DP IB Psychology: SL

Factors Influencing Diagnosis

Contents

Defining 'Normal' vs 'Abnormal' Behaviour

What is 'Normal' Behaviour?

Is it possible to define ‘normal’ behaviour?

- ‘Normal’ behaviour could be defined as any behaviour which falls within **accepted social norms** e.g. washing regularly; walking on the pavement; speaking in grammatical, coherent sentences
- ‘Normal’ behaviour could be said to obey behavioural **conventions** as laid down by specific societies and **cultures**
- ‘Normal’ behaviour in one society or culture may not be considered normal by another society or culture e.g. marrying someone of the same sex is considered normal in some cultures and countries but not in others; belief in **demonic possession** may be considered normal in some countries or cultures but not in others
- When ‘normal’ behaviour is adhered to it tends to go unnoticed and not draw attention to itself
- Normality is **subjective** and may operate at an **idiosyncratic** level e.g. one person may eat boiled cabbage for breakfast and cornflakes for dinner every day which may be viewed as abnormal by others but for the individual concerned this diet represents their own version of ‘normal’

What is 'Abnormal' Behaviour?

Is it possible to define 'abnormal' behaviour?

- 'Abnormal' behaviour could be defined as any behaviour which falls outside of accepted social norms e.g. not washing regularly; walking down the middle of the road rather than on the pavement; speaking in ungrammatical, incoherent sentences
- 'Abnormal' behaviour could be said to flout, disregard or disobey behavioural **conventions** as laid down by specific societies and **cultures**
- 'Abnormal' behaviour may be viewed with alarm, distress or fear by those observing it
- 'Abnormal' behaviour tends to be noticeable; it draws attention to itself and will probably stand out distinctly from agreed social and cultural norms
- 'Abnormal' behaviour may result in unpleasant, negative consequences for the individual displaying it e.g. avoidance or abuse from others; being **sectioned** against their will; finding themselves in situations which are a danger to their physical and emotional health

Changing Definitions of Abnormality

How have attitudes towards 'normal' and 'abnormal' behaviour changed over time?

- Some behaviours which today (in most Westernised or industrialised societies) are viewed as normal were once labelled 'abnormal' e.g. **homosexuality**
- **Perceptions** of normality have changed over the centuries as societies have become increasingly sophisticated and tolerant of a range of behaviours and lifestyle choices which in previous decades or centuries may have resulted in social condemnation or even **criminal charges**
- Behaviours which have previously been viewed (both officially and unofficially) as 'abnormal' include epilepsy; homosexuality; living in poverty; being pregnant and unmarried
- Some cultures may still view specific behaviours such as homsexuality as 'abnormal' thus normality and abnormality cannot be said to be **universal** variables

Which studies investigate normality vs abnormality?

- **Jahoda (1958)**: set out criteria for identifying mentally healthy people
- **Mojtabai (2011)**: bereavement-related depression should not be considered 'abnormal' as it is part of the grieving process i.e. a normal response to bereavement

Both Jahoda (1958) and Mojtabai (2011) are available as Two Key Studies of Normality vs Abnormality – just navigate the Factors Influencing Diagnosis section of this topic to find them.

Worked Example

The question is, '*Evaluate one or more studies which focus on concepts of normality and abnormality*'. *[22]*

The question is asking you to weigh up the strengths and weaknesses of research used to investigate concepts of normality/abnormality. Here are two exemplar paragraphs for guidance:

Motjabai (2011) used a retrospective (i.e. looking back across time) longitudinal design for his research into grieving and depression. The researcher wished to test the hypothesis that individuals with bereavement-related depressive episodes do not have a higher risk of subsequent depressive episodes compared with individuals without a lifetime history of depression. The use of a longitudinal design was suitable for this topic as bereavement-related depression is a variable that cannot be studied via a typical snapshot design experiment. Rather it must take the form of research conducted over time in order for real changes to occur mapped to real-world experiences.

One limitation of using self-reporting methods however, is that they tend to result in the collection of quantitative data which means that the results lack explanatory power. In this study, interviews were conducted but the qualitative data was translated into quantitative data which inevitably loses much of the human element (e.g. thoughts, feelings, emotion) in the process. The study can therefore highlight what takes place after bereavement and who is more prone to depression but not why.

Factors Which influence the Diagnosis of Abnormal Behaviour

Diagnosing Abnormality

- There are key **criteria** available to **clinicians** which they use in order to **classify** or **diagnose** specific behaviours as 'abnormal'
- Most of the measures used to determine abnormality follow the **biomedical model** of disease which will (generally but not always) tend to result in some form of **drug therapy** being used to treat the illness e.g. **antidepressants** in the treatment of **depressive disorders**
- Clinicians tend to use four different (though overlapping) **measures** for determining whether an individual is exhibiting abnormal behaviour:

Table 1: Definitions of Abnormality

Measure	Explanation
Statistical deviation	Behaviour which falls outside of agreed **statistical parameters** e.g. an **IQ** of less than 70 is considered abnormal
Failure to function adequately	Behaviour which does not **conform** to accepted social standards e.g. not washing, not eating
Deviation from social norms	Behaviour which is shocking, surprising or which **challenges** social norms e.g. someone wearing a plant pot on their head
Deviation from ideal mental health	Behaviour which is not completely 'perfect' for that individual e.g. an inability to handle **stress**

Evaluation of the measures of abnormality

Statistical deviation:

Strengths

- The measures provide clear points of comparison between people, making it easy to test and to use as an **analytical tool** e.g. if person X scores 70 on an IQ test this falls a long way below the **mean average** for the population
- Applying statistical deviation as a measure includes the use of a **standardised tool** which means that the measure has built-in **reliability**

Weaknesses

- Statistical deviation would not recognise **depression** as abnormal behaviour because depression is estimated to affect around 280,000,000 people across the world at any given time i.e. it is not statistically deviant
- Some behaviours which are statistically deviant e.g. having an IQ of 175, are not necessarily undesirable or adverse yet they fall within the same frame of reference as do low IQ scores which limits the **usefulness** of this measure

Failure to function adequately (FTFA)

Strengths

- This measure provides clear guidelines for the classification and diagnosis of abnormality as it is focused on **observable** signs that an individual is not coping e.g. lack of hygiene, clear **behavioural distress signals**
- Checklists such as those provided by Rosenhan & Seligman (1989) can be used to assess the degree of FTFA which increases the reliability of the measure

