Spring Semester 2018
Wednesdays 9-12, Xianlin I-112

Phone: 86229323 (H)
Office: Heren Lou #315
Email: hillerschen@nju.edu.cn
Office hours: Mon 10-11

3. Paradigms, classification & assessment

Paradigms of thought in Abnormal Psychology

= How to think of mental disorders?

- Frameworks (high level of abstraction)
- Schools (lower level of abstraction)
  - Psychoanalysis
  - Behaviorism
  - Cognitivism
  - Humanism/Existentialism
  - Antipsychiatry
  - Others
- Etiology (vulnerability-stress model)

Traditions/frameworks

(sensu Bastine, 1998)

"Paradigm" as a concept in the narrow sense does not fit the reality of clinicial psychology
=> more "humble" terminology

Frameworks (high level of abstraction)

- The organic framework
- The psychosocial framework
- The biopsychosocial framework

Psychological „Schools"/Theories

(lower level of abstraction)

Current trends

- *Earlier:*
  universal theories which can explain every disorder
- *Today:* specific theories and empirical investigations about specific disorders, i.e., one theory (or more) per disorder, re-orientation towards a biological model
- However
  - Today's theories are still colored by some assumptions of former universal theories and ideas.
  - There is always a time gap between scientific results and practical implementation.
  - In psychology: Necessity to act!

Biological model

- Mental disorders = brain disorder
- Major reasons: brain chemistry, genetic abnormalities, evolutionary leftovers
- Treatments: drugs, electroconvulsive therapy, neurosurgery

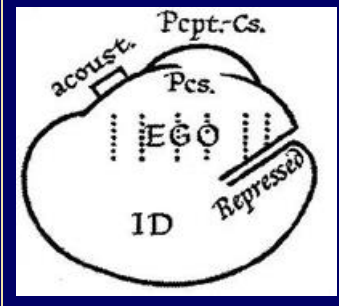
Reading recommendation

Dar-Nimrod, I., & Heine, S. J. (2011). Genetic essentialism: On the deceptive determinism of DNA. *Psychological Bulletin, 137,* 800-818. doi:10.1037/a0021860

Psychoanalysis - Freud (1)

- Mental disorder = disease
- Major reasons: childhood trauma, the unconscious, and ego-anxieties („psycho-dynamics“)

In Freud's words (1923):



"Thus the ego, driven by the id, confined by the super-ego, repulsed by reality, struggles ... [in] bringing about harmony among the forces and influences working in and upon it," [and readily] "breaks out in anxiety — realistic anxiety regarding the external world, moral anxiety regarding the super-ego, and neurotic anxiety regarding the strength of the passions in the id."

Psychoanalysis - Freud (2)

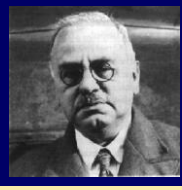
Etiology of mental disorders

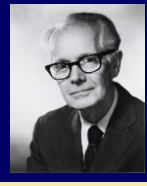
ego anxieties (and different defense mechanisms accordingly) lead to different problems depending on which stage a distressing experience happened and in which the adult „fixates", e.g.

- ***Oral stage:*** depression
- ***Anal stage:*** obsessive-compulsive disorder
- ***Phallic stage:*** antisocial personality
- ***Latency stage:*** lack of self-control
- ***Genital stage:*** self-identity problems

Psychoanalysis – Other directions

- *Alfred Adler:* individual psychology (holism), community minority complex.
- *Carl Gustav Jung:* collective unconscious; ultimate goal is the fusion of the conscious with the uncounscious
- *Heinz Kohut:* unified self is the final goal
- *Melanie Klein:* human interactions more important in the development of personality than the Id, object-relations theory



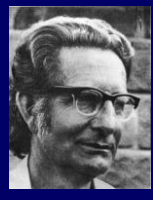



Psychoanalysis as a therapy

- ***Goals:*** gaining insight in the unconscious and working through it/catharsis => cure
- ***Methods:*** non-directive; free association, dream interpretation, therapist-patient relationship (transference, counter-transference)
- ***Duration:*** long term (up to 300-400 sessions) and short-term (25 sessions) interventions depending on the kind of psychoanalysis

Behaviorism (1)

- Mental disorder = learned dysfunction
- Major reasons: conditioning processes



Hans Eysenck

Marsha Linehan

Joseph Wolpe

Behavior Therapy (2)

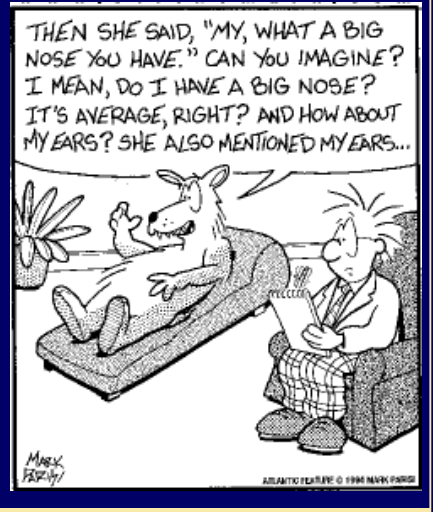
- Mowrer: both learning principles (classical and operant conditioning) are responsible for the development and maintenance of a mental disorders
- ***Goals:*** education, behavior change, condition-specific interventions; especially useful for phobias
- ***Methods:*** directive; systematic desensitization, flooding
- ***Duration:*** normally short (< 25 hours)
- ***Problems:*** Certain phenomena cannot be explained by simple learning processes!

