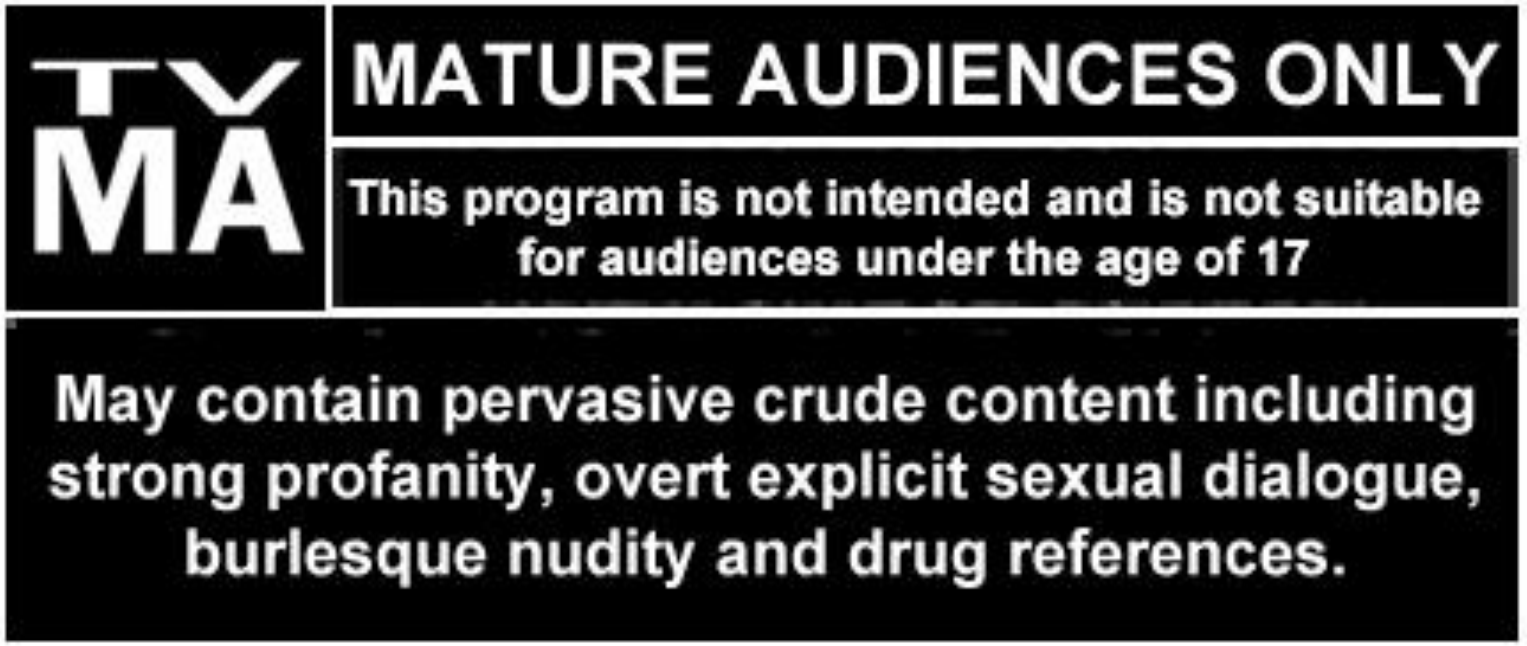
It isn’t whatcha got, it’s whatcha do…

A behavioral view of mental health diagnoses

Warning!!!



Well probably not sexual dialogue and nudity, but I like to be thorough…Ok, maybe nudity but I'm not using a webcam so not to worry.

Some notable quotes…

- "In today's society, consumed with the idea that many of our problems are beyond our control, we have steered away from *descriptions* of how people are and have drifted, dangerously, towards *prescriptions* for what people have…"
- "Children once described as *being* a problem are now described as *having* a disorder…"
- "There is a disturbing trend to attribute extremes in behavior, potentially simply natural variation, to something that is fundamentally (medically) *wrong* with the person..."