Weaknesses

- FTFA is an overly **subjective measure** as one person's lack of hygiene may be another person's eco-friendly refusal to use deodorant which means that the FTFA measure may lack **validity**
- Some behaviours may appear to have the characteristics of FTFA but in fact are simply expressions of personal choice e.g. swimming with sharks may put a person's life in some danger but it would be difficult to argue that their behaviour is abnormal based on this criterion alone

Deviation from social norms (DSN)

Strengths

- An understanding of and **adherence** to what is agreed behaviour per society/culture could be said to be a **guiding principle** for harmonious living so this measure may help to identify behaviour which is damaging to other people and to society in general
- Someone who deviates from social norms may actually be giving a 'cry for help' with their behaviour e.g. by continually getting into fights with strangers, so this measure could be a good way of noticing that someone is in need of some sort of intervention

Weaknesses

- This measure may give rise to **culture bias** as some behaviours which are acceptable in one culture may be viewed adversely by another culture
- This measure may be mis-used by those in power to control or quash minority groups who are do not fall in line with current policy or prevailing **social mores** e.g. the Suffragette and Civil Rights movements were initially ridiculed and vilified by the press and some public figures

Deviation from ideal mental health (DIMH)

Strengths

- This is an **holistic** measure as it takes into account all facets and behaviours of a person
- This measure has good **application** as it can be used as the basis for **therapy** and treatments with its emphasis on the whole person and on positive mental health and **wellbeing**

Weaknesses

- This measure is almost impossible to live up to as it requires each individual to reach the highest levels of positive mental wellbeing (e.g. constantly **self-actualising**; being completely free of stress; being successful in love, work and leisure time) which may actually lead to people feeling demotivated and low in **self-esteem**
- This measure is also prone to **culture-bound syndrome** as it emphasises the importance of the individual which is not aligned with the attitudes and beliefs of **collectivist cultures**

Two Key Studies of Normality vs Abnormality

Key Study One: Jahoda (1958)

Aim: To determine a specific set of **criteria** which identify **ideal mental health** in humans.

Participants: 740 adults who represented workers from a range of occupations, both skilled and unskilled.

Procedure: The participants responded to a **survey** consisting of 40 items which were designed ultimately to determine what a **model** of ideal mental health should include.

Results: Jahoda identified six **characteristics** which she suggested demonstrate ideal mental health in a person:

- **1. A positive attitude towards the self,** which involves an individual having self-confidence, self-reliance, and initiative, whilst having a realistic understanding of their own strengths and weaknesses
- **2. Growth, development, and self-actualisation,** which could involve an individual progressing in their academic life/career; having the capacity to develop a mature and balanced outlook on life
- **3. Integration,** which involves an individual developing a holistic outlook on life; feeling secure within themselves and being able to withstand mental stress
- **4. Autonomy**, which involves an individual exercising independence, decision-making and **self-determination**
- **5. Accurate perception of reality,** which involves an individual using **objective**, **unbiased** evidence in their **appraisal** of other people and the world in general (the ability to be **empathic** is also key to this characteristic
- **6. Environmental mastery**, which involves an individual feeling confident and capable when operating within their social roles e.g. as a colleague, as a parent, as a team-member

Conclusion: Ideal mental health can be determined via an individual satisfying the six criteria outlined in the model.

Evaluation of Jahoda (1958)

Strengths

- The model provides a clear **baseline** for determining the characteristics of ideal mental health and, as Jahoda points out, good mental health cannot simply be defined as a *lack* of poor mental health, thus the model has some **validity**
- The model has good **application** for **therapeutic settings** as it could be used to form a template or checklist to track and identify a client/patient's progress through their mental health journey

Weaknesses

- It could be argued that to achieve all six of these criteria at the same time is impossible for most people thus the model lacks some **reliability** as it is unlikely to show **consistency** over time
- Jahoda's model is unlikely to be **culturally relevant** for all people as it assumes an **individualistic** approach (e.g. self-actualisation) which means that it lacks **external validity**

Key Study Two: Mojtabai (2011)

Aim: To investigate the idea that individuals with **bereavement-related depressive episodes** do not have a higher risk of depression overall compared with individuals who have not had depression in their lifetime i.e. simply suffering a bereavement will not lead to future depression in an individual.

Participants: A **community-based sample** of participants (who were taking part in the *National Epidemiologic Survey on Alcohol and Related Conditions*) from the USA who were tested in two phases (43,093 in phase 1; 34,653 in phase 2).

Procedure:

- The participants were part of a **retrospective longitudinal** study into **grieving** and depression conducted from 2001– 2002 and from 2004–2005
- The researchers used **structured interviews**, using the *Alcohol Use Disorder and Associated Disabilities Interview Schedule – **DSM-IV** version* to guide the type of questions asked
- The interview schedule described above was designed as a **diagnostic tool** used to diagnose **mood, anxiety, substance abuse,** and other related disorders
- The researchers measured the participants' **demographic** characteristics, including their age at the onset of their depression; any history of depression in their family; if they had used mental health services, and any new depressive episodes they experienced during the 3–year follow up period
- Major depressive episodes were defined as having a duration of at least 2 weeks, during which the participant would have experienced 5 or more of the nine *DSM-IV* symptoms, particularly **impairmen**t and/or **distress**
- The **qualitative data** collected via interview was translated into **quantitative data** via a specific **scoring system**

Results:

- Participants with bereavement-related, single, brief depressive episodes tended to be older at onset, were more likely to be African-American, and were less likely to have had impairment, anxiety disorders or a previous psychiatric treatment history
- These participants were also less likely than other participants with bereavement-unrelated single, brief depressive episodes to experience **fatigue**, increased sleep, feelings of worthlessness, and suicidal thoughts
- These participants also had a much lower risk of developing depression during the follow-up period

Conclusion: Depressive symptoms associated with bereavement can be explained by the bereavement itself, they are not signs that a person is prone to depression generally so **DSM-5** should exclude bereavement-related depression from the list of depressive episodes requiring treatment.

