profession

- Clinical psychology has roots that extend back before the field of psychology began -- roots in philosophy, medicine, and other sciences
- 1879 marks the beginning of modern psychology, Wilhelm Wundt established 1st laboratory in Germany that studied mental health processes -- used empirical methods to understand human behavior -- use of observation and experimentation
- Lightner Witmer -- 1st clinical psychologist & headed the University of Pennsylvania program; Used scientific method to diagnose and treat a client

History of Clinical Psychology

Empirical Tradition of Clinical Psychology

- Emphasis on scientific approach to understanding human behavior and diagnosis of problems
- Not trained in clinical application
- Less emphasis on treatment
- Beginning of debate between clinical psychology as a science versus clinical application (scientific research emphasis vs. treatment or clinical application)
- Belief that scientific evidence should be the basis for clinical practice

History of Clinical Psychology

Witmer's Influence:

- Established the first "psychological" clinic
- Proposed a new profession named clinical psychology
- Served as founder and editor of the first journal in the field called, "The Psychological Clinic"
- Influenced and anticipated future developments in clinical psychology, including an emphasis on children, use of clinical interventions, collaboration with other professions in providing treatment

History of Clinical Psychology

The Psychometric Tradition

- Began early in the fields of astronomy and anatomy
- Studied individual differences
- By 19th century, German anatomist Franz Gall had interest in individual differences
- Developed phrenology, the study of mental characteristics and the shapes of heads -- practice of assessing personality by reading bumps or variations in the skull

History of Clinical Psychology

Assumptions of Phrenology

- Each area of the brain is associated with a different function
- The more developed each area of the brain, the strong and better the functioning of the area of the brain
- Pattern of over or underdevelopment of each faculty is reflected in corresponding bumps or depressions in the skull

History of Clinical Psychology

- Interest in individual differences continued and was heavily influenced by Charles Darwin's *Origin of Species*, specifically that individual differences occur within and between species and natural selection takes place in part on the basis of those characteristics
- Galton was influenced by ideas put forth by his cousin Darwin; used these ideas to try explain differences in mental abilities; use of quantitative methods to understand differences among people; pursued interests in sensory acuity, motor skills, and reaction time

History of Clinical Psychology

Galton:

- Tried to distinguish from low and high intelligence on the basis of individual ability
- Measured individual differences using mental imagery, word association test

History of Clinical Psychology

- James McKeen Cattell furthered the tradition of studying individual differences and studied differences in intelligence; developed a battery of 10 tests and wanted to discover the constancy of mental processes and use the findings to determine the selection and training of people as well as in the detection of disease
- Credited with merging individual mental measurement with the new science of psychology
- First to use the term mental test
- Primarily used sensorimotor measurements

History of Clinical Psychology

Alfred Binet

- Frenchman who was interested in mental measurement
- Founded the first psychology laboratory in France
- Developed measures of complex mental ability in normal and abnormal children to help with remediation of mentally retarded children
- Expanded measurement to include areas such as comprehension, attention, suggestibility, etc..
- Believed that intelligence should be measured using higher mental processes not just sensorimotor processes
- Created the first “true” psychological test of mental ability with his colleague Theodore Simon

History of Clinical Psychology

Stanford-Binet:

- Introduction of modern day of intelligence testing
- Adapted by Lewis Terman at Stanford University
- Standardized items on Americans and is currently in its 5th revision
- Believed that intelligence was inherited and a strong predictor of one's success and wanted to use IQ tests as a means to identify appropriate job placement
- Was so popular that current APA President at that time Robert Yerkes used it to develop the Army Alpha and Army Beta tests to classify army recruits (high officer material vs. rejects)

History of Clinical Psychology

World War I and Intelligence Tests:

- Raised status of psychologists
- Grounded psychology and no longer seen as lofty and soft
- Help to solidify differences in society based on “innate” ability/intelligence
- Used to justify racial, ethnic, and gender discrimination

History of Clinical Psychology

Binet-Simon Test of Intelligence:

- Created a 30-item test of intelligence; Focused on three areas which were: Judgment, Comprehension, and Memory
- Items on test were arranged in order of difficulty from least to most difficult

In later revision of test:

- Included more items on the test
- Items grouped by the ages at which children passed them

History of Clinical Psychology

Scientific Method vs. Clinical Application:

- Need for clinical applications/treatments not just research driven
- Early psychologists very reluctant to shift from research to applied psychology

Three Factors that influenced move towards clinical application:

- Psychological testing of intelligence as well as personality and psychopathology
- Emergence of child guidance clinics and the use of treatment of social as well as educational problems
- Eagerness to learn “psychoanalysis” which was the predominant approach to psychotherapy being used by psychiatrists, particularly in Europe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- Three types of theories of the causes of abnormal

behaviors have competed for dominance across history.

The biological theories saw abnormal behaviour as similar to physical diseases, caused by

the breakdown of systems in the body. The appropriate cure was the restoration of bodily health.

- The supernatural theories saw abnormal behaviour as a result of divine intervention, curses, demonic possession, and personal sin. To rid the person of the perceived affliction, religious rituals, exorcisms, confessions, and atonement were prescribed.

Theories of Abnormalities

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What is Psychopathology

Symptoms that cause mental, emotional and/or physical pain.

Criteria for Abnormality

1. Suffering: If people suffer or experience psychological pain we are inclined to consider this as indicative of abnormality.
2. Maladaptiveness: Maladaptive behavior is often an indicator of abnormality. The person with anorexia may restrict her intake of food to the point where she becomes so emaciated that she needs to be hospitalized.
3. Statistical Deviancy: The word abnormal literally means "away from the normal."

4. Violation of the Standards of Society: All cultures have

rules. Some of these are formalized as laws.

5. Social Discomfort: When someone violates a social rule, those around him or her may experience a feeling of discomfort or unease.

