Diagnosing Mental Disorders
• Discuss cultural and ethical considerations in diagnosis
Key understanding...

• There are a number of important **ethical** and **cultural issues** involved in diagnosis, and these greatly influence the diagnostic process.
Rosenhan (1973) ‘On being sane in insane places’.

• Rosenhan wanted to test the reliability of psychiatric diagnoses. He conducted a field experiment where eight healthy people—five men and three women, all researchers—tried to gain admission to 12 different psychiatric hospitals. They complained that they had been hearing voices. The voices were unclear, unfamiliar, of the same sex and said single words like “empty” or “thud”.

• These were the only symptoms they reported. Seven of them were diagnosed as suffering from schizophrenia. After the individuals had been admitted to psychiatric wards, they all said they felt fine, and that they were no longer experiencing the symptoms. It took an average of 19 days before they were discharged. For seven of them, the psychiatric classification of the time of discharge was “schizophrenia in remission’ implying that the schizophrenia might come back.

• Rosenhan was not content with the findings that normal people could be classified as abnormal, so he decided to investigate if abnormal individuals could be classified as normal. He told the staff at a psychiatric hospital that pseudo-patients would try to gain admittance. No pseudo-patients actually appeared, but 41 real patients were judged with great confidence to be pseudo-patients by at least one member of staff. Of these genuine patients, 19 were suspected of being frauds by one psychiatrist and another member of staff.

• Rosenhan concluded that it was not possible to distinguish between sane and insane in psychiatric hospitals. His study demonstrates the lack of scientific evidence on which medical diagnoses can be made. It also raises the issue of treatments—that is, if they are always properly justified.
More reliability issues....

• The Rosenhan study illustrates the concerns about reliability in diagnosis of psychiatric illness. The diagnostic classification systems have been accused of being unreliable.

• Using the same diagnostic manual, two psychiatrists could easily diagnose the same patient with two different disorders.

• Beck et al. (1962) found that agreement on diagnosis for 153 patients between two psychiatrists was only 54 per cent.

• Cooper et al. (1972) found that New York psychiatrists were twice as likely to diagnose schizophrenia than London psychiatrists, who in turn were twice as likely to diagnose mania or depression when shown the same videotaped clinical interviews of patients.
Di Nardo et al. (1993) studied the reliability of DSM-IV for anxiety disorders. Two clinicians separately diagnosed 267 individuals seeking treatment for anxiety disorders. They found high reliability for obsessive-compulsive disorder (OCD) (.80), but very low reliability for assessing generalized anxiety disorder (GAD) (.57), mainly due to problems with interpreting how excessive a person’s worries were.
More validity issues....

• Lipton and Simon (1985) randomly selected 131 patients in a hospital in New York and conducted various assessment procedures to arrive at a diagnosis for each person.

• This diagnosis was then compared with the original diagnosis. Of the original 89 diagnoses of schizophrenia, only 16 received the same diagnosis on re-evaluation; 50 were diagnosed with a mood disorder (e.g. depression), even though only 15 had been diagnosed with such a disorder initially.
More validity issues....

- Since diagnostic classification systems are not 100 per cent objective, the diagnosis may be influenced by the *attitudes* and *prejudices* of the psychiatrist.

- Certain groups of patients to be more prone to depression (e.g. elderly people living alone), and therefore more likely to interpret symptoms as related to depression even though the same symptoms would be interpreted as something else if they were presented by a different person.

- When this occurs consistently to a specific group it is called *overpathologization*.
Szasz also pointed at serious ethical issues in diagnosis.

In his book *Ideology and Insanity* (1974), Szasz argued that people use *labels* such as ‘mentally ill, criminal, or foreigner’ in order to socially exclude people.

People who are different are *stigmatized* (they may experience prejudice and discrimination).

The psychiatric diagnosis provides the patient with a new identity—for example, they become a “schizophrenic”.

**Ethical Issues: Labelling & Stigma**
Ethical Issues: Labelling & Stigma

• The criticism raised by Szasz, and the ethical implications in diagnosis, have eventually influenced the classification systems: in DSM-IV it is recommended to refer to an individual with schizophrenia.

• There remain, of course, considerable ethical concerns about labelling which result from identifying someone’s behaviour as abnormal, since a psychiatric diagnosis may be a label for life.

• Even if a patient no longer shows any symptoms, the label “disorder in remission” still remains. — suggesting that they still have the disorder but its simply not manifesting itself.
Ethics: The Self Fulfilling Prophecy following diagnosis...