Movie recommendation "A clockwork orange"

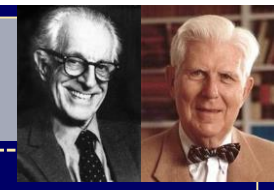
Kubrick (1971)

Cognitivism (1)

- Mental disorder = dysfunctional cognitions
- Major reasons: learning processes in childhood lead to automatic (faulty) thoughts



Cognitivism (2)



Ellis: A-B-C-Theory

A activating event	→	B cognitive processing	→	C response emotional/behavioral

misinterpretations

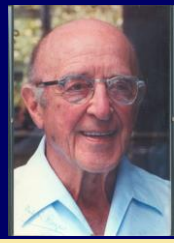
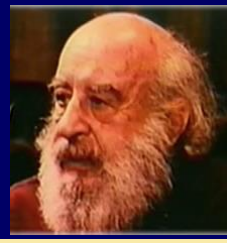
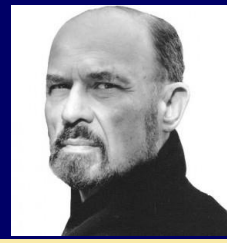
Beck: first response is always automatic and unconscious; if these underlying *schemata* causing the first response are faulty, mental disorders might develop

Cognitive behavior therapy (3)

- ***Goals:*** change cognitive mistakes, change behavior
- ***Methods:*** directive; teaching coping skills via cognitive challenge, cognitive challenge, Socratic dialogue, activation, relaxation
- ***Duration:*** normally short (< 25 hours)
- Further develoment: ACT therapies („acceptance and committment“) accepting thoughts as thoughts without changing them

Humanist-existentialist models (1)

- Mental disorder = mismatch between ideal self and actual self, interrupted growth process
- Major reasons: conditioned positive reward; obstacles in our environment that inhibit self-actualization

Humanism (2)

Rogers

- Everybody wants to grow, mature his/her personality (=innate drive) = self-actualization;
- We have a free will to choose our environment and we create our own subjective world
- Three elements are important to achieve self-acutalization:
  - Unconditional positive regard
  - Genuineness
  - Empathy

Maslow

- Hierarchy of needs: Only if the basic needs are fulfilled, one can achieve self-actualization (only few people reach this).

Existentialism (3)

- Existence includes that we will die, but have the freedom to choose to give meaning to our lives or not.
- Goal: stop avoiding, accept self-responsibility

"Imagine an iron house: without windows or doors, utterly indestructible, and full of sound sleepers – all about to suffocate to death. Let them die in their sleep, and they will feel nothing. Is it right to cry out, to rouse the light sleepers among them, causing them inconsolable agony before they die?" (Lu Xun, 1917)

Humanistic-existentialist therapies (4)

Example: client-centered therapy (Rogers)

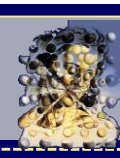
Goal: helping the client to find out about his/her optimal development towards self-actualization, freeing the client from externally set standards

Methods: „non-directive"; empathic understanding, genuineness, unconditional positive reward

Duration: generally short-term

Problems: most suitable for YAVIS-patients (**Y**oung, **A**ttractive, **V**erbal, **I**ntelligent, **S**uccessful)

In Yalom's words



"I believe that a different therapy must be constructed for each patient because each has a unique story. As the years pass, this attitude moves me farther and farther from the center of professional psychiatry, which is now so fiercely driven by economic forces in precisely opposite directions—namely accurate de-individualizing (symptom-based) diagnosis and uniform, protocol-driven, brief therapy for all."

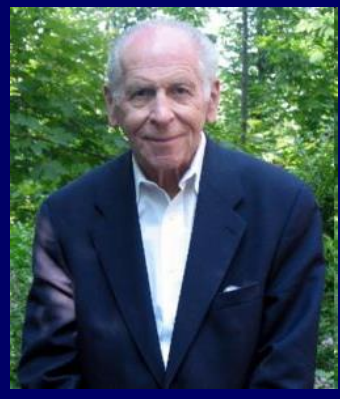
From: http://www.yalom.com/pagemaker.php?nav=bio

Anti-psychiatry/Labelling approach

- Mental disorder =
  - Non-existent
  - Label put on a person by the more powerful society (political dimension)
  - Vehicle for personal growth

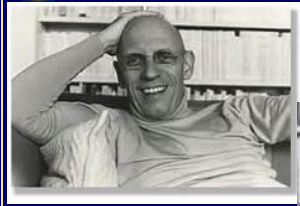
⇒ ***Therapy***
= therapeutic communities, focus on the patient's perspective

- Rebellious movement in the 60s against psychiatry and the pure medical model (Szasz, Laing, Goffman, Basaglia)
- ***Problems:*** unorganized, sometimes severe consequences such as increased rate of homeless people