Evaluation of Motjabai (2011)

Strengths

- The two large sample sizes used in both phase 1 and phase 2 (more than 10,500 participants in the combined total) gives this study good **reliability** due to the **robustness** of the quantitative data collected
- The recommendation by Motjabai to challenge the idea that bereavement-related depression is a mental illness is one which could be helpful to those affected by grief and in turn this could lead to more acceptance that grief and its attendant low mood is a natural part of the grieving process

Limitations

- It is possible that some of the participants may have succumbed to **social desirability bias** when describing their depressive episodes (e.g. by over-playing or under-playing their symptoms depending on what may have seemed more socially acceptable to them) which would impair the validity of the findings
- The findings could - ironically - lead to some bereaved individuals feeling that it is 'wrong' to experience bereavement-related depressive episodes in the future and this may result in them under-reporting or hiding their symptoms

Worked Example

ERQ (EXTENDED RESPONSE QUESTION) 22 MARKS

The question is, '*Evaluate **one or more** studies which focus on the concepts of normality and abnormality'. [22]*

This question is asking you to weigh up the strengths and weaknesses of one or more studies which investigate concepts of normality/abnormality. Here are two paragraphs which deal with the same evaluation issue, first as a strength and then as a weakness of the model:

Jahoda's (1958) model of ideal mental health could be said to be groundbreaking to some extent in that it posits a framework whereby mental health - rather than illness - can be measured. The tendency up until Jahoda's model was to think about mental health only in terms of negative perspectives e.g. checklists and questionnaires which are designed to identify disorders such as

depression or anxiety. This focus on the positive side of mental health is a strength of the model as it provides clear milestones which could be used for therapeutic purposes e.g. a patient may be able to claim that they have satisfied the criteria for at least one of the six criteria which could in turn motivate them to working towards full mental wellness.

A weakness of the model is its emphasis on 'ideal mental health', the seemingly impossible attainment of all six criteria all at the same time which may de-motivate someone who is striving to achieve good mental health. If someone has achieved 'only' three of the criteria they may feel that they are worthless, hopeless, a failure when in fact it would be very difficult for even the most balanced, upbeat and positive person to be able to lay claim to all six criteria consistently. In this way the model is flawed as it does not acknowledge that full and 'perfect' mental health is not really achievable or maybe even desirable: a certain degree of stress or uncertainty in a person's life may actually be good for them and may push them to develop and grow as a human being in many ways.

Diagnostic & Statistical Manual of Mental Disorders (DSM-5)

What is the DSM-5?

- The **DSM-5** stands for the **Diagnostic and Statistical Manual** which is now in its fifth edition (hence the -5 in the title), having last been published in 2013 and updated in 2022
- The DSM-5 is a **diagnostic tool** used by any medical professional who is qualified to give a **diagnosis** pertaining to a **mental disorder** e.g. doctors, clinicians, **psychiatrists**
- The DSM-5 is published by the **American Psychiatric Association (APA)** who, at given intervals, **review and revise** the current edition and make recommendations as to what should be removed from or added to the next edition
- Some behaviours or conditions which appeared in previous editions of the DSM have since been removed from more recent editions e.g. **homosexuality** (removed in 1973); **gender identity disorder** (removed in 2012)
- Some behaviours or conditions which did not appear in previous editions of the DSM have since been added to the DSM-5 e.g. **hoarding disorder** and **binge eating disorder** (both were added in 2013)

How is the DSM-5 different to previous versions of the DSM?

- Previous versions of the DSM (which you may be familiar with via your study of Psychology) used five **axes** to **categorise** the different **dimensions** of mental disorder **classifications** e.g. Axis I grouped **clinical disorders** such as **anxiety, schizophrenia** and **depression** together
- The DSM-5 has removed the five axes in a bid to simplify and streamline the manual and the means by which a mental disorder can be diagnosed
- Medical experts had complained that there was very little difference between some of the axes which, they argued, could lead to confusion, **unreliable** diagnoses and, potentially, the patient receiving the wrong **treatmen**t for their condition
- The DSM-5 uses a **single axis system** i.e. it has combined axes 1–3 into a single axis that accounts for mental and other **medical** diagnoses specifically related to **brain dysfunction** or illness
- The DSM-5 removed the distinct categories it had previously used for mental health diagnoses, medical diagnoses, and personality disorders
- The DSM-5 is organised into three sections:
    - Section I: DSM-5 Basics: a guide for medical professionals on how the manual should be used
    - Section II: Diagnostic Criteria & Codes: the largest section in the manual which comprises **types, definitions and explanations** of conditions/disorders

Section III: Emerging Measures & Models: information and guidance as to how to apply specific diagnostic tools, the ways in which **culture** may affect diagnosis and an insight into which conditions/disorders may be included in future editions

Evaluation of the DSM-5

Strengths

- The most recent revisions to the DSM-5 reflect **social change** and **socially sensitive** issues e.g. the removal of gender identity disorder means that individuals who do not **conform** to traditional gender roles/identity are not classified as **abnormal**/mentally ill
- The DSM-5 acknowledges that **cultural differences** must be considered when making a diagnosis which should ensure that **ethnocentricity** and **universality** do not interfere with diagnosis

Limitations

- As is the case with all diagnostic manuals there is the risk that being given a diagnosis of mental illness can lead to **stigmatisation** and 'labelling' of the individual as 'abnormal'
- The DSM-5 uses broad categories to determine the type of disorder and how it should be treated which tends to lose the individual and the complex nature of their condition in the process which means that it may lack validity

International Classification of Diseases (ICD11)

What is the ICD-11?

- The ICD-11 stands for the International Classification of Diseases which is now in its eleventh edition (hence the -11 in the title), having last been published in 2022
- The ICD-11 is a diagnostic tool used by any medical professional who is qualified to give a diagnosis pertaining to both physical and mental disorders e.g. doctors, clinicians, psychiatrists
- The DSM-5 is published by the **World Health Organisation (WHO)** who, at given intervals, **review and revise** the current edition and make recommendations as to what should be removed from or added to the next edition
- The ICD-11 does not just focus on mental disorders: its scope includes **physical illnesses** and conditions such as **Covid-19**
- The ICD-11 works on a **global scale** (the DSM-5 is only focused on North America), looking at the causes of, the extent of and the consequences of disease and **morbidity** rates across the world
- The ICD-11 uses the data it has gathered to inform worldwide **health initiatives** and research into disease (both physical and mental)

How is the ICD-11 different to previous versions of the ICD?