Some notable quotes…

- "We are rapidly becoming a nation in which falling at either end of the bell shaped curve of human behavior is indicative that we must *have* something and that only medication can return us to the safety and sanity of the middle of the distribution."

- Merrill Winston, 3/25/14

Some notable quotes…

- "The great thing about quoting yourself is that it's really hard to screw it up, and even if you did, no one but you would know about it."

---Merrill Winston (later that same day)

Problems and Pitfalls in Diagnosis

- Diagnosis comes from a great medical tradition in which a patient presents with symptoms and the physician uses established guidelines to determine which disease or syndrome they have, which then suggests a course of treatment (also largely determined by standards of care).
- This process is far from perfect in the field of general medicine, but is always progressing.

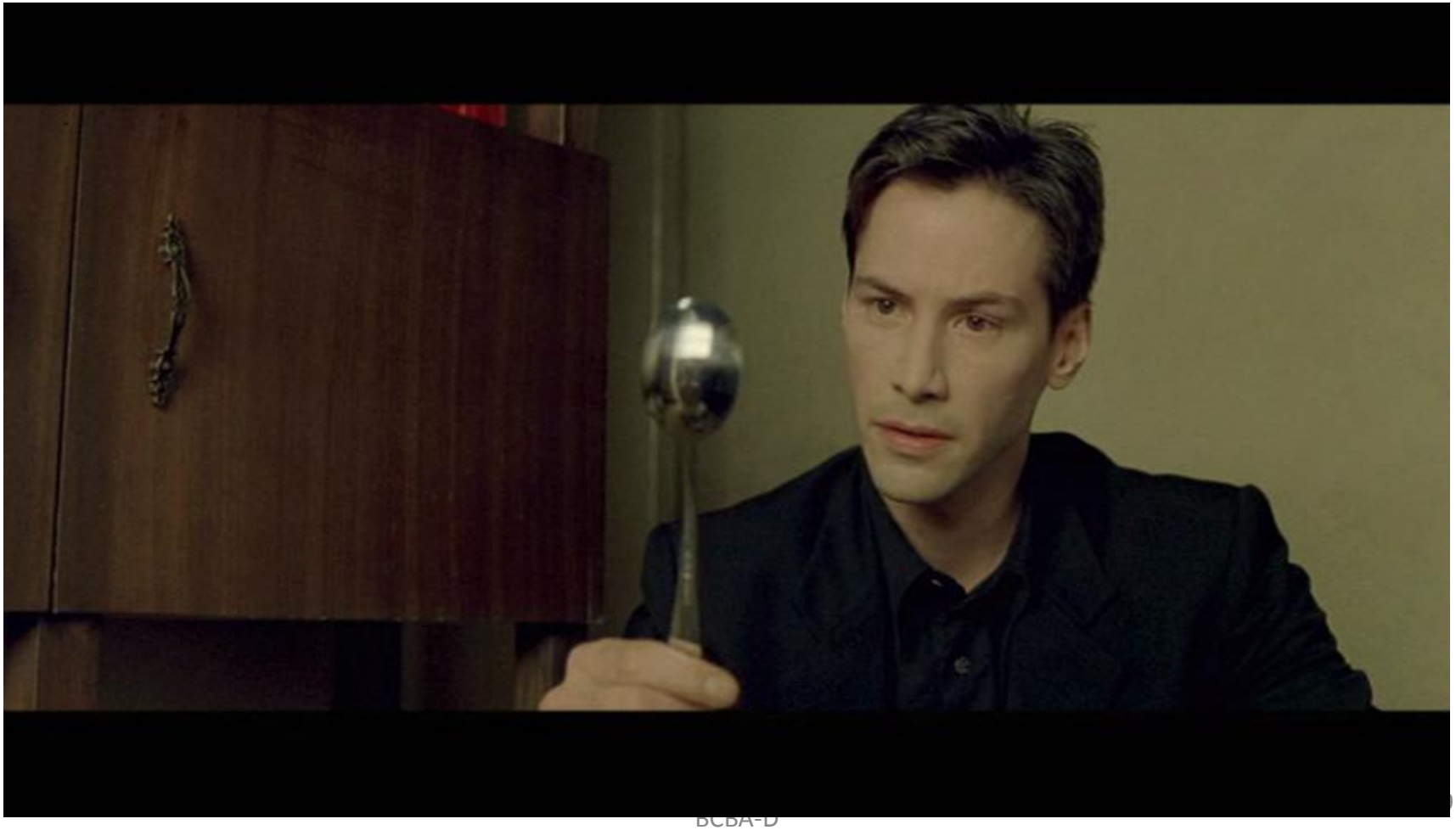
Problems and Pitfalls in Diagnosis

- In the field of psychiatry however, there are no “acid tests” to show conclusively that anybody “has” anything! Often times, professionals will “overturn” each other’s diagnoses. This means that the same problems encountered in general medicine are only exacerbated in psychiatry.
- General medicine however, employs many standardized objective measurements that can easily verify any state or condition of the person or that individual’s physiological processes.

Problems and Pitfalls in Diagnosis

- However, everyone can agree (given the standard for the range) that you do in fact HAVE high blood pressure (still not the same “have” as you “have” kidney stones!).
- Taking this analogy to psychiatry….people will less likely agree as to exactly how high your blood pressure is, or if you even have it at all!
- If diagnosis and treatment is imperfect in general medicine with objective, standardized measurement, how is it going to suffer when assessment is often highly subjective and idiosyncratic?

There is no spoon!



There is no spoon!

- Boy: Do not try and bend the spoon. That's impossible. Instead only try to realize the truth.
- Neo: What truth?
- Boy: There is no spoon.
- Neo: There is no spoon?
- Boy: Then you'll see that it is not the spoon that bends, it is only yourself.
- The DSM V is a big drawer full of spoons

You don’t “have” anything!

You don't "have" anything!

- There are all sorts of "haves" in medicine
- You have hypertension (a deviation from the norm)
- You have a mitral-valve prolapse (structural pathology)