Paul-Michel Foucault

(1926-1984)



„The discourse creates the objects of which they speak.“

“Madness and Civilization: A History of Insanity in the Age of Reason” (1961; engl. transl. 1965)

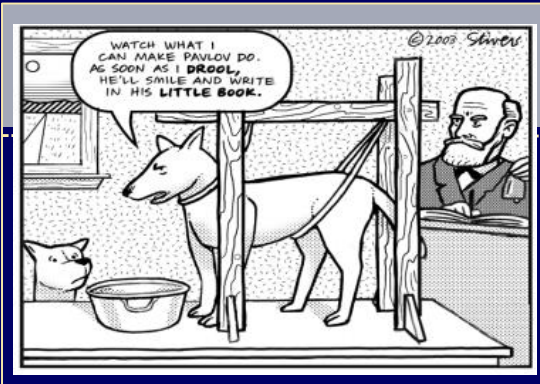
"He struck me as completely amoral, I'd never met anyone who was so totally amoral" ... "I mean, I liked him personally, it's just that I couldn't make sense of him. It's as if he was from a different species, or something."

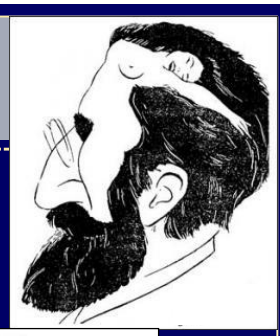
Noam Chomsky
as cited in Miller (1993)

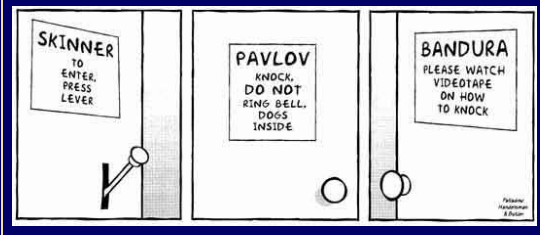
Chomsky vs. Foucault debate (1971):
http://v.youku.com/v_show/id_XMjE2MDY0MDcy.html

Other approaches

- Systemic explanations (incl. family systems)
  - Mental disorders = dysfunctional structures
  - Patient is just „index"-patient
  - Treatments: reframing, paradoxical interventions e.g. with the whole family present
- Multicultural explanations
  in line with post-modern activity theory, mental disorders connected to discrimination of minority groups, cultural influences on diagnoses and treatments
- And many more!







Summary

Scientific perspective	Name for the problem	Goal for psychotherapy
Psychiatry	disease	biological curing
Psychoanalysis	disease, but caused by intrapsychic conflicts	restructuring the personality
Humanism	disordered subjective experience	self-actualization
Behaviorism and Cognitivism	functional disorder	enhancing coping skills (behavior & thinking), changing environment
Antipsychiatry, labelling approach	social deviation/there is no mental illness	social reintegration
Interpersonal approaches	disordered social system	changing social system

Comer's summary

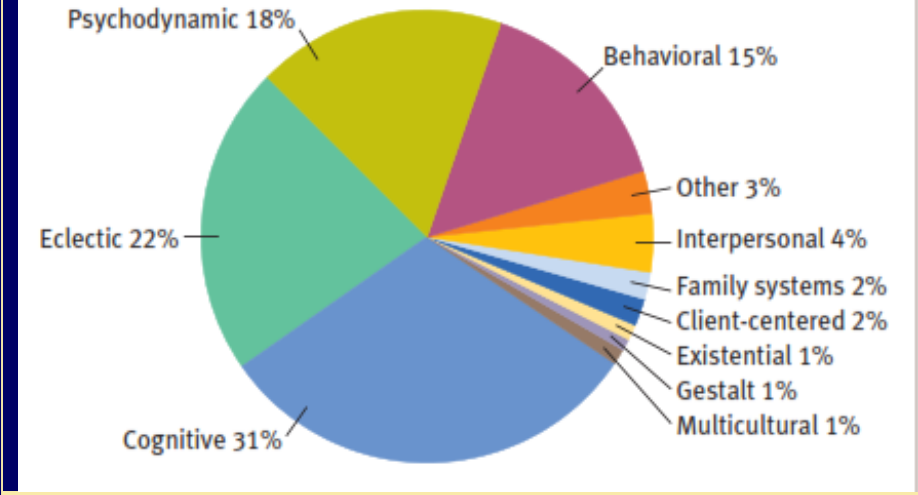
(see also Table 3-4, p. 92, 9th ed.)