- Changes to ways in which diseases, disorders and causes of death are **coded** mean that the ICD-11 provides a more **refined and detailed** tool for the classification of both physical and mental illnesses than in previous versions
- This refinement to the coding system means that illnesses can be classified and recorded more specifically and precisely
- The ICD-11 has been translated into 43 languages and makes more allowance for **cultural variations** than did previous versions
- The ICD-11 takes into account the growing importance of **digital technology** and so it has been designed with user-friendly software and a platform which can be accessed globally
- Some behaviours or conditions which appeared in previous editions of the ICD have since been removed from the ICD-11 e.g. **acute stress disorder**; **personality disorders** (these have been combined into just 'personality disorder' singular)
- Some behaviours or conditions which did not appear in previous editions of the ICD have since been added to the ICD-11 e.g. **gaming disorder** and **prolonged grief disorder**

Evaluation of the ICD-11

Strengths

- The global scale of the ICD-11 means that it has wider **generalisability** and application than the DSM-5
- The inclusion of physical illnesses along with mental illnesses means that the link between both mind and body is acknowledged hence it takes a more **holistic** approach than the DSM-5

Limitations

- The inclusion of physical illnesses along with mental illnesses could, conversely, mean that the manual is 'diluted' in its approach to diagnosis i.e. it is trying to cover too many bases all at once
- The removal of 'personality disorders' from the ICD-11 could result in a patient being **misdiagnosed** e.g. they may present with **antisocial personality disorder** but their diagnosis would be more generalised under ICD-11 criteria which could result in them receiving insufficient treatment for their disorder

Two Key Studies of Classification Systems

Your notes

Key Study One: Haroz et al. (2017)

Aim: To investigate the **diagnostic criteria** of the **DSM-5** with regard to possible **culture bias** linked to the diagnosis of **depression**.

Participants: 16,130 records were used to form the basis of this research which comprised of 138 studies with data derived from 170 **samples** across 77 nationalities/ethnicities (the total number of participants across the sample is not stated in the original article).

Procedure:

- A review of **qualitative** research on depression across the world conducted between August and December 2012 (updated in June 2015)
- **Statistics** were used to compare features of depression across **nationality, region, gender and context** i.e. qualitative data was translated into **quantitative data**
- Four independent experts **rated** the items from 1–5 on measures such as their **credibility**, lack of **bias** and **transferability** and these ratings were compared with the DSM-5 and other established systems for measuring depression

Results:

- The DSM-5's classification for diagnosis of depression agreed with 7 of the 15 features identified by the experts
- Several other features of depression which occur frequently (e.g. poor concentration) were not given priority by the DSM-5 and thus were not included as a standard way of measuring depression
- The DSM-5 model was found to not adequately reflect the experience of depression at worldwide or regional levels i.e. it is overly **individualistic** and westernised in its approach

Conclusion: The DSM-5 may not be applicable to a range of cultures across the world and may suffer from cultural bias which means that it may lack **validity**.

Evaluation of Haroz et al. (2017)

Strengths

- The results of the study could be used to inform clinicians to be wary of assuming a **universalist** approach and to consider the role of culture carefully when forming a diagnosis
- The large sample size should ensure that the quantitative results are **robust** which should increase the **reliability** of the findings

Limitations

- Using **secondary data** means that the researchers could not be 100% confident that all the studies included in the research had been conducted with care and attention to detail which would affect the credibility of the research
- Translating qualitative data into quantitative data necessarily involves sacrificing meaning, **subjectivity** and context so that the data's **explanatory power** is lost

Key Study Two: Mojtabai (2011)

Aim: To question whether **bereavement-related depression** should be excluded from the DSM-5.

Participants: A **community-based sample** of participants (who were taking part in the *National Epidemiologic Survey on Alcohol and Related Conditions*) from the USA who were tested in two phases (43,093 in phase 1; 34,653 in phase 2).

Procedure:

- The participants were part of a **retrospective longitudinal** study into **grieving** and depression conducted from 2001 to 2002 and from 2004 to 2005
- The researchers used **structured interviews**,using the *Alcohol Use Disorder and Associated Disabilities Interview Schedule-**DSM-IV** (DSM-4) version* to guide the type of questions asked
- The interview schedule described above was designed to as a **diagnostic tool** used to diagnose **mood, anxiety, substance abuse,** and other related disorders
- The researchers measured **demographic** characteristics of the participants including their age at the onset of their depression; if there was a history of depression in their family; if they had used mental health services, and any new depressive episodes they experienced during the 3-year follow up period
- Major depressive episodes were defined as having a duration of at least 2 weeks, during which the participant would have experienced 5 or more of the nine *DSM-IV (DSM-4)* symptoms, particularly **impairmen**t and/or **distress**
- The **qualitative data** collected via interview was translated into **quantitative data** via a specific **scoring system**

Results:

- Participants with bereavement-related, single, brief depressive episodes tended to be older at onset, were more likely to be African-American, and were less likely to have had impairment, anxiety disorders or a previous psychiatric treatment history
- These participants were also less likely than other participants with bereavement-unrelated, single, brief depressive episodes to experience **fatigue**, increased sleep, feelings of worthlessness, and suicidal thoughts
- These participants also had a much lower risk of developing depression during the follow-up period

Conclusion: The **DSM-5** should exclude bereavement-related depression from the list of depressive episodes requiring treatment as these can be explained by the bereavement itself, they are not signs that a person is prone to depression generally.

Evaluation of Mojtabai (2011)

Strengths

- The use of a longitudinal design meant that the researchers were able to track depressive episodes across time which enabled them to form their conclusion that depression is a natural consequence of bereavement, thus the findings have validity
- Research such as this is important as it can help to inform future revisions and reviews of the DSM-5 which shows that the findings have good **application**

Limitations

- It is possible that participants suffering from depression may not be able to assess their feelings and mood **objectively** which means that the results could lack reliability
- The responses of the participants may have been affected by investigator effects (i.e. they may have liked/disliked the researcher disproportionately) which would in turn decrease the validity of their response

Worked Example

The question is, '*Discuss the use of classification systems in diagnosis*'. *[22]*

This question is asking you to offer a considered and balanced review of the use of classification systems in diagnosis that includes a range of arguments, factors or explanations. Here is an exemplar paragraph for guidance:

Classifying mental disorders can be problematic because to do so requires using diagnostic tools that are standardised and which are in agreement as to what constitutes 'abnormal' behaviour. Motjabai's (2011) research highlighted one issue with the DSM-IV (now in its fifth iteration as the DSM-5) in that it classified bereavement-related depressive episodes as evidence of abnormal behaviour. A common sense view of bereavement is that it tends to produce low mood, dysphoria, tearfulness etc. in the bereaved person, all of which are understandable features of the grieving process. To label depressive symptoms as 'abnormal' in the context of bereavement means that someone who is progressing through the stages of grief might be told by a clinician that they have clinical depression. This diagnosis could in turn lead to a self-fulfilling prophecy ('They told me I'm depressed, therefore I must be') and to treatment which is not necessarily helpful or appropriate e.g. SSRIs prescribed for long-term use.