6. Irrationality and Unpredictability

7. Dangerousness

Psychological Theories

PSYCHOANALYSIS

Sigmund Freud (1856-1939) developed psychoanalysis as

(1) a theory of psychological development, personality, and neurosis;

(2) a method for studying symbolic cognitive processes and the unconscious; and

(3) a technique of psychotherapy.

PSYCHOANALYTIC THEORY

There are 3 intertwined strands:

- a ***structural theory*** of personality and the topography of the mind
- a theory of development positing a series of standard ***psychosexual stages***, each marked by
  - a sensual focus on a particular part of the body
  - the need to confront a certain challenging conflict
- the central concept of the ***unconscious***, referring to the hidden workings of dynamic mental processes that cause most emotionally-significant behavior

THE STRUCTURAL THEORY

- ID pleasure principle/primary process
- EGO reality principle/secondary process
- SUPEREGO
  - conscience
  - ego ideal
- ID/EGO conflicts can cause ***neurotic anxiety***
- conflicts between the EGO and external reality can cause ***realistic anxiety***
- conflicts between the EGO and SUPEREGO can cause ***moral anxiety***

The “it” (or, the id) . . .

- The minds of newborn children have practically no structure initially, so infants tend to go directly into action to satisfy the demands of the instincts; the guiding principle is the ***pleasure principle***.
- Infants’ thinking patterns are dominated by hallucinatory images, the type we are familiar with when we are daydreaming or dreaming. This form of cognition is known as ***primary process***, a form of wishful thinking that coincides with the infant’s difficulty in separating fantasy from reality.

The “me” (or, the ego) . . .

- Children learn to follow the ***reality principle*** in dealing effectively with life’s demands. This coincides with the development of the ***ego***. The id is the original pleasure-seeking mind, driven by instincts, and the ego is the newer, realistic one, driven by the need to compromise with the demands, pressures, and frustrations imposed by the outside world. Threats, internal or external, create anxiety, a signal to the ego to deal effectively and practically with the problem.
- A more mature thinking style develops, ***secondary process*** thinking, that realistic, pragmatic, goal-oriented, rational cognitive activity that we associate with waking life in adulthood.

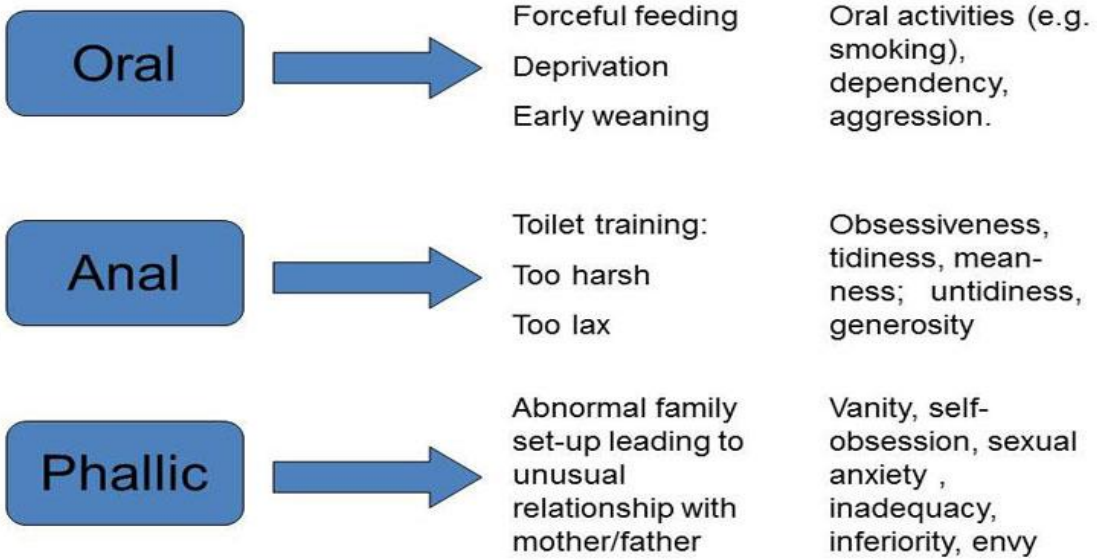
The “over-me” (or, the superego) . . .

- The ***superego*** is an ideal ego that, as the conscience, exercises moral censorship on behavior.
- It contains the commands and prohibitions that we learn from parents, teachers, and others in authority during our childhood years.
- It both arises from, and allows resolution of, the Oedipus complex that all humans have to negotiate at about the age of five

STAGES OF PSYCHOSEXUAL DEVELOPMENT

- ORAL
- ANAL
- PHALLIC
  - The Oedipus Complex
  - The Case of *Little Hans*
- LATENCY
- GENITAL

Fixation + Adult Personality



The oral stage (0 – 18 months)

- Newborn infants are already equipped with a sucking reflex that allows them to feed from the mother's breast or from the bottle, but the breast or the bottle are not always available.
- The resulting frustration is the first significant psychological challenge faced by the infant. Handled poorly, this frustration can lead to ***fixation***.
- Unconsciously, the oral stage brings the hidden threat of the loss of the parent who brings food.

The anal stage (18 months to 4 years)

- The conflicting tendencies are between being tidy, clean, dutiful, and cooperative versus being messy, rebellious, and uncooperative.
- Ideally, parents will approach toilet-training sensitively, presenting neither too great nor too small a challenge at each point.
- If fixation occurs, the child may develop personality traits that are symbolically related to toileting behavior:
- Uncooperative, mean, stingy, and emotionally constricted ***versus*** generous, giving, careless, wasteful, and emotionally expressive.

The phallic stage (4 - 6 years)

- Themes of rivalry with the same-sex parent for the attention of the other; the Oedipus Complex is resolved partly by ***repression*** and partly by ***identification***, though the process differs for boys and girls.
- “The girl accepts castration as an accomplished fact, whereas the boy fears the possibility of its occurrence” (Freud, 1924/1989, p. 665).