Comparing the Models

	Biological	Psychodynamic	Behavioral	Cognitive	Humanistic	Existential	Family-Social	Multicultural
Cause of dysfunction	Biological malfunction	Underlying conflicts	Maladaptive learning	Maladaptive thinking	Self-deceit	Avoidance of responsibility	Family or social stress	External pressures or cultural conflicts
Research support	Strong	Modest	Strong	Strong	Weak	Weak	Moderate	Moderate
Consumer designation	Patient	Patient	Client	Client	Patient or client	Patient or client	Client	Client
Therapist role	Doctor	Interpreter	Teacher	Persuader	Observer	Collaborator	Family/ social facilitator	Cultural advocate/ teacher
Key therapy technique	Biological intervention	Free association and interpretation	Conditioning	Reasoning	Reflection	Varied	Family/ social intervention	Culture-sensitive intervention
Therapy goal	Biological repair	Broad psychological change	Functional behaviors	Adaptive thinking	Self-actualization	Authentic life	Effective family or social system	Cultural awareness and comfort

Theoretical orientations in the US

from Comer (2015, p. 72)



Situation in China

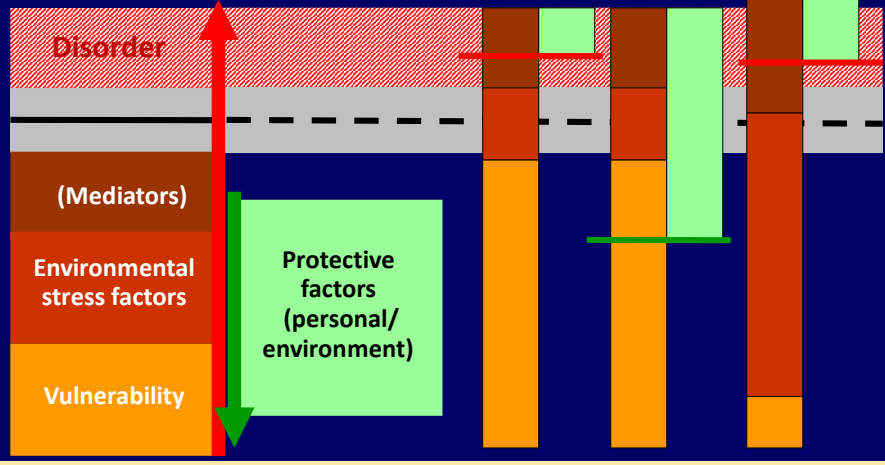
What are the most frequently used theoretical orientations of psychotherapists/counselors/social workers in China?

https://jdxl-file.b0.upaiyun.com/uploads/report2016.pdf

Etiology of mental disorders

Vulnerability (diathesis)-stress-model

Risk of developing a mental disorder

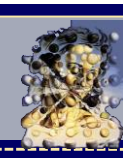


Classification and assessment

Thought organization (logic) (1)

- Providing an exact definition of mental disorders is difficult
- Classification catalogues are compromises to tackle the difficult concept
- We need classification systems although they go along with disadvantages
- When assessing mental disorders, measures follow usual criteria for quality (reliability, validity, standardization).
- Many tools can be used in different settings to make sense of a person's mental state (and therefore also mentally disordered state). They depend also on our paradigm of thought.
  Examples:
  - Intelligence tests (= performance tests)
  - Personality tests or tests of specific disorders (= self-description)
  - Projective tests (Rorschach, TAT)
  - Mental status exam (mix of observation and inquiry)

Thought organization (logic) (2)



- Common classification systems and their underlying structure/logic
  - DSM-5
  - ICD-10
  - CCMD-3
  - RDoC
- How to make a diagnosis based on the classification systems
- How many people suffer from mental disorders?
  - Concepts of prevalence and incidence
  - China vs. the world

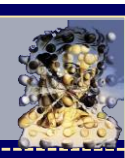
Definition of mental disorder (1)

DSM-5 (2013, p. 20)

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. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Definition of mental disorder (2)

DSM-IV



"… it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'. The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations."

Mental disorders in clinical practice

„Abnormal behavior" *is* what is classified in a classification catalogue.

- This catalogue is subject to constant research and change (cf. norms discussion)
- Reflects the values in our society now.
- Promises scientific scrutiny: reliability, validity (Yet, cannot keep that promise perfectly.)

= „as good as it gets" compromise

Reasons for exact classification

- Facilitiating professional exchange (communication)
- Enhanced reliability and validity (?)

=> making research possible

- Institutional reasons (health insurance, legal system)
- Ideally: judgment about best treatment („empirically supported“)

Problems (cf. discussion later)

- Labelling may lead to stigmatizing
- Criteria-is-all thinking way instead of seeing the person

Hence: Important is ***how*** a diagnosis is used!

Classification systems

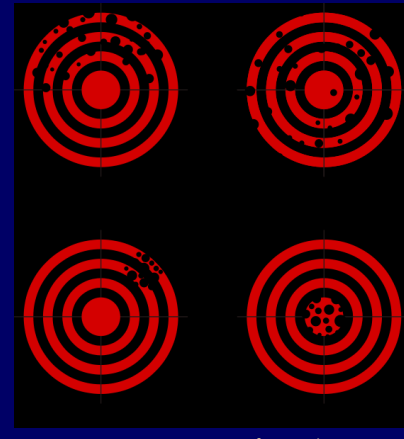
- The Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text-revised (***DSM-5***; APA, 2013)
- The International Classification of Diseases, Injuries and Causes of Death, 10th edition (***ICD-10***; WHO,1992)
- The Chinese Classification and Diagnostic Criteria of Mental Disorders, 3rd edition (***CCMD-3***; Chinese Society of Psychiatry, 2001).