What are Clinical Biases?

Clinical Bias in Diagnosis

- **Bias** is present when an attitude/viewpoint/opinion is directed towards what should be a **universally** agreed or accepted way of dealing with a subject or with a person or group of people
- Bias prevents **impartiality, neutralit**y and **objectivity** being applied e.g. to the depiction of **social or cultural groups** in the media; to the perception of some social or cultural groups in terms of their intelligence, ability or skills; to the **diagnosing** of some social or cultural groups depending on whom is responsible for the diagnosis
- Clinical bias in diagnosis occurs when the diagnosing clinician allows their own **prejudice, discrimination** or **political** views to influence the diagnostic procedure
- Clinical bias may occur at both the **conscious** and the **unconscious** level i.e. the clinician may be fully aware of their bias or they may be oblivious to it
- One negative consequence of clinical bias in mental health diagnosis is that a patient may not be heard properly, their **symptoms** may be dismissed or ignored which in turn may lead them to think that they are 'making a fuss' or that their symptoms are nothing to be concerned about
- Another negative consequence of clinical bias in diagnosis is that the wrong treatment or no treatment at all may be diagnosed which could have devastating consequences for the patient
- The **medical model** (as adhered to by many clinicians in Westernised, **individualistic** cultures) may be implicated in perpetuating clinical biases, particularly **gender bias** and **culture bias**

Clinical diagnosis should not be at the mercy of any sort of bias.

What is Gender Bias in Diagnosis?

- **Gender bias** is the tendency to either over-estimate (**alpha bias**) or under-estimate (**beta bias**) differences between males and females, usually resulting in one of the genders being viewed as inferior/abnormal and/or being treated negatively or unfairly
- One general example of gender bias can be seen in the **gender pay gap** (women are paid less than men for performing the same task)
- Gender bias in diagnosis may result in one gender being given preferential treatment in diagnosis while the other gender is treated according to the clinician's **assumptions** or prejudices (which are often the result of **stereotyping**)
- Women are more likely than men to be diagnosed with **depression** and physicians perceive divorced, separated or widowed women presenting with health issues as more likely to be depressed than men presenting with the same issues (Bertakis et al., 2001)
- Gender may be used to guide and inform mental illness diagnosis - often incorrectly - which can obscure the symptoms and lead to **disparity** in diagnosis (this links to the issue of **reliability** of diagnosis which is covered on a separate RN)
- Gender bias is more likely to affect females than males as medicine has traditionally been a field in which men have predominated and much of the medical '**norms**' for ideal mental (and physical) health have been based on male models (Vlassoff, 2007)

What is Culture Bias in Diagnosis?

- **Culture bias** is the tendency to assume that one culture provides a template for 'normality' so that other cultures are viewed as inferior/abnormal and the members of those cultures may be treated negatively or unfairly
- Culture bias can be seen in research studies which take an **ethnocentric** approach, assuming that behaviour is **universal**, ignoring **cultural relativism**

- Culture bias in diagnosis may result in one culture being given preferential treatment in diagnosis while the other culture is treated according to the clinician's **assumptions** or prejudices (which are often the result of **stereotyping**)
- More people from African-Caribbean backgrounds are diagnosed with **schizophrenia** in the UK and USA than are Caucasian people (McLeod, 2018)
- People from Puerto Rico have a tendency to respond to **stress** with severe physiological responses such as fainting fits and **heart palpitations** but these symptoms have frequently been **misdiagnosed** as **psychotic episodes** by clinicians from the USA (Guaraccia et al.,1990)
- Culture may be ignored and symptoms misunderstood if **culture-bound syndromes** are not considered as part of the diagnostic process (this links to the issue of **validity** of diagnosis which is covered on a separate RN)
- Culture bias is more likely to affect people from **collectivist** cultures as these cultures are more likely to be guided by **culture-bound** concepts of mental health and to use **traditiona**l forms of treatment rather than adhering to the medical model

Which studies investigate clinical biases in diagnosis?

- **Longnecker et al. (2010)** - gender bias in the diagnosis of schizophrenia
- **Jenkins-Hall & Sacco (1991)** - culture bias in the diagnosis of depression

Both Longnecker et al. (2010) and Jenkins-Hall & Sacco (1991) are available as Two Key Studies of Classification Systems – just navigate the Factors Influencing Diagnosis section of this topic to find them.

Two Key Studies of Clinical Biases

Key Study One: Longnecker et al. (2010)

Aim: To investigate the **gender ratios** (i.e. how many males, how many females took part per study) present in research studies on **schizophrenia.**

Participants: A total of 252,578 participants (147,725 male; 104, 853 female = 66% male; 34% female) amassed from 220 articles taken from a range of psychological journals.

Procedure: A **review article** in which a range of studies were analysed by the researchers to look for inconsistencies in terms of the number of males and females who featured as participants.

Results: The findings included the following observations:

- One **meta-analysis** that the researchers reviewed showed that the number of males used in schizophrenia is almost double that of the number of females used (1.94 males for every female participant)
- Males outnumbered females across all of the studies reviewed
- Males develop schizophrenia at an earlier age than females so this may be one reason for the gender imbalance in research
- Females who developed schizophrenia after the age of 45 were excluded from some early research which has resulted in this **diagnostic bias** towards males
- Females may be under-used as participants in studies of schizophrenia which means that the findings and conclusions of schizophrenia research may **over-represent** the male experience and **under-represent** the female experience

Conclusion: Females presenting with schizophrenic symptoms may be misdiagnosed due to clinicians operating a gender bias based on under-representation of females in research studies.