• Scheff (1966) argued that one of the adverse effects of labels is the *self-fulfilling prophecy*—people may begin to act as they think they are expected to.

• They may internalize the role of “mentally ill patient” and this could lead to an *increase* in symptoms.

• Doherty (1975) points out that those who reject the mental illness label tend to improve more quickly than those who accept it.
• In addition, those who are labeled as ‘mentally ill’ often endure prejudice and discrimination.

• In a study carried out by Langer and Abelson (1974), investigating people social perceptions, they were all shown the same videotape of a younger man telling an older man about his job experience.

• If the viewers were told beforehand that the man was a job applicant, he was judged to be attractive and conventional-looking, whereas if they were told that he was a mental hospital patient he was described as tight, defensive, dependent, and frightened of his own aggressive impulses.

• This clearly demonstrates the power of schema processing – peoples prior knowledge/prejudice influences how they interpret the new information.
Ethics: Confirmation bias

• Clinicians tend to have expectations about the person who consults them, assuming that if the patient is there in the first place, there must be some *disorder to diagnose*.

• Since their *job* is to diagnose abnormality, they may overreact and see abnormality wherever they look. This was clearly demonstrated by Rosenhan’s (1973) study.

• Clinicians often 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 no positive correlation between the number of assessment techniques used and the accuracy of an eventual diagnosis.
Ethics: Confirmation bias

• Another ethical issue in diagnosis also refers to confirmation bias.

• Once the pseudo-patients in Rosenhan’s (1973) study were admitted to mental wards, it was very difficult for them to get out; one participant took 52 days to convince medical staff that he was well and the whole thing was an experiment.

• The problem is that once admitted, all behaviour is perceived as being a symptom of the illness.
Ethics: Confirmation bias

The behaviours exhibited by Rosenhan’s participants were all regarded as being symptomatic of schizophrenia—for example, pseudo-patients were never asked why they were taking notes, but this was recorded by nurses as “patient engages in writing behaviour”, implying paranoid behaviour.

Pacing the corridors out of boredom was seen as nervousness and agitated behaviour; waiting outside the cafeteria before lunchtime was interpreted by a psychiatrist as showing the “oral acquisitive nature of the syndrome”.

Other aspects of institutionalization also contribute to the difficulty in assessing patients accurately.
This is produced in institutions through a lack of rights, constructive activity, choice, and privacy, as well as frequent verbal and even physical abuse from attendants. All these examples of powerlessness and depersonalization are illustrated brilliantly in the film *One Flew Over the Cuckoo’s Nest.*
AIMS & PROCEDURES: The study of the “Effect of client race and depression on evaluations by European American therapists” by Jenkins-Hall and Sacco (1991) involved European American therapists being asked to watch a video of a clinical interview and to evaluate the female patient.

There were four conditions representing the possible combinations of race and depression:
1. African American and non-depressed;
2. European American and non-depressed;
3. African American and depressed;
4. European American and depressed.

FINDINGS: Although the therapists rated the non-depressed African American and European American in much the same way, their ratings of the depressed women differed, in that they rated the African American woman with more negative terms and saw her as less socially competent than the European American woman.
Cultural Issues: Cultural Relativism

• It is difficult to define and diagnose mental disorders, because each culture has a different set of norms and expectations.

• Doctors diagnosing mental disorders need to be aware of this, and the DSM-IV takes this into account ‘a clinician who may be unfamiliar with the nuances of an individual's culture, may diagnose a mental disorder, when their behaviour is in fact normal in their culture’.
Cultural Issues: Culture Bound Syndromes

- Conceptions of abnormality differ between cultures, and this can have a significant influence on the validity of diagnosis of mental disorders. Though many disorders appear to be universal—that is, present in all cultures—some abnormalities, or disorders, are thought to be culturally specific.

- These disorders are called culture-bound syndromes.

- For example, the disorder *shenjing shuairuo* (neurasthenia) accounts for more than half of psychiatric outpatients in China. It is listed in the second edition of the *Chinese Classification of Mental Disorders* (CCMD-2), but it is not included in the DSM-IV used in the western world.