Problems with classification

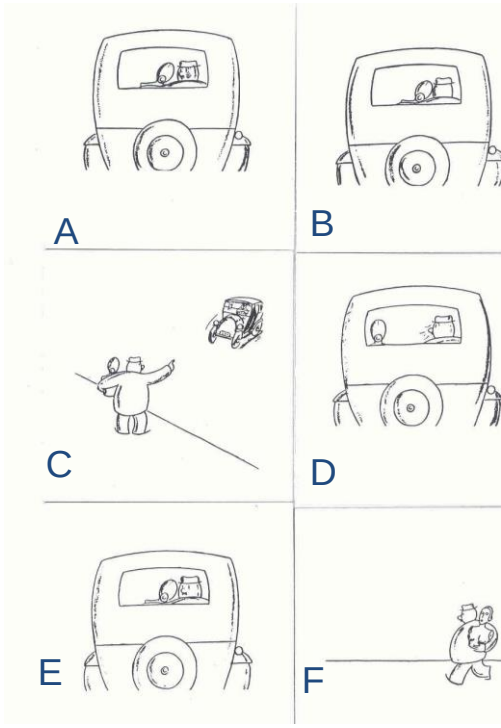
- low (construct) validity (= inner structures not cogent)
- Problems with atypical cases (and *most* cases are not prototypical!)
- Therapeutically of little use
- Adjustments according to new research is very slow! Old terms still prevail, e.g. psychopath, multiple personalities
- „Criteria is all“ thinking way: it seems that background knowledge is redundant (which is wrong!)
- Amount of diagnoses increases/thresholds decrease “pathologization”
- Vicious cycle: research determines classification, classification determines what (and how) is being resesarched

Assessment

- Quality of assessment
  - Reliability
  - Validity
  - Standardization (?)
- Clinical tests
- Clinical interviews
  - Unstructured
  - Structured
- Clinical observation
- Differential diagnosis



Picture from: Dilmen, 2012
https://en.wikipedia.org/wiki/File:Reliability_and_validity.svg



Exemplary items of common tests (1)

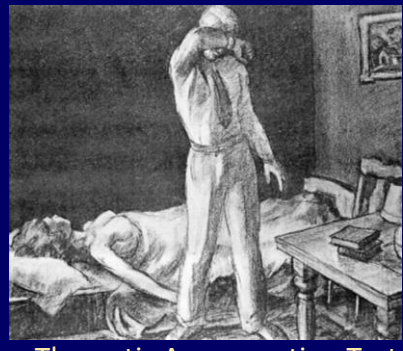
Intelligence

Examplary items of common tests (2)

- "I am easily embarrassed." Y/N (personality)
- "My activities and interests are often criticized by others." Y/N (personality)
- Suicidal ideas (Beck Depression Inventory)
  - 0 I don't have any thoughts of killing myself
  - 1 I have thoughts of killing myself, but I would not carry them out
  - 2 I would like to kill myself
  - 3 I would kill myself if I had the chance.

Exemplary items of common tests (3) – Projective tests

Rorschach inkblot test (personality)



Thematic Apperception Test, TAT (personality)

Example: Test validity (1)

from Wu Bo's PhD thesis (吴波）

14、下面是一些心理健康服务方法，请根据您使用这些方法的情况，在相应栏目下划“✓”

方法类别	使用该方法的频率			
	从不使用	有时使用	经常使用	总是使用
精神分析疗法				
行为疗法				
来访者中心疗法				
家庭治疗				
认知				

业的自我分析、体验和督导）等。第二部分是心理健康服务方法使用量表，为方便被试应答和统计分析，对国内心理学学术刊物中发表的与心理健康服务方法相关的文献进行梳理，总结出我国心理健康服务中最为常见的 18 种方法，考察这些方法的使用频率（1＝从不使用，2＝有时使用，3＝经常使用）。共 18 个题项。内部一致性系数 α 为 0.807。为避免出现对服务方法的总结有疏漏的情况，在问

Example: Test validity (2)

from Wu Bo's PhD thesis (吴波）

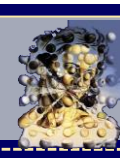


表 7　18 种心理健康服务方法的使用情况

	心理健康服务方法			从业者使用的方法数量		
方法类别	N	M	SD		N	百分比
认知疗法	2133	2.51	0.791	只用 1 种方法	66	3.1
认知行为	2133	2.24	0.853	用 2 种方法	106	5.0
理性情绪	2133	2.23	0.874	用 3-5 种方法	536	25.1
来访者中心疗法	2133	2.21	0.948	用 6 种以上方法	1425	66.8
行为疗法	2133	2.20	0.708			
精神分析	2133	1.92	0.721			

内部一致性系数 α 为 0.807。为避免出现对服务方法的总结有疏漏的情况，在问

Example: Test validity (3)

from Wu Bo's PhD thesis (吴波）

表 9 心理健康从业者方法使用的性别和年龄差异

	性别			年龄			
服务方法	女	男	T 值	< 30	30-45	〉45	F 值
认知疗法	2.50±0.79	2.52±0.79	0.49	2.56±0.77	2.46±0.81	2.54±0.73	3.874*
认知行为	2.22±0.86	2.25±0.85	0.61	2.30±0.84	2.17±0.86	2.25±0.84	5.855**
理性情绪	2.15±0.87	2.27±0.87	2.97**	2.34±0.86	2.14±0.87	2.17±0.86	13.977***