The latency stage (7 to puberty)

- Either a time when whatever may be going on psychosexually is hidden or latent,
- or a stage in which the child's ego functioning develops as he or she learns to deal with the practicalities of school, peer relationships, etc.

The genital stage (puberty to young adulthood)

- After puberty comes the ***genital stage*** in the teenage years, in which young adults learn to focus their sexual interests upon another person.

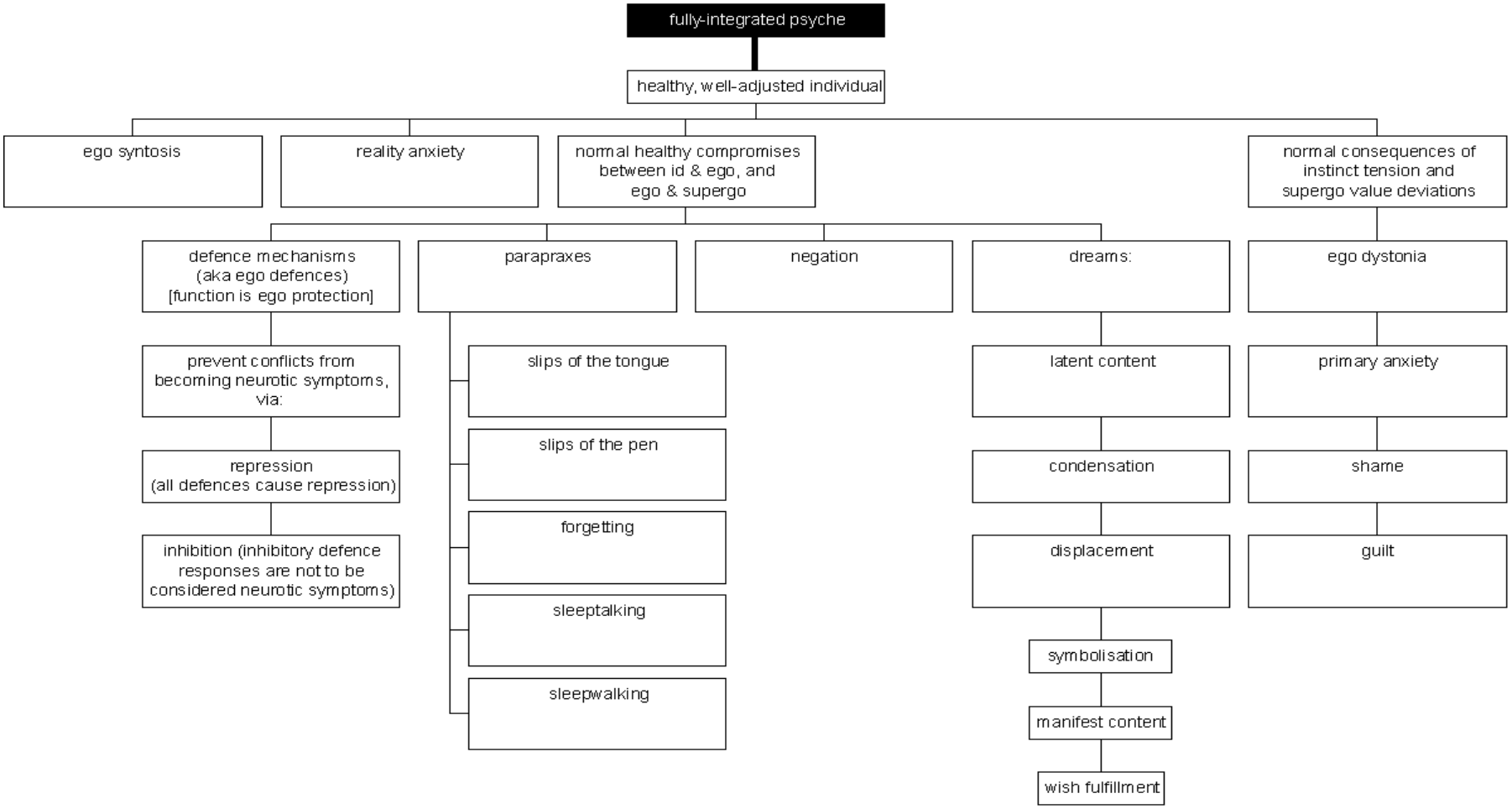
DEFENSE MECHANISMS

- these were described by Anna Freud
- examples include:
  - REPRESSION
  - PROJECTION
  - DENIAL
- defense mechanisms operate unconsciously to protect the ego from threats from the id and from external reality

Psychoanalysis: Influences on Clinical Psychology

- First systematized school of psychotherapy
- Several psychodynamic therapies developed in reaction to Freudian psychoanalysis
- Unconscious processes
- Psychological testing
  - Projective tests

Classical Psychoanalytic Theory of Normal Adjustment



The NEO-FREUDIANS

- the terms include ***ego psychology, object relations,*** and the ***cultural school*** of psychoanalysis
- ***neo-Freudians*** was the label both for the innovators in general and for the specific sub-group who gave prominence to interpersonal relationships in personality, psychopathology, and psychotherapy
- Erich Fromm, Karen Horney, and Harry Stack Sullivan represent the Adler-like neo-Freudians who rejected the libido theory and stressed the importance of interpersonal issues

Stage 1 Undifferentiated stage	**New born baby has just image of self. Infants believe that caregivers and itself are one. Both have same feelings and desires.**
Stage 2 Symbiosis	Infant now can distinguishes between good and bad aspect of self plus other image
Stage 3 Speration-individuation	Child begins to differentiate between the self and the other but the child only focues on good other or bad other.
Stage 4 Integration stage	Now child is able to distinguish between the self and the other and integrate the good or bad images of self and other into complex reresentation

Splitting: Many people with psychopathology can not fully resolve stage 2 and 3 and prone to seeing self as all good or all bad.
Borderline Personality Disorder