- Many of the symptoms of neurasthenia listed in CCMD-2 are similar to the symptoms that would meet the criteria for a combination of a mood disorder and an anxiety disorder under DSM-IV.
## Cultural Issues: Culture Bound Syndromes

**Table 4.1 >> Culture-bound syndromes**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Country/Culture</th>
<th>Characteristics</th>
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<tbody>
<tr>
<td>Latah</td>
<td>Malaysia, Indonesia, Bantu in Africa</td>
<td>Exaggerated response to a minor stimulus; tendency to mimic people nearby in speech and gesture; only occurs in females.</td>
</tr>
<tr>
<td>Behainin</td>
<td>Bali</td>
<td>Abdominal pain, headache, ringing in the ears, impaired vision, screaming, weeping and convulsions; exhaustion follows episode and individual (usually female) has no memory of what happened.</td>
</tr>
<tr>
<td>Taijin-kyofusho</td>
<td>Japan and some other Asian countries</td>
<td>Occurs mainly in males; anxiety, fear of rejection, fear of eye contact, blushing, worry about body odour.</td>
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<tr>
<td>Bulimia nervosa</td>
<td>North America and Western Europe</td>
<td>Food binging, self-induced vomiting; may occur alongside depression and substance abuse.</td>
</tr>
<tr>
<td>Tabanka</td>
<td>Trinidad</td>
<td>Depression in men abandoned by their wives; high rate of suicide.</td>
</tr>
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Source: Based on Geiselman (1988)
Cultural Issues: Culture Bound Syndromes

- The American Psychiatric Association (APA) has now formally recognized culture-bound syndromes by including a separate listing in the appendix of DSM-IV (1994).

- However, as Fernando (1988) points out, many of these “exotic” conditions actually occur quite frequently, but as long as they are limited to other cultures they will not be admitted into mainstream western classification, and the potential remains for misdiagnosis and improper treatment.

- Depression, which is common in western culture, appears to be absent in Asian cultures. In trying to understand the reason for this, it has been observed that Asian people tend to live within an extended family, which means that they have ready access to social support.
Groups of people within a wider culture can have their own set of norms and beliefs.

E.g. African Caribbean, Asian communities in the UK.

This may lead to misunderstanding, Cochrane (1977) pointed out that there were more diagnosis of schizophrenia amongst the African Caribbean community, and this may be that their variations in communication style deviate from white social norms, leading to misdiagnosis.
Attitudes, values and beliefs change over time, e.g. in the early 20th century unmarried women who became pregnant were sometimes taken to mental institutions.

They are cases of these women remaining in these institutions for the rest of their lives.

Attitudes towards homosexuality have changed, until 1973 the American Psychiatric Association classified homosexuality as a mental disorder.
However, as Rack (1982) points out, Asian doctors report that depression is equally common among Asians, but that Asians only consult their doctor for physical problems, and rarely report emotional distress.

They do not see this as the responsibility of the doctor, and instead tend to sort it out within the family. They might seek help for the physical symptoms of depression, such as tiredness, sleep disturbance, and appetite disturbance, but would probably not mention their mood state.

Tahassum et al (2000) conducted an interview study of the emics (culturally specific) and etics (culturally universal) aspects of depression in the UK Pakistani community (Studied in the Sociocultural LOA) clearly demonstrate this.
Cultural Issues: Reporting Bias

- Since there is a reporting bias (not all cultures report mental health issues) it makes the cross-cultural comparison of research difficult.

- One of the major difficulties with studies using diagnostic data is that figures are based on hospital admissions, which may not reflect the true prevalence rates for particular ethnic groups or particular disorders.

- Low admission rates found in many minority ethnic groups may reflect cultural beliefs about mental health.
Cultural Issues: Social Stigma

- Cohen (1988) explains that in some parts of India, mentally ill people are seen as cursed and looked down on.

- Rack (1982) points out that in China mental illness also carries a great stigma, and therefore the Chinese are careful to label only those whose behavior is indisputably psychotic—that is, where thinking and emotion are so impaired that the individual is out of contact with reality.

- In addition to cultural attitudes, low admission rates can also reflect a minority group’s lack of access to mental health care.
Some psychologists, however, argue that it is not just a misinterpretation of diagnostic data, but that real differences exist between cultures in the symptomology of disorders.

For example, Marsella (2003) argues that depression takes a primarily **affective** (emotional) form in individualistic cultures. In these cultures, feelings of loneliness and isolation dominate.

In more collectivist societies, somatic (physiological) symptoms such as headaches are dominant. Depressive symptom patterns differ across cultures because of cultural variations in sources of stress, as well as resources for coping with stress.
Kleinman (1984) has studied the somatization of symptoms in Chinese depressive patients—that is, the bodily symptoms of psychological dysfunction.