Example: Test validity (4)

from Wu Bo's PhD thesis (吴波）

13、通常情况下，针对单个来访者，您的咨询与治疗次数是：

	没有	有时	较多	总是
1 次				
2-3 次				
4-8 次				
8 次以上				

Experiment

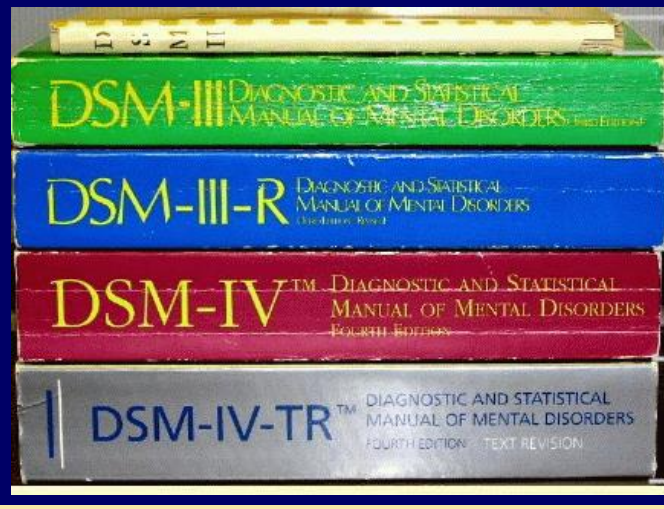
Mental status exam
(= structured interview)

I. Appearance (observed)
II. Behavior (observed)
III. Attitude (observed)
IV. Level of Consciousness (observed)
V. Orientation (inquired)
VI. Speech and Language (observed)
VII. Mood (inquired)
VIII. Affect (observed)
IX. Thought Process/Form (observed/inquired)
X. Thought content (observed/inquired)
XI. Suicidality and homicidality (inquired)
XII. Insight and judgment (observed/inquired)
XIII. Attention Span (observed/inquired)
XIV. Memory (observed/inquired)
XV. Intellectual Functioning (observed/inquired)

Classification systems

- The Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text-revised (***DSM-5***; APA, 2013)
- The International Classification of Diseases, Injuries and Causes of Death, 10th edition (***ICD-10***; WHO,1992)
- The Chinese Classification and Diagnostic Criteria of Mental Disorders, 3rd edition (***CCMD-3***; Chinese Society of Psychiatry, 2001).

DSM-5



DSM - Structure

DSM-IV-TR	DSM-5
Axis I: Clinical symptoms	Required: Section II diagnosis Section III: alternative model for personality disorders
Axis II: Personality disorders and mental retardation	
Axis III: Physical conditions	-
Axis IV: Severity of psychosocial stressors	*Optional* "Other conditions that may be a focus of clinical attention" pp. 715ff.
Axis V: Level of functioning (0-100)	*Optional* (Disability assessment schedule, WHO, p. 747f.)

DSM-5: Subtypes and specifiers

Subtype
mutually exclusive and jointly exhaustive sub-categories

Specifier
further information relevant for management

- *Course related*
  - *recurrent* (=symptoms again after a symptom-free period)
  - *in remission* (=currently there are no symptoms)
- *Severity related:* mild, moderate, severe
- *Related to descriptive features*
  e.g. without insight; with mixed-emotional features; with panic disorder

Example: Adjustment Disorder (1)

Adjustment Disorders

Diagnostic Criteria

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
   1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
   2. Significant impairment in social, occupational, or other important areas of functioning.
C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
D. The symptoms do not represent normal bereavement.
E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Example: Adjustment Disorder (2)

Specify whether:

309.0 (F43.21) With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.

309.24 (F43.22) With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.

309.28 (F43.23) With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.

309.3 (F43.24) With disturbance of conduct: Disturbance of conduct is predominant.

309.4 (F43.25) With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.

309.9 (F43.20) Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

Change of norms example from the DSM

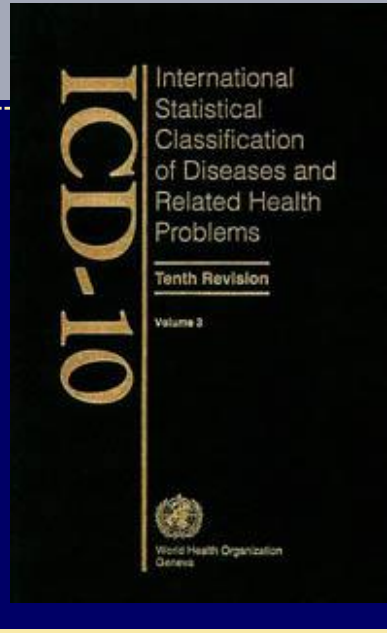
- DSM-I: "homosexuality"
- DSM-II (7th edition): "sexual orientation disturbance"
- DSM-III: ego-dystonic homosexuality
- DSM-IIIR: category removed
- DSM-IV-TR: "sexual disorder not otherwise specified" if "persistent and marked distress about one's sexual orientation"
- DSM-5: category removed

Note: still existing in CCMD-3 62.31

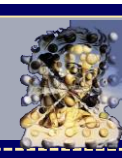
Outlook: More than DSM-5?