Humanism

- a loosely grouped set of approaches to psychotherapy
- Emphasize potential for positive development and personal growth
- Related to existentialists
- Existential philosophy emphasizes freedom to choose
- With freedom comes responsibility

Client-Centered Therapy

- Carl Rogers (1902- 1987)
- Developed thinking about psychotherapy in the 1940s and 1950s
- Landmark paper in 1957
- Essential conditions for therapeutic change

Assumptions of client-centered therapy

- Actualizing tendency
- Orgasmic Valuing Process
  - Trusting our innate sense of what feels right people will move toward actualizing tendency
- Conditions of Worth
- Therapeutic Principles
  - Nondirective
  - Therapist-offered conditions
    - Empathy
    - Unconditional Positive Regard
    - Genuineness

Humanism: Influences on Clinical Psychology

- Springboard to a variety of forms of psychotherapy
  - Existential analysis
  - Client-centered therapy
  - Gestalt therapy
- Therapist-Offered Conditions central to strong therapist-client alliance across therapies
- Fostered research on *process* of psychotherapy

Behavioral Models

Behavioral Models: Key Assumptions

- Rejection of medical model
- Abnormal – normal continuum
- Basis in experimental psychology
- Direct modification of overt behavior
- Focus on maintaining factors
- Commitment to experimental evaluation of treatment

Behavior Therapy: History

- South Africa
  - Joseph Wolpe (*Psychotherapy by Reciprocal Inhibition*, 1958)
- England
  - Hans Eyesenck
  - Monte Shapiro
- United States
  - John B. Watson
  - B.F. Skinner

Learning Theory

- Classical conditioning
  - Unconditioned Stimulus (UCS)
  - Unconditioned Response (UCS)
  - Conditioned Stimulus (CS)
  - Conditioned Response (CR)
- Operant Conditioning
  - Reinforcement
  - Schedules of reinforcement
  - Extinction

Behavioral Models: Influences on Clinical Psychology

- Challenged psychodynamic myths
  - e.g., symptom substitution
- Single case experimental design
- Extensive research on behavioral therapies
- Empirically supported treatments

Cognitive Model

Cognitive Models: Development

- Aaron Beck
  - Cognitive therapy
- Albert Ellis
  - Rational-Emotive Behavior Therapy
- Albert Bandura
  - Social Learning Theory

Cognitive Models: Key Assumptions

- Behavior and emotions are influenced by thoughts and beliefs about events more so than the events themselves
- Expectancies
  - Outcome expecations
  - Self-efficacy
- Observational learning

Cognitive Models: Links to Behavior Therapy

- Commitment to empirical research
- Ties to experimental psychology (cognitive psychology)
- Social learning theory an expansion of classic learning theory

Cognitive Models: Influences on Clinical Psychology

- Empirically supported
  - Panic disorder
  - Social anxiety
  - Depression
  - Bulimia
- Increased in popularity
  - Popular among clinicians
  - Popular among clinical scientists

Interpersonal theories of Abnormality

Early Social & Moral Development

Erikson's Stage Theory in its Final Version			
Age	*Conflict*	*Resolution or "Virtue"*	*Culmination in old age*
Infancy (0-1 year)	Basic trust vs. mistrust	Hope	Appreciation of interdependence and relatedness
Early childhood (1-3 years)	Autonomy vs. shame	Will	Acceptance of the cycle of life, from integration to disintegration
Play age (3-6 years)	Initiative vs. guilt	Purpose	Humor; empathy; resilience
School age (6-12 years)	Industry vs. inferiority	Competence	Humility; acceptance of the course of one's life and unfulfilled hopes
Adolescence (12-19 years)	Identity vs. Confusion	Fidelity	Sense of complexity of life; merging of sensory, logical and aesthetic perception
Early adulthood (20-25 years)	Intimacy vs. Isolation	Love	Sense of the complexity of relationships; value of tenderness and loving freely
Adulthood (26-64 years)	Generativity vs. stagnation	Care	Caritas, caring for others, and agape, empathy and concern
Old age (65-death)	Integrity vs. Despair	Wisdom	Existential identity; a sense of integrity strong enough to withstand physical disintegration