- You have Dizziness (a symptom of a variety of medical conditions)
- You have HIV (a communicable disease)

You don't "have" anything!

- The notion that you "have" a mental disorder in the sense that you have high blood pressure (or kidney stones) is misleading and encourages circular reasoning.
- Saying that you had a stroke BECAUSE you have high blood pressure is NOT the same as saying that you hallucinate BECAUSE you have schizophrenia!
- Schizophrenia is no more the cause of hallucinations than being a "bully" is the cause for punching people in the face and laughing about it!
- Autism is no more of a cause for stereotyped self-

You don't "have" anything!

- Hallucinating IS Schizophrenia.
- Engaging in stereotypies IS Autism.
- Purposefully stepping on someone's jacket because it "shouldn't have been on the floor in the first place" IS being an A-Hole!
- Do persons diagnosed as having autism and schizophrenia or ADHD or depression or Bi-polar disorder "have" major problems? Undeniably.

You don't "have" anything!

- That these individuals "have" anything besides bizarre behavioral excesses or lack of certain skills is unclear at best.
- Regardless of what anyone <u>believes</u> to be something wrong with the brain or nervous system or neurotransmitters, (which is highly debatable) one thing is abundantly clear…
- Mental Health diagnoses are made solely on the basis of behavior! **Things you do that you shouldn't, and things you should do, but don't** (a bit oversimplified, but don't worry, I'll complicate it shortly).

Measurement and diagnosis

- Even though diagnosis is based on an individual's behavior, very little behavior is ACTUALLY OBSERVED DIRECTLY!
- Behavior that is observed in real time is not often measured very accurately (if even formally measured).
- It would be like having a blood pressure cuff that only registered low, medium, or high.
- Naturally some clinicians may spend more time than others actually observing behavior and conducting probes to look for certain

Measurement and diagnosis

- Much of the behavior observed is verbal behavior.
- This verbal behavior comes from a variety of sources; parents, direct-care staff, social workers, teachers, and even the patients themselves.
- In the case of the patient, the verbal behavior may be observed directly but is seldom directly measured (e.g., they answered a “voice in their head” 5 times in 10 minutes).
- More typically, a standardized diagnostic test or instrument is used that at best indirectly measures verbal behavior (that of the patient, caregiver or the clinician).