He argues that it is impossible to compare depression cross-culturally because it may be experienced with substantially different symptoms or behaviours—for example, either as lower back pain (in China) or as feelings of guilt and anxiety (in western cultures).

This makes it difficult for clinicians accurately to diagnose and suggest treatments. According to Kleinman, it is perhaps difficult to classify such different behaviours and symptoms as belonging to the same psychological disorder.
Cultural Issues: Cultural Blindness

- Cochrane and Sashidharan (1995) point out that it is commonly assumed that the behaviors of the white population are normative, and that any deviation from this by another ethnic group reveals some racial or cultural pathology.

- Conversely, as Rack (1982) points out, if a member of a minority ethnic group exhibits a set of symptoms that is similar to that of a white British-born patient, then they are assumed to be suffering from the same disorder, which may not actually be the case.
• For example, within the culture of one ethnic group it might be regarded as normal to “see or hear” a deceased relative during the bereavement period.

• Under DSM-IV criteria, this behaviour might be misdiagnosed as a symptom of a psychotic disorder.
How can psychologists/psychiatrists avoid cultural bias influencing a diagnosis?

- Clinicians should make efforts to learn about the culture of the person being assessed. This knowledge can come from professional development, consultation with colleagues, or direct discussion with the individual (Sattler 1982).

- Evaluation of bilingual patients should really be undertaken in both languages, preferably by a bilingual clinician or with the help of a trained mental health interpreter.

- Research suggests that patients may use their second language as a form of resistance, to avoid intense emotional responses.
How can psychologists/psychiatrists avoid cultural bias influencing a diagnosis?

• Diagnostic procedures should be modified to ensure that the person understands the requirements of the task. Symptoms of disorders should be discussed with local practitioners.

• Often, symptoms are described differently in different cultures. In the psychiatric survey of the Yoruba in Nigeria, it was decided to include culture-specific complaints such as feeling an “expanded head” or “goose flesh”.

• When assessing post-traumatic stress disorder (PTSD) among Rwandans after the genocide, researchers worked with local healers to determine what was a normal Rwandan grief process, and which responses the community considered to be abnormal.
Possible exam question

Discuss the validity and reliability of diagnosis.

Assessment advice
The command term “discuss” requires that you present a balanced review of the issues involved in making reliable and valid diagnosis and you must include a range of arguments. This means considering the extent to which diagnosis is or is not reliable and valid and why this could be so. Start by deciding what your main claim could be and then construct an argument supporting this. For this you need to include appropriate evidence.
• Find two different psychological disorders on
www.mentalhealth.com/p20.html and read the
descriptions of them and suggestions for treatment.

1 Why do you think that there are both a US and a European
description of the disorders? Compare and contrast the
descriptions.

2 Now search the Internet for the same disorders in another
culture, for example Chinese, and compare the descriptions
to the other ones. Discuss your findings.

3 Compare and contrast treatments for the disorders you
have chosen.
Apply your knowledge

Read the following description of Anne and answer the questions below.

Anne is a 16-year-old girl living in the Midwest United States. She is currently in the IB programme at her local school. Her appearance is strikingly different from the other girls in her class. She wears blouses which she has made out of various scraps of material, and these are accompanied by the same pair of trousers every day. She is a talented artist, and she draws constantly, even when told by the teacher that she will lose marks for not paying attention in class. She has no friends at school, but seems undisturbed by the fact that she eats lunch by herself and walks alone around the campus. Her grades are inconsistent; if she likes a class she gets top marks, but will do no work at all in those she dislikes. Anne often talks to herself. She refuses to watch television, calling it a “wasteland”. She even refuses to watch videos/DVDs in class, saying that they are poor excuses for teaching. Her parents say that they do not understand her; she isn’t like anyone in their family. Anne seems unaware of her social isolation, but occasionally can be very critical of her classmates. Her brother is embarrassed by her behaviour and distances himself from her at school.

1. Do you think this person’s behaviour is normal?
2. Do you think it is dysfunctional?
3. Why or why not?
1) “There are controversies surrounding the concept of abnormality.” With reference to this statement, discuss the concepts of normality and abnormality.

2) Making reference to relevant research, examine the reliability and validity of diagnosis.

3) Discuss cultural and ethical considerations in diagnosis.