Family System Theory

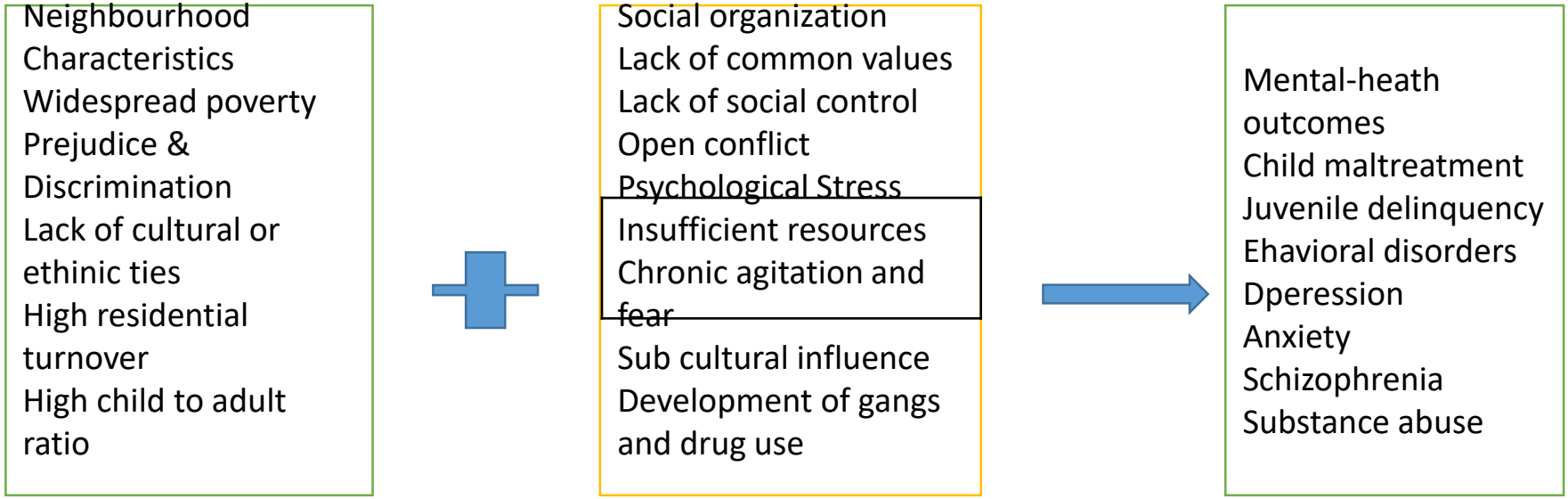
Inflexible Family

Mesh Family

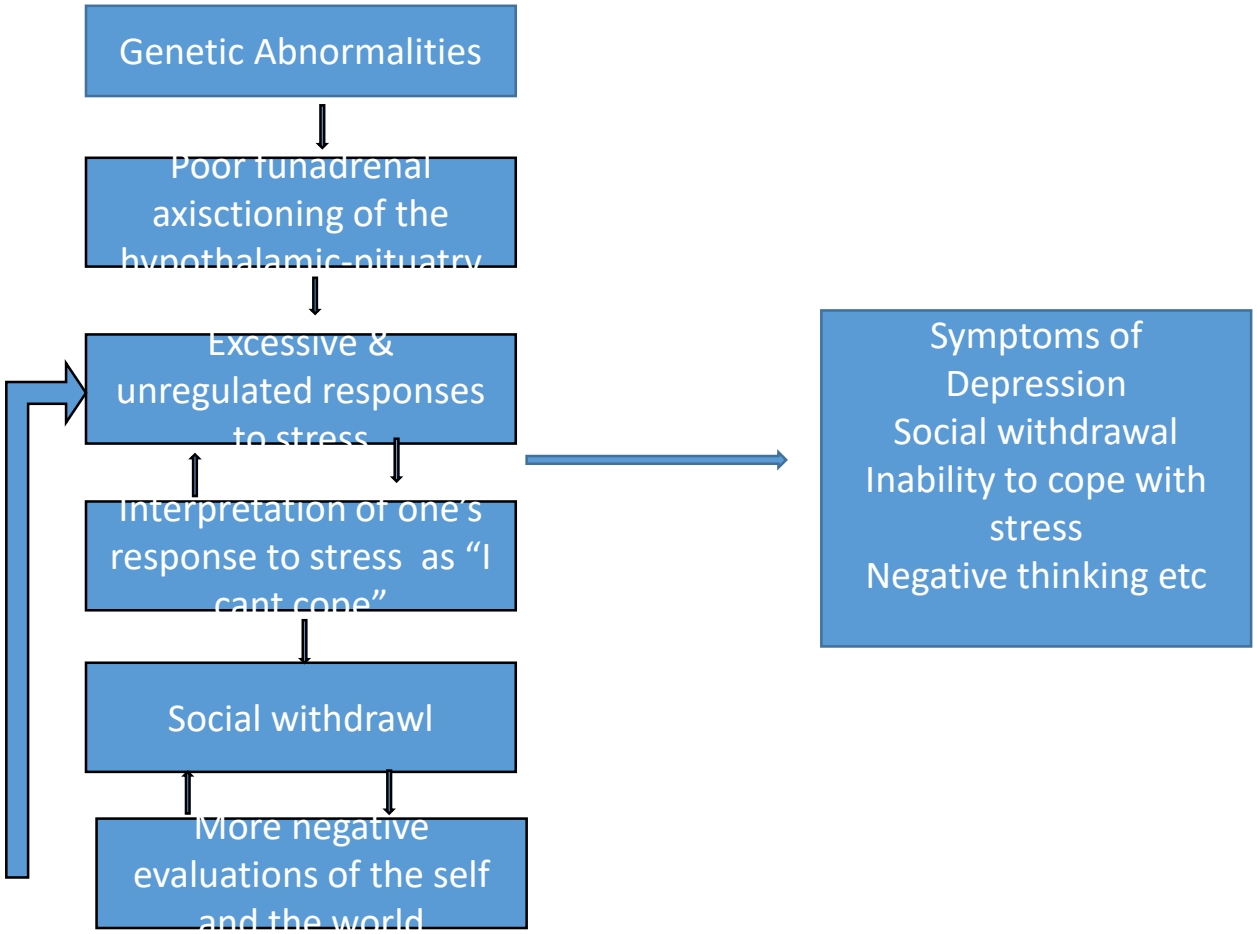
Disengaged Family

Pathological -triangular relationships

social structural model of mental health



Some Biological, psychological and Social Factors



Assessment & Diagnosis

Dr. Sadia Malik

The Purposes of Psychiatric Diagnosis

1. To define clinical entities, so that clinicians have the same understanding of what a diagnostic term means

2. To determine treatment

How well a diagnosis defines a disorder and guides treatment depends on it's validity and reliability

Two Diagnostic Approaches

1. Descriptive – diagnoses based on relatively objective phenomena that require little clinical inference (signs, natural history, etc.) – focus on what
2. Psychological (or dynamic) – diagnoses based primarily on inferred causes and mechanisms, with symptoms frequently being seen as superficial manifestations of a more profound underlying process – focus is on why

Two Diagnostic Approaches

Both approaches are valuable – each addresses a different aspect of psychopathology

Ex: delusions

Descriptive – Are they fixed? Vague? Paranoid? Circumscribed?