NIMH: Research Domain Criteria project (RDoC) as an alternative, biologically-based classification system (far away from results)

http://www.nimh.nih.gov/research-priorities/rdoc/index.shtml



ICD-10 (1)



5 hierarchy levels

e.g. F32.10

- *Fxx.xx:* chapter 5 of the ICD
- *F3x.xx:* Mood (affective) disorders
- *F32.xx:* Major depressive disorder, Single episode
- *F32.1x:* Currently moderate
- *F32.10:* Without somatic symptoms

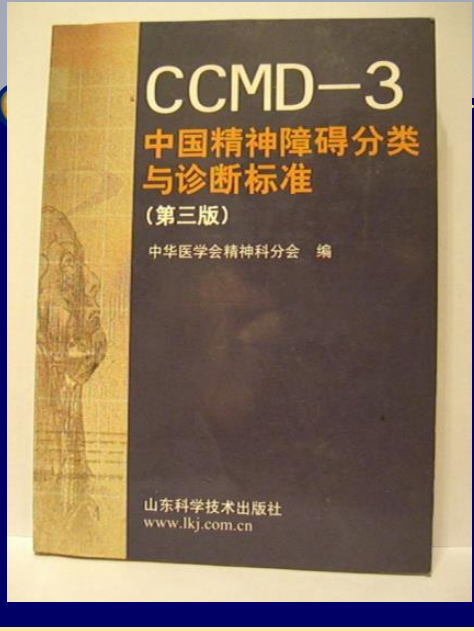
ICD-10 (2) F subchapters

- **F00-F09** Organic, including symptomatic, mental disorders.
- **F10-F19** Mental and behavioral disorders due to psychoactive substance abuse.
- **F20-F29** Schizophrenia, schizotypal and delusional disorders.
- **F30-F39** Mood (affective) disorders.
- **F40-F48** Neurotic, stress-related and somatoform disorders.
- **F50-F59** Behavioral syndromes associated with physiological disturbances and physical factors
- **F60-F69** Disorders of adult personality and behavior
- **F70-F79** Mental retardation
- **F80-F89** Disorders of psychological development
- **F90-F98** Behavioral emotional disorders with onset usually occurring in childhood or adolescence

ICD-10 (3)

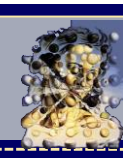
- DCR = diagnostic criteria for research
  criteria more strict to match DSM-IV precision
- Z-codes = factors influencing health status and contact with health services

CCMD-3 (1)



- Two parts
  - Classification and Diagnostic /criteria
  - Treatment and Care Based on symptoms AND partly etiology
- Since CCMD-2 (1995) oriented towards ICD-10 terminology adding also DSM criteria.

CCMD-3 (2) Main difference: "neurosis" concept ("神经症")



Major criterion: lack of organic basis

1. Symptomatic symptom: (a) phobia; (b) OCD; (c) panic attack; (d) anxiety; (e) hypochondriac symptoms; (f) somatic symptoms; (g) neurasthenic symptoms; (h) mixture of above symptoms
2. Severity of illness: impairment of social functioning or inextricable mental agony
3. Course criteria: continuous for at least 3 months
4. Exclusion: organic/substance-induced/mood disorders, paranoid psychosis, schizophrenia

Most similar: neurasthenia

- (ICD: F48.0; cf. CCMD: 43.5 神经衰弱), ICD and CCMD criteria for neurasthenia are not the same
- DSM-5 does neither contain neurosis nor neurasthenia

Excursus: Neurosis and psychosis

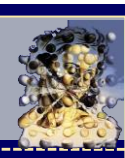
Psychosis (gr. psyche – mind, osis – disease/condition)

- *Today:* severe mental disorder, person detached from reality, disintegration of personality
- Formerly: consequence of organic or brain change/disease
- exogenous: organic basis/cause
- endogenous: without (observable) organic basis/cause
- not based on unconscious conflicts (except for "narcissistic neuroses", Freud)
- not explainable from a person's life context

Neurosis (gr. neuron – nerve, osis – disease/condition)

- *Today:* disorder of behavior manifesting during the development of a human being, out of human control, but with insight
- 18th century: disease of the nervous system without organic causation
- Freud: disorder based on unconscious conflicts that CAN be uncovered by psychoanalysis (!), individual still functioning in reality

CCMD (3) Treatment principles Examples

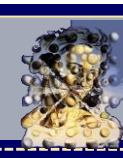


- Assessment
  1. Influences of psychiatric symptoms
  2. Psychosocial factors
  3. Positive history of suicidal attempts of the patient or his/her family
  4. Personality defect (note the language!)
  5. Postpsychotic depression
- Aim
  1. To eliminate his/her suicidal idea and behavior
  2. To make him/her understand harms of this kind of behavior
  3. To seek help and control attempts when suicidal idea presents