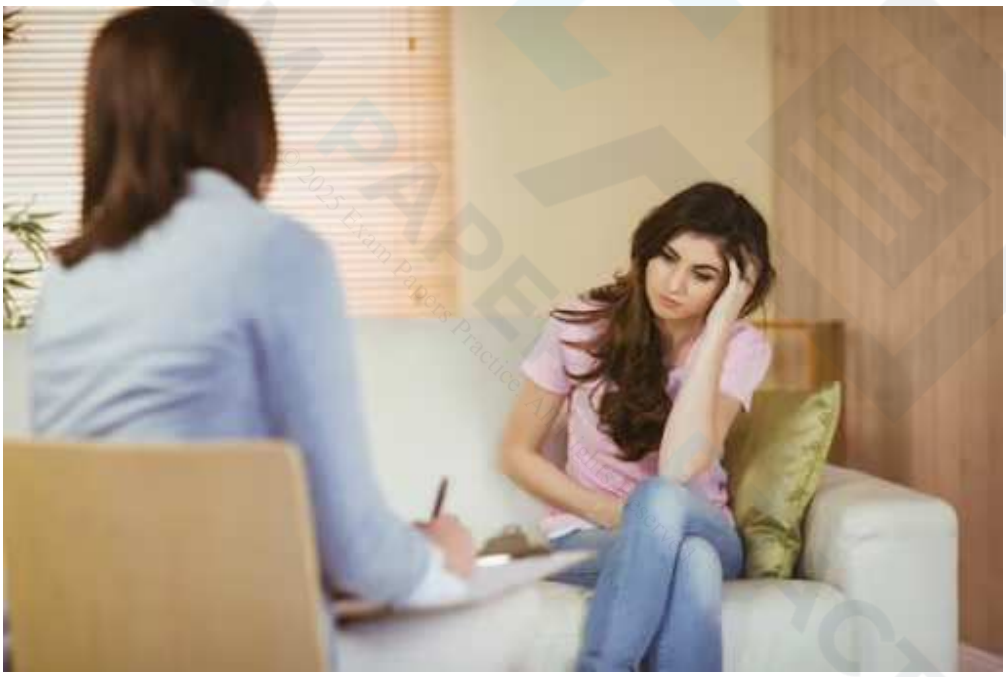
Evaluation of Longnecker et al. (2010)

Strengths

- A total sample size of 252,578 participants provides **robust quantitative data** that should withstand **statistical analysis** making the research **reliable**
- The findings of this research have good **application** and could be used to inform clinicians to treat males and females equally when they present with schizophrenia-type symptoms

Limitations

- The findings cannot determine why this gender imbalance in schizophrenia research happens, it can only suggest reasons which means that it lacks **explanatory power**
- The research studies in this review article were taken from seven different psychological journals which means that there could be inconsistencies to do with control, precision and procedure across the studies which would affect the reliability of the findings



Everyone should be treated with respect by their clinician – regardless of gender, ethnicity, age etc.

Key Study Two: Jenkins-Hall & Sacco (1991)

Aim: To investigate culture bias in the diagnosis of **depression**.

Participants: 62 White psychotherapists from the USA (39 female: 23 male with a mean age of 36 years) who were in possession of a Master's degree and who had been practising as a psychotherapist for at least three years.

Procedure:

- The participants watched a 3-minute video of a (fake) consultation between a client and a therapist
- The **independent variable** comprised four **conditions**:
  - A White female client acting 'depressed'
  - A Black female client acting 'depressed'
  - A White female client acting 'nondepressed'
  - A Black female client acting 'nondepressed'
- This was an **independent measures design** which meant that each therapist viewed only one of the above four conditions
- The fake consultations between client and therapist were developed using a script of questions taken from a **standardised depression inventory**
- The answers to the questions were written so as to highlight the presence or absence of the major **symptoms** of depression e.g. low mood; lack of interest in usual pastimes; difficulty sleeping
- The participants thought that they were viewing a real client/therapist interaction; they had no idea that the consultations were fake
- Once the participants had watched the video they filled in a **questionnaire** which used different **rating scales** measuring a range of **variables** linked to the 'client' viewed in the video including her **depressive symptoms**, **social skills** and **psychological state**

Results:

- The participants were able to correctly diagnose each woman in the 'depressed' condition, giving them high ratings on the depressive symptoms scale
- The Black non-depressed and the White non-depressed clients were rated similarly overall
- The participants gave lower ratings for social skills and **likeability** to the Black depressed clients, scoring them significantly more negatively on these dimensions than they did for the White depressed clients
- A combination of being both Black and depressed resulted in a more negative overall rating than for any other condition.

Conclusion:

- The therapists showed a racial bias against Black clients in that they evaluated depressed Black clients more negatively than they did depressed White clients
- Negative evaluations based on ethnicity, race or skin colour could bias the diagnostic process and may result in a depressed client receiving adverse, negative and ultimately harmful treatment

Evaluation of Jenkins-Hall and Sacco (1991)

Strengths:

- This findings of this study support previous research which showed that Black people may be discriminated against by White professionals if they are judged according to their culture/ethnicity rather than according to their symptoms
- The use of several different standardised rating scales is an example of **data triangulation** which increases both the **validity** and **reliability** of the study

Limitations

- Some of the participants may have realised that the consultations were fake, giving rise to **demand characteristics** which would lower the **ecological validity** of the study
- This is **socially sensitive** research which should be handled carefully as, once published, it could be used to perpetuate **stereotypes** about minority groups

Worked Example

The question is, '*Discuss the role of clinical bias in diagnosis'. [22]*

This essay question is asking you to offer a considered and balanced review of the role of clinical bias in diagnosis that includes a range of arguments, factors or hypotheses. Here is an exemplar paragraph for guidance:

Research in non-Western, collectivist cultures has found that there is more than one way of presenting with abnormal behaviour. Many non-Western cultures have identifiable mental disorders which cannot easily be categorised through the use of the ICD 11 or DSM-5 classification systems. These culture-specific mental disorders are referred to as culture-bound syndromes. The indigenous name is used in their description and they remain closely or even exclusively associated with the culture or population in which they were first identified e.g. hsieh-ping: (Taiwan) a brief trance state during which one is possessed by an ancestral ghost, who often attempts to communicate to other family members. Symptoms include tremors, disorientation and delirium, and visual or auditory hallucinations. Not understanding the cultural context of these symptoms would mean that the sufferer is at the mercy of a diagnosis which ignores their cultural significance and which could result in misdiagnosis leading to incorrect, even harmful, treatment.

How are Validity & Reliability Relevant to Diagnosis?