Dynamic – inner mechanism (e.g., projection) that produces the delusion

Dimensions of Diagnosis

- Categorical vs. dimensional
- Monothetic vs. polythetic

- Categorical diagnosis – all persons assigned to the same category are alike with respect to some attribute
- Dimensional – all persons rated on pre-determined dimensions

Dimensional Approaches to Diagnosis

- All persons are rated on a pre-determined, quantitatively-based dimensions
- Ex: Axes IV and V of DSM-IV-TR

- In dimensional approaches, there is no assumption of behavioral discontinuity – psychopathology is seen as falling on a continuum
- “more this or less that” not “either/or”

- Monothetic diagnosis – each category is associated with specific criteria, all of which are considered essential to that category's definition (also called classical categorization)

- Effects:
- 1. comparatively few persons will met the criteria of any one category
- 2. for those who do, they will show a high degree of behavioral similarity

- Polythetic (prototypal) diagnosis – each category is associated with a number of criteria, only some of which are necessary for a diagnosis to be assigned.

Two advantages over the categorical approach

- 1. requires fewer categories to classify the great variety of behavioral variation (greater simplicity)
- 2. more reliable – clinicians do not have to agree on every criterion to arrive at the same diagnosis

Disadvantage: individuals with the same diagnosis may bear little resemblance to each other, in terms of presenting complaints

- There is a third, mixed approach, in which some criteria are considered necessary for a diagnosis, while other criteria may or may not be met.

- Ex: Criteria A & B are essential to this diagnosis, while any combination of 2 of the 4 of criteria C, D, E & F will do.

Historical Overview of Psychiatric Classification

The science of classifying abnormal patterns of behavior and experience is called nosology.

The root of nosology can be traced back to Hippocrates, who established a classification scheme that remained influential throughout ancient Greece and Rome

Diagnostic categories included mania, melancholia and hysteria

DSM-I

- The first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories.
- Used the term “reaction,” reflecting Adolph Meyer’s psychobiological view that mental disorders represented reactions of the personality to psychological, social and biological factors

DSM-II

- ICD-6 (1948) had been the first ICD to include a subdivision on mental disorders, but had only been adopted by 6 countries by 1959. Stengel (1959) found many diagnostic systems in use around the world.
- This led to the need for a consensual system for all WHO countries, which was to be included in the ICD-8.
- The resulting system was adopted, with minor revisions, and published as DSM-II in 1968.

Technical Advances of the ’70’s

- Throughout the 1970’s, a number of researchers developed operational criteria for making diagnostic decisions.
- Feighner, Robins, Guze, et al. (1972) derived explicit diagnostic criteria for 16 diagnostic categories (the “St. Louis Group” at Washington University) – these criteria demonstrated improved reliability, compared with DSM-II diagnoses

DSM-III

In 1974, the APA appointed the Task Force on Nomenclature and Statistics to begin work on DSM-III

Emphasis was placed on increasing reliability and clinical utility

Represents a “dramatic departure” from previous DSM’s

Innovations of DSM-III

1. Provided a definition of the term “mental disorder”
2. Presented diagnostic criteria for each disorder
3. Introduced the multiaxial diagnostic format
4. Redefined a number of major disorders (e.g., elimination of “neurosis”)
5. Added new diagnostic categories (e.g., personality disorders)
6. Presented a hierarchical organization of diagnostic categories
7. Presented a systematic description of each disorder

Innovations of DSM-III

8. Provided decision trees for differential diagnosis
9. Provided a glossary of technical terms
10. Published reliability data from field trials
11. Utilized a descriptive, a theoretical approach

DSM-III-R

Published in 1987, as a result of on-going research and resulting progress in the understanding of the diagnostic categories.

Represented a number of changes, including a revision of the multiaxial system (especially Axis II, which was broadened to include mental retardation, and Axis V, which introduced a more comprehensive rating scale).

DSM-IV-TR

- Published by the American Psychiatric Association
- Primarily used in the United States
- Includes information only on mental illnesses
- Classifies mental illnesses into different types of disorders (Mood disorders, psychotic disorders, eating disorders, etc.)

Multiaxial Classification

- Axis I – Clinical Disorders

  Other Conditions That May Be a Focus of Clinical Attention
- Axis II – Personality Disorders

  Mental Retardation
- Axis III – General Medical Conditions
- Axis IV – Psychosocial and Environmental Problems
- Axis V – Global Assessment of Functioning

DSM 5

- The DSM 5 May 2013.
- Research started in 1999.
- The DSM makes the American Psychiatric Association over $5 million a year, historically adding up to over $100 million.

Goals for Improving the DSM

- Changes should be based on empirical research rather than clinical consensus.
  - Behavioral science
  - Neuroscience
  - Molecular genetics
- Move toward a classification based on etiology.

DSM-5 Structure

- Section I: Basics
- Section II: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
- Appendix

Section I: Basics

- Introduction
- Use of the Manual
- Cautionary Statement for Forensic Use

Section I: Basics: Introduction

- DSM-5 has better reliability than DSM-IV.
- Research to validate diagnoses continues.
- The boundaries between many disorder categories are fluid over the life course.
- Symptoms assigned to one disorder may occur in many other disorders.
- DSM-5 accommodates dimensional approaches to mental disorders.

- DSM-5 provides explicit diagnostic criteria for each mental disorder, supplemented by dimensional measures when appropriate.
- Many mental disorders are on a spectrum with related disorders that have shared symptoms.
- The boundaries between disorders are porous.

- Disorder categories in earlier DSMs were overly narrow, resulting in the widespread use of Not Otherwise Specified (NOS) diagnoses.
- DSM-5 removes the NOS diagnosis. It adds

  Other Specified Disorder (criteria vary by disorder)

  Unspecified Disorder (for use when there is insufficient information to be more specific)

- For example, suppose a client has significant depressive symptoms but does not meet all the criteria for a major depressive episode.
- The diagnosis would be “Other specified depressive disorder, depressive episode with insufficient symptoms.”

Two Clusters of Disorders

- Internalizing group

  Disorders with prominent anxiety, depressive, and somatic symptoms

- Externalizing group

  Disorders with prominent impulsive, disruptive conduct, and substance use symptoms

Disorders within these clusters are adjacent in the DSM-5.