An actual exchange between DR. and Patient..

- Doctor: “Do you hear voices”
- Patient: “Yes”
- Doctor: “Who’s voice do you hear?”
- Patient: “Yours!”

Measurement and diagnosis

- For some individuals, there may be indirect measurement of motor behavior, but these are usually in the form of rating scales and subject to interpretation by the clinician and others (as with ADHD).
- Many times, the person's own verbal behavior directly impacts on the process of diagnosis and treatment, e.g., "I hear voices" or "I am often sad."
- It may be difficult to verify the extent to which an individual's description of their own behavior is accurate.

Measurement and diagnosis

- Reports by these other individuals are now "second hand" observations of the patient's behavior and are often plagued by imprecision, exaggeration, and outright confabulation!
- Even the DSM-IV (now V) used phrases like "often does not seem to listen to what is being said." How often is often?

Measurement and diagnosis

- Sometimes a person's family history figures into the formulation of a diagnosis, but this is either a verbal report by a relative of the individual about their own behavior (I suffer from bipolar disorder) OR a verbal report about the someone else's diagnosis.
- Family history of mental illness is subject to the same problems listed above, only it is difficult to verify the accuracy of prior diagnoses or verbal or written reports.

Another quote…

- "It is often said that diagnosis is an art, if so, it's a velvet painting of Elvis, not a "Mona Lisa.""

  ---Me (again)

- Even if diagnosis were much more precise, there would still not be any "tit-for-tat" medications that virtually always work with a particular diagnosis for this is not usually the case in the field of general medicine.

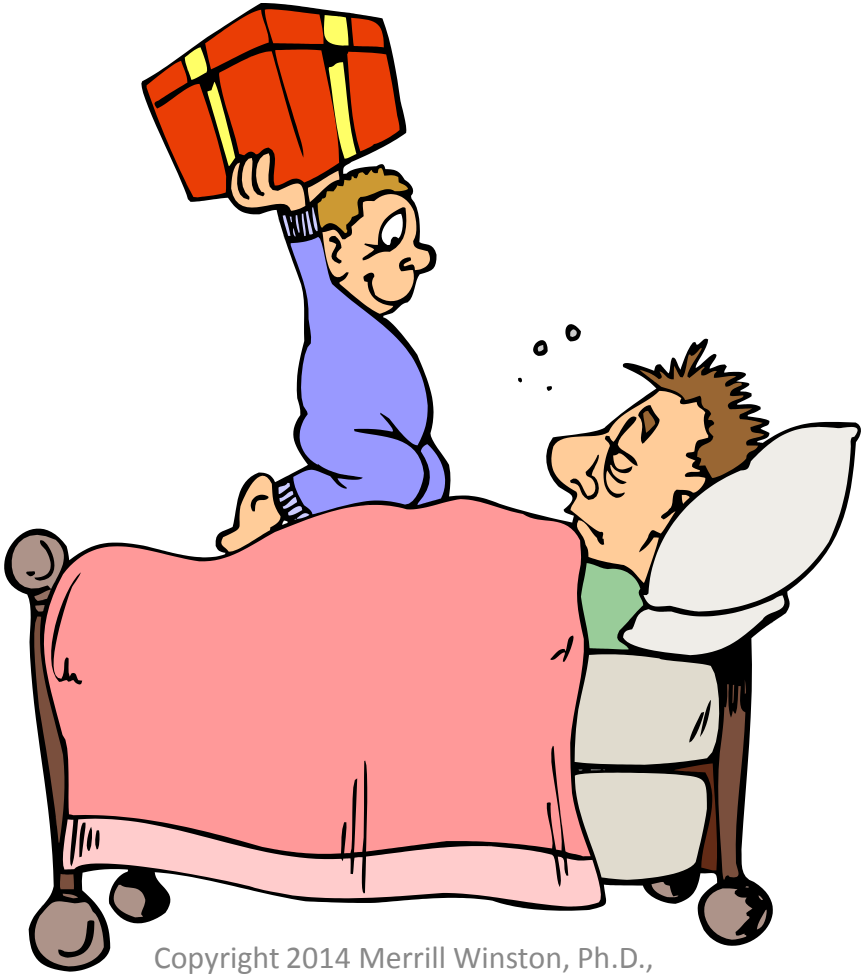
Tit for tat treatment….