Validity and Diagnosis

- For a mental illness **diagnosis** to be **valid** it must accurately reflect the patient's **symptoms**, free from **bias** (**clinical biases** in diagnosis are covered in a separate revision note)
- A valid diagnosis is one which should **classify** and describe a genuine **pattern of symptoms** resulting from a real underlying cause
- A valid diagnosis will result in appropriate **treatment** being prescribed with the expectation of improvement and progress as a result of this treatment
- Due to the complex nature of mental illness the diagnostic process is not always straightforward e.g. is the patient's low mood due to **depression, anxiety, OCD** or could it be part of a potentially more serious disorder such as **schizophrenia**?
- It is arguably more difficult for a clinician to diagnose a specific mental illness than it is for them to diagnose a physical illness e.g. Covid-19 is detectable by testing saliva; a broken bone shows up on an X-ray

Reliability and Diagnosis

- For a mental illness diagnosis to be **reliable** there should be **agreement** and **consistency** across different diagnostic settings i.e. the same diagnosis for the same symptoms presented by the same patient should be made, regardless of who is in charge of the diagnosis
- **Classification systems** such as the **DSM-5** and the **ICD 11** aim to **standardise diagnostic criteria** so as to ensure built-in reliability
- Due to the complex nature of mental illness the likelihood of **symptom overlap** is common, making reliable diagnosis problematic e.g. if a patient reports hearing voices along with the compulsion to wash their hands every 10 minutes this may result in one diagnosis of schizophrenia whereas another clinician may diagnose OCD
- Patients who are **comorbid** may find that the treatment prescribed is based on only one of their disorders rather than taking both of them into consideration (e.g. **SSRI**s for their depression but nothing for their **social phobia)**
- The symptoms of mental illnesses are difficult to measure as they are experienced **subjectively** and may even defy measurement (e.g. how can **delusions** be measured **objectively**?) which is a challenge when it comes to making a reliable diagnosis

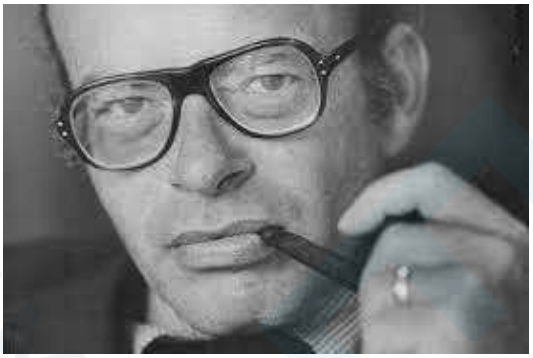
Which studies investigate validity & reliability of diagnosis?

- **Rosenhan et al. (1973)** - mental illness diagnosis may not be valid and may result in people being stigmatised
- **Nicholls et al. (2000)** - eating disorders in children are not diagnosed reliably and the process needs to be reviewed

Both Rosenhan et al. (1973) and Nicholls et al. (2000) are available as Two Key Studies of Validity & Reliability of Diagnosis – just navigate the Factors Influencing Diagnosis section of this topic to find them.

Two Key Studies of Validity & Reliability of Diagnosis: Rosenhan et al. (1973); Nicholls et a. (2000)

Key Study One: Rosenhan (1973)



Rosenhan: a man with a plan…

Key study one (validity of diagnosis): Rosenhan (1973)

Aim:

- To investigate the **validity** of mental illness **diagnosis**
- To investigate the consequences of the '**sticky label**' of a mental illness diagnosis

Participants:

- The study used **naive participants** from the following:
- The staff and patients from 12 **mental hospitals** from across the USA
- The hospitals varied in terms of age, location, staff-patient ratios, expertise

Observers:

- Rosenhan recruited eight **confederates** who comprised his sample of **pseudopatients** who infiltrated the mental hospitals and made **covert observations** of the hospital staff and patients
- The pseudopatients consisted of 3 females and 5 males with Rosenhan himself assuming a pseudopatient role as well
- The pseudopatients were from a range of different backgrounds and none of them had a mental illness

- The pseudopatients were told to use fake names and occupations when they presented themselves for diagnosis

Procedure:

- The confederates recruited by Rosenhan (known as 'pseudopatients' as they would be faking their symptoms) were instructed to present themselves at one of the 12 hospitals selected by Rosenhan
- Upon getting an appointment with a doctor they were told to report the following symptoms: *I have been hearing a same-sex voice in my head which repeats the words 'empty', 'hollow' and 'thud'*
- The pseudopatients were told to behave normally during the consultation and not to fake any other symptoms of mental illness
- All but one of the pseudopatients were admitted to hospital with a diagnosis of **schizophrenia** (one of them was admitted with a diagnosis of **bi-polar disorder**)
- Once the pseudopatients had been admitted to hospital Rosenhan's instructions were that they were to never mention their (fake) symptoms again, to behave normally and to persuade the hospital to release them as soon as possible
- Rosenhan also told the pseudopatients to keep notes of what they **observed** during their time in hospital relating to both staff and patients
- The pseudopatients were told not to take any drugs administered to them by hospital staff but to dispose of them discreetly
- The **dependent variable** was the number of days spent in hospital before release
- The overarching **method** of this research is a **covert participant observation**

Results:

- The notes made by the pseudopatients while in hospital detailed the everyday interactions between staff and patients
- Interactions between staff and patients was sparse, with staff often ignoring patients, dismissing their requests (e.g. asking when visiting hours were), making **little eye contact** with the patients
- Normal behaviours were often interpreted by staff as aspects of mental illness e.g. three pseudopatients were told that their writing was evidence of **pathological behaviour**, labelling this is 'writing behaviour' rather than simply 'writing'
- One one occasion a psychiatrist pointed to a group of patients queuing for lunch and labelled this behaviour as '**oral-acquisitive syndrome**' rather than simply accepting that they were just queuing up for lunch
- None of the staff suspected that the pseudopatients were fake, however 35 out of 118 patients approached the pseudopatients and voiced their suspicions that the pseudopatients were not actual patients (some of the patients thought that the pseudopatients might be undercover journalists)

- The pseudopatients spent from 7 to 52 days in hospital (**mean**=19 days)
- All but one of the pseudopatients were released from hospital with a diagnosis of 'schizophrenia in **remission**'

Conclusion:

- There are questions to be asked re: the validity of mental illness diagnosis as the doctors should not have diagnosed any of the pseudopatients with schizophrenia or bi-polar disorder as their (fake) symptoms do not align with either of these diagnoses
- Once someone has been diagnosed with a mental illness this becomes a 'sticky label' through which all subsequent behaviours are viewed and judged
- Patients hospitalised with a mental illness experience **depersonalisation** due to the indifferent, sometimes hostile treatment at the hands of hospital staff

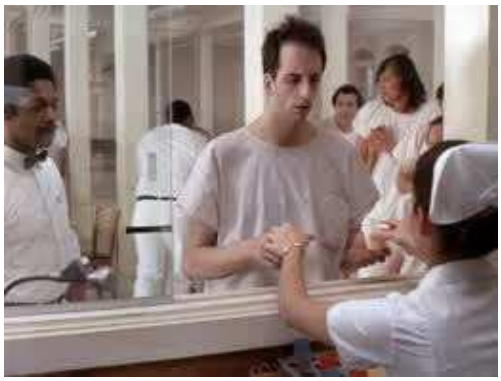
Evaluation of Rosenhan (1973)

Strengths

- The use of research in the field via covert observational methods means that the observed participants are unlikely to have succumbed to the **observer effect**, making the findings high in **ecological validity**
- This was a controversial, ground-breaking study which provoked important discussion about how people suffering from mental disorders are treated by institutions

Limitations

- The study does raise some **ethical concerns**: the staff and patients of the hospitals were **deceived**; the hospital participants could not give their **informed consent** or be given the **right to withdraw** plus their **privacy** was compromised
- A sample of only 8 pseudopatients is not enough from which to draw strong and meaningful conclusions plus there is the possibility that the pseudopatients might have succumbed to **confirmation bias** in reporting their observations



One of Rosenhan's key findings was that mental hospitals rob people of their individuality.

Key Study Two: Nicholls et al. (2000)

Aim: To evaluate the reliability of **diagnostic classification systems** for **eating disorders** when applied to children and young adolescents.

Participants: 81 children aged 7–16 who had been selected via **random sampling** from a **population** of 226 child patients attending a clinic specialising in **eating disorders.**

Procedure:

- Each child was assessed by one of six clinicians
- The clinicians were asked to use either the DSM-IV, the ICD 10 or the Great Ormond Street Hospital (GOSH) diagnostic manual in to form their diagnosis of each child
- Each clinician gave their diagnosis as to which specific eating disorder the child was suffering from, using one of the three diagnostic manuals cited in the above bullet point
- Two clinicians assessed each child (each clinician having used a different diagnostic manual to the other) without knowing about each other's diagnosis i.e. they were **blind** to the pre-existing diagnosis

Results:

- **Inter-rater reliability** values were calculated for each of the three diagnostic manuals used to come to reach the diagnosis
- The higher the inter-rater value is, the more reliable the diagnosis is
- The results per diagnostic manual were as follows:
- GOSH: 0.879
- DSM-IV: 0.636
- ICD 10: 0.357
- The GOSH definitions included **anorexia** and **bulimia nervosa**, **food avoidance emotional disorder, selective eating** and **pervasive refusal to eat** amongst their classification of eating disorders
- GOSH criteria bad been specifically developed to classify child and adolescent eating disorders: they were more **reliable** than the DSM IV and ICD 10 criteria, which showed little consistency, especially the ICD 10, which had the lowest inter-rater reliability of all the classification systems
- The DSM-IV and the ICD 10 focused too much on body shape and weight which are invalid criteria when diagnosing eating disorders in children

Conclusion: The DSM and ICD are not suitable classification systems for the diagnosis of eating disorders in children; a clinician working diagnosing children with eating disorders requires tailor-made criteria such as those supplied by GOSH.

Evaluation of Nicholls et al. (2000)

Strengths

- The study's use of blind clinicians (who did not know the diagnosis given by their counterpart) increases the validity of the findings as it helps to eliminate **bias** from the assessments provided
- The findings are vital in that they pinpoint flaws in the more traditional classification systems and highlight how children with eating disorders should be diagnosed

Limitations

- A sample of 81 children from the UK is small and unrepresentative of the wider population, making the results difficult to generalise
- The research only highlights how children with eating disorders should be diagnosed, it does not account for other disorders which may also require a separate and specific classification system

Summary Table: Key Studies of Factors Influencing Diagnosis

Key Studies Summary of Factors Influencing Diagnosis

SUMMARY TABLE: KEY STUDIES OF FACTORS INFLUENCING DIAGNOSIS	
Topic	**Two Key Studies**
Normality vs Abnormality ▪ Use both of these studies to answer a question on normality vs abnormality ▪ Use Mojtabai (2011) to answer a question on classification systems as well	Jahoda (1958) Mojtabai (2011)
Classification Systems ▪ Use both of these studies to answer a question on classification systems ▪ Use Mojtabai (2011) to answer a question on normality vs abnormality as well ▪ Use Haroz et al. (2017) to answer a question on validity and reliability of diagnosis as well	Haroz et al. (2017) Mojtabai (2011)
The Role of Clinical Biases in Diagnosis ▪ Use both of these studies to answer a question on the role of clinical biases in diagnosis	Longnecker et al. (2010) Jenkins-Hall & Sacco (1991)
Validity & Reliability of Diagnosis ▪ Use both of these studies to answer a question on the role of validity and reliability of diagnosis ▪ Use Nicholls et al. (2000) to answer a question on classification systems as well	Rosenhan (1973) Nicholls et al. (2017)

How do I use these studies in an exam question on this topic?

- IB students have a lot of content to cover (particularly students taking Psychology at Higher Level) so the purpose of this revision resource is to slim down and streamline the number of studies you need per

topic/exam question

- Remember that all Paper 2 questions are ERQs (Extended Response Questions) which are worth 22 marks, take an hour to write and need to be rich in critical thinking
- The exam question command term will be one of the following:'Evaluate', 'Discuss', 'Contrast' or 'To what extent'
- Each command term requires you to answer the question in slightly different ways, using the content as shown in the summary table above i.e. specific studies per topic/question
- In order to slim down the content you need to revise you can see above how some of the studies can be used for more than one potential exam question
- Mojtabai (2011), Haroz et al. (2017) and Nicholls et al. (2000) can be used to answer more than one potential exam question so you may decide to keep all of these studies and 'throw away' any studies which you find that you don't need to revise