Organization of Disorders

- Disorders are organized on developmental and lifespan considerations.
- DSM-5 begins with diagnoses that manifest early in life, then adolescence and young adulthood, then adulthood and later life.

Cultural Issues

- Culture shapes the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis.
- Section III contains a Cultural Formulation.
- The Appendix contains a Glossary of Cultural Concepts of Distress.
- More information on culture and diagnosis is online at www.psychiatry.org/dsm5

Cultural Issues, cont.

- DSM-5 replaces the construct of the culture-bound syndrome in DSM-IV with 3 concepts:
  - Cultural syndrome: a cluster of invariant symptoms in a specific cultural group
  - Cultural idiom of distress: a way of talking about suffering among people in a cultural group
  - Cultural explanation or perceived cause for symptoms, illness, or distress

DSM-5 is Non-Axial

- DSM-IV axes I, II, and III have been combined.
- Continue to list relevant medical conditions.
- The GAF in DSM-IV has been eliminated. Instead, use the World Health Organization Disability Assessment Schedule (WHODAS).
- The WHODAS-2.0 is on page 747 of the DSM-5 and is also available online.

Section I: Basics: Use of the Manual

- Clinical Case Formulation
  - Making diagnoses requires clinical judgment, not just checking off the symptoms in the criteria.
  - The client's cultural and social context must be considered.
  - The DSM-5 does not include all possible mental disorders.

Definition of a Mental Disorder

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

There is usually significant distress or disability in social or occupational activities.

- The diagnosis of a mental disorder should have clinical utility; it should help clinicians to determine prognosis and treatment plans.

- The diagnosis of a mental disorder is not equivalent to a need for treatment.

- Until etiological or pathophysiological mechanisms are identified to validate specific disorders, the most important standard for the disorder criteria will be their clinical utility.

- The etiology of most mental disorders is unknown.
- The pathological physiological mechanisms for most mental disorders are unknown.
- Until such factors are identified, it will be difficult to fully validate specific disorders.

- In the absence of clear biological markers for mental disorders, it has not been possible to completely separate normal and pathological symptom expressions contained in diagnostic criteria.
- Therefore, a generic diagnostic criterion is “the disturbance causes clinically significant distress or impairment . . . .”

- Diagnoses are made on the basis of
  - The clinical interview
  - DSM-5 text descriptions
  - DSM-5 criteria
  - Clinician judgment

Steps in Making a Diagnosis

- Administer cross-cutting assessments
- Administer WHODAS 2.0
- Conduct clinical interview
- Determine whether a diagnostic threshold is met
- Consider subtypes and/or specifiers
- Consider contextual information, disorder text, distress, clinician judgment
- Apply codes and develop a treatment plan

Section I: Basics: Cautionary Statement for Forensic Use of DSM-5

- The diagnosis of a mental disorder does not imply that the person meets legal criteria for the presence of a mental disorder or a specific legal standard for competence, criminal responsibility, disability, etc.
- Having a diagnosis does not imply that the person is (or was) unable to control his or her behavior at a particular time.

Highlights of Specific Disorder Revisions

Neurodevelopmental Disorders

- Autism Spectrum Disorder (ASD) replaces DSM-IV's Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder, etc.
- Rationale: Clinicians had applied the criteria for these disorders inconsistently and incorrectly. There was not enough data to justify continuing to separate these disorders.

- Specifiers can be used to describe variants of Autism Spectrum Disorder.
- For example, the former diagnosis of Asperger's Disorder can now be diagnosed as Autism Spectrum Disorder, without intellectual impairment and without structural language impairment.
- Or Asperger's could be diagnosed as Autism Spectrum Disorder, mild.

Intellectual Disability

- The term “Intellectual Disability” replaces “Mental Retardation.”
- DSM-5 places greater emphasis on adaptive functioning deficits rather than IQ scores alone.

- Attention-Deficit/Hyperactivity Disorder
  - Age of onset was raised from 7 years to 12 years.
  - The symptom threshold for adults was reduced to five symptoms.
- Specific Learning Disorder
  - Now presented as a single disorder, with specifiers for deficits in reading, writing, and mathematics.

Schizophrenia Spectrum and Other Psychotic Disorders

- Schizophrenia
  - Elimination of special treatment of bizarre delusions and special hallucinations in Criterion A.
  - At least one of two required symptoms to meet Criterion A must be delusions, hallucinations, or disorganized speech.
  - Specific subtypes were deleted due to poor reliability and validity.

- Schizoaffective Disorder
  - Now based on the lifetime (rather than the episodic) duration of the illness.
- Catatonia
  - Now exists as a specifier for many mental disorders.

Bipolar and Related Disorders

- Mania and Hypomania
  - Criterion A now includes increased energy/activity as a required symptom.
  - “Mixed episode” is replaced with a “with mixed features” specifier.
  - “With anxious distress” was added as a specifier for bipolar and depressive disorders.

Depressive Disorders

- The bereavement exclusion was eliminated from major depressive episode (MDE).
  - In some people, a major loss can lead to a MDE.
- Disruptive Mood Dysregulation Disorder (DMDD) was added.
  - For children with extreme behavioral dyscontrol but persistent rather than episodic irritability.
  - This should decrease the number of children diagnosed with bipolar disorder.

- Dysthymic Disorder was renamed Persistent Depressive Disorder.

Anxiety Disorders

- DSM-5 has four chapters to cover the anxiety disorders covered by two chapters in DSM-IV.
  - Anxiety Disorders
  - Obsessive-Compulsive & Related Disorders
  - Trauma- & Stressor-Related Disorders
  - Dissociative Disorders

Anxiety Disorders

- Anxiety Disorders
  - Panic attacks was added as a specifier for any mental disorder.
  - Panic attacks can occur in many mental disorders.

Obsessive-Compulsive & Related Disorders

- Hoarding Disorder was added.
- Excoriation (Skin-Picking) Disorder was added.

- Body Dysmorphic Disorder (BDD) was moved from the chapter on somatic disorders to the chapter on OCD & Related disorders.