Other classification systems

- Third Cuban Glossary of Psychiatry (GC-3)
- French Classification for Child and Adolescent Mental Disorders
- Latin American Guide for Psychiatric Diagnosis (GLDP)

The NIMH Research Domain Criteria (RDoC) Project



- Main idea: mental disorders = brain disorders
  http://www.ted.com/talks/thomas_insel_toward_a_new_understanding_of_mental_illness?anguage=en
- Not designed as a system of psychiatric classification (yet?)
- No a priori stance about form
  = "vision for the future", currently fluid
- Basic assumptions
  - There are more basic and less basic levels of analysis.
  - Dimensional framework, no clear-cut boundaries
  - Provisional and open outlay

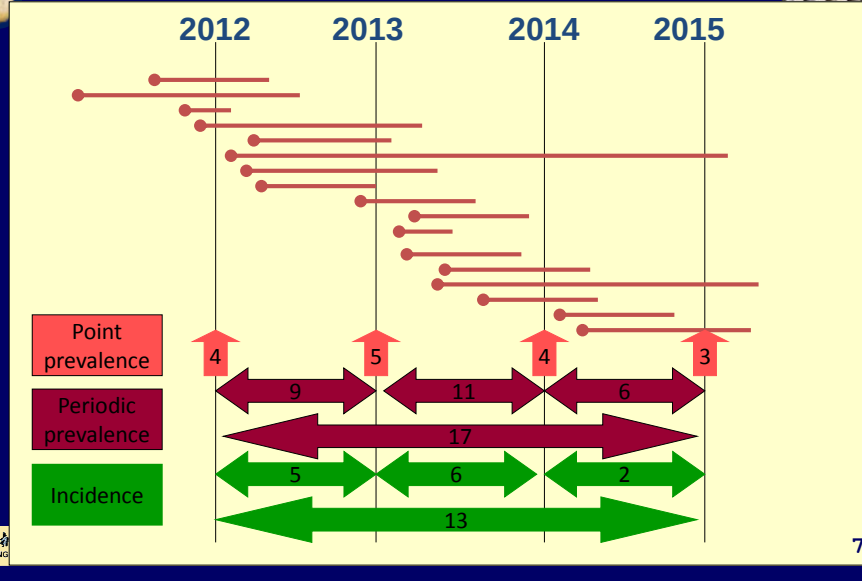
Main differences - summary

- ICD and DSM both purely empirical/descriptive
  (At least they try to be)
- CCMD: partly includes etiological considerations and treatment codes, more abstract
- Usage/spread
  - ICD-10: obligatory for practitioners in most European countries, and the U.S. (ICD-9) though often neglected in the U.S.
  - CCMD-3: used by 95% of all psychiatrists in China (Zou, 2006)
  - DSM-5: valid in the U.S. and important for international research
- Nomenclature: mostly standardized for all systems
- Future: further standardization
  Chen Yanfang : "ICD-11 with Chinese characteristics"

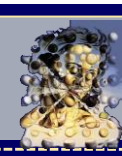
Differential diagnoses according to the classification systems

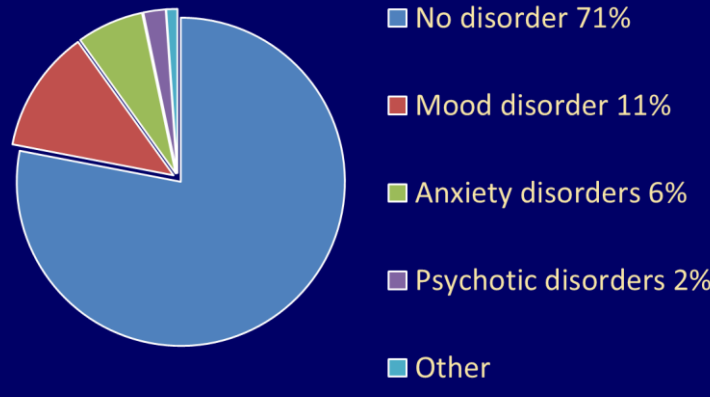
- Normally, a patient is interviewed (objectivity problem!).
- There are *standardized* interviews for both classification systems (= „fixed questions“):
  - SCID: Structured Clinical Interview for DSM
  - CIDI: Composite International Diagnostic Interview (for ICD-10)
  - RTHD: Rating Test for Health Problems and Diseases (CCMD-3)
- Several additional tests (also dimensional scales) can be applied to find out more about specific disorders.
- Besides this, the current life situation and context has to be assessed
- In the end, all pieces of information are being put together.

Prevalence and incidence



Prevalence of mental disorders in China (1-month prevalence)





Phillips, M. R., Zhang, J., Shi, Q., Song, Z., Ding, Z., Pang, S., Li, X., Zhang, Y., & Wang, Z. (2009). Prevalence, treatment, and associated disability of mental disorders in four provinces in China during 2001-2005: An epidemiological survey. *Lancet, 373,* 2041-2053. doi: doi:10.1016/S0140-6736(09)60660-7