A “delusional” specifier was added for both OCD and BDD.

Trauma- & Stressor-Related Disorders

- Posttraumatic Stress Disorder
  - The stressor criterion (A) is now more explicit.
  - Criterion A2 (subjective reaction) is eliminated.
  - The symptom clusters were enlarged from 3 to 4.
  - Separate criteria were added for children age 6 and younger.
  - Reactive attachment disorder was separated into RAD and disinhibited social engagement disorder.

Dissociative Disorders

- Text was added to support Criterion D (exclusion based on cultural or religious practices).
  - This is to emphasize that possession states do not necessarily indicate the presence of Dissociative Identity Disorder if the possession state is recognized in the client's culture or subculture.

Dissociative Disorders

- Dissociative fugue was removed as an independent disorder but was added as a specifier for any dissociative disorder.

Somatic Symptom and Related Disorders

- The emphasis is placed on disproportionate thoughts, feelings, and behaviors that accompany symptoms, rather than on whether the symptoms are medically unexplained.
- Somatic Symptom Disorder replaces somatoform disorder, hypochondriasis, and the pain disorders.

Feeding and Eating Disorders

- Binge Eating Disorder (BED) is new.

- The diagnosis of Anorexia Nervosa no longer requires amenorrhea as a diagnostic criterion.

Sleep-Wake Disorders

- Primary Insomnia renamed Insomnia Disorder.
- Subtypes expanded for Circadian Rhythm Sleep Disorders.

Gender Dysphoria

- Newly added as a separate diagnostic class (and chapter) in DSM-5.
- Replaces Gender Identity Disorder.
- Focuses on the dysphoria.
- Should be less stigmatizing than GID.

Disruptive, Impulse-Control, and Conduct Disorders

- Conduct Disorder

  Added a specifier “with limited prosocial emotions.”

- Intermittent Explosive Disorder

  Provides more specific criteria to define outbursts.

  Trichotillomania was moved from the Impulse-Control Disorder chapter in DSM-IV to the Obsessive-Compulsive and Related Disorders chapter in DSM-5.

Substance-Related and Addictive Disorders

- Substance Use Disorder (SUD)
  - Substance abuse and substance dependence are combined into a single disorder.
  - Severity can be rated as mild, moderate, or severe.
  - Craving was added as a new criterion for SUD.
  - Legal consequences was removed as a criterion.

- Substance Use Disorders, cont.
  - Cannabis withdrawal is a new disorder.
  - Caffeine withdrawal is a new disorder.

- Non-Substance-Related Disorders
  - Gambling Disorder
    - “Pathological Gambling” in DSM-IV was renamed “Gambling Disorder” and moved from the Impulse Control Disorders chapter to the chapter in DSM-5 called Substance-Related and Addictive Disorders.

    - Internet Gaming Disorder is included in Chapter 3 as a “condition for further study.”
    - No other behavioral addictions are mentioned.

Neurocognitive Disorders

- The word dementia was eliminated; the new term is Major Neurocognitive Disorder.
  - The word “Dementia” was linked to old age diseases and clinicians tended to be pessimistic about its prognosis.
- Mild Neurocognitive Disorder is new.
  - This condition exists and treatment can help.
  - Neurocognitive decline is not inevitable.

Adjustment Disorders

- The chapter “Adjustment Disorders” in DSM-IV was incorporated into the chapter on Trauma- and Stressor-Related Disorders in DSM-5.
- Criterion B-1 was rephrased as “marked distress that is out of proportion to the severity or intensity of the stressor.”
  - Symptoms are in response to an identifiable stressor.

Personality Disorders

- All 10 PDs in DSM-IV remain intact in DSM-5.
- Note that “Axis II” in DSM-IV no longer exists.
- Section III of the DSM-5 contains an alternate, trait-based approach to assessing personality. It helps with the diagnosis of people who meet the core criteria for a PD but do not meet the criteria for a specific type of PD.

Paraphilic Disorders

- Emphasizes paraphilic *disorders* rather than paraphilias.
- Paraphilias that do not involve non-consenting victims are not necessarily indicative of a mental disorder.
- To have a paraphilic disorder requires distress, impairment, or abuse of a non-consenting victim.

Other Conditions That May Be A Focus of Clinical Attention

- The list of “V-Code” and other conditions was expanded to 134 separate conditions.
- Examples
  - Relational Problems
  - Abuse and Neglect
  - Educational and Occupational Problems
  - Phase of Life Problem
  - Malingering

Section III: Emerging Measures and Models

- Optional Assessment Measures
  - Level 1 Cross-Cutting Symptom Measure
    - To measure depression, anger, mania, anxiety, etc.
    - To screen for important symptoms; self-administered by patient; brief (1-3 questions per symptom domain).
  - Level 2 Cross-Cutting Symptom Measure
    - To be done when a Level 1 item is endorsed at the level of “mild” or greater.

Emerging Measures, cont.

- Diagnosis-Specific Severity Measures
  - To document the severity of a specific disorder.
  - Some are clinician-rated, some are patient-rated.

Emerging Measures, cont.

- WHO Disability Assessment Schedule 2.0
  - Replaces the GAF Scale in DSM-IV
  - Is recommended but not required.
  - Has 36 self-administered questions.

- Cultural Formulation
  - Outline for Cultural Formulation
  - Cultural Formulation Interview

Conditions for Further Study

- Attenuated Psychosis Syndrome
- Persistent Complex Bereavement Disorder
- Caffeine Use Disorder
- Internet Gaming Disorder
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury

Suicidal Behavior Disorder

- A suicide attempt within the past 24 months.
- The act is not nonsuicidal self-injury.
- Suicidal ideation does not qualify.

Nonsuicidal Self-Injury

- In the last year the person has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body . . . with the expectation that the injury will lead to only minor or moderate physical harm (i.e. there is no suicidal intent).
- Five additional criteria.