- OCD
- ADHD
- Schizoaffective
- Social Anxiety

- Luvox
- Adderal
- Risperdal
- Zoloft

With 4 Diagnoses your 5th one is Free!!!

Morning Dysphoric Disorder (MDD)



Morning Dysphoric disorder (MDD)

- Symptoms occur upon awakening and include:
  - Irritability
  - Raspy voice
  - Sluggishness
  - Excessive Yawning
  - Extreme halitosis
  - Shuffling Gait
  - Feelings of despair (especially on Mondays)
  - Excessive sleepiness
  - Cognitive impairment
  - Flat affect
  - Alogia

Morning Dysphoric Disorder (MDD)

- Treatment of choice
  - 60mg caffeine in a hyper-thermic liquid suspension (taken orally)
  - Repeat dosage if necessary throughout morning

Diagnostic labels tend to generate rigid rule following

- One of the many problems with diagnoses is that they generate a tremendous amount of rule following
- Autism is a “thing” that you have
- Therefore one strategy that works for autism should be used for all children with the label
- Children with Autism are “visual learners” so they all need visual schedules because they all have the same label
- Children with Autism have “sensory issues”
- Children with Autism _____ (fill in)
- THERE ARE NO CHILDREN WITH AUTISM
- THERE IS **THIS CHILD** IN FRONT OF US RIGHT NOW WITH THE **SAME LABEL** AS CHILDREN WHO ARE VERY, VERY DIFFERENT FROM **THIS CHILD**

Diagnostic labels tend to generate rigid rule following

- Believing Autism is a “thing” that you have leads to all sorts of statements like:
- What treatment modality is best for Autism?
- What is the best Autism food?
- What is the best Autism classroom?
- Is it a behavior or just the Autism?
- What is the best Autism furniture? (www.autismfurniture.com) (I’m NOT kidding)

How should behavior analysts look at mental illness?

- If we can at least agree (regardless of hypotheses of etiology) that mental illness is diagnosed through behavior, on what then, specifically, are clinicians basing their diagnoses?
- All mental illness diagnoses appear to reflect (to varying degrees) the following sorts of "problems."

How should behavior analysts look at mental illness?

- Behavior that someone does, but should NOT do (often these are based on socially norms like lighting cats on fire).
- Behavior that someone does not do but that they should do. (smile when someone smiles at them) this is a behavior that they *could do* but simply don't.
- Behavior that is acceptable at nominal levels but that occurs too frequently (or not frequently enough).

Behavior that occurs too frequently…

- Q: What do you call someone who kills someone with a knife by stabbing them once?
- A: A murderer
- Q: What do you call an individual who kills someone with a knife by stabbing them eighty-seven times?
- A: A homicidal maniac with psychopathic tendencies
- Alternate answer: Very Thorough

How should behavior analysts look at mental illness?

- The class of behavior is appropriate for a given stimulus (verbal aggression when there is blocked access to reinforcement), but the magnitude or duration of the response is too great in relation to the stimulus. What is too great is generally determined by laws and/or social norms (context is king)
- Magnitude: Destroying the entire the room because no one saved any orange juice for you.

How should behavior analysts look at mental illness?

- Duration: Laughing for 10 minutes after hearing a joke that is only mildly amusing to most people.
- Remember, it's not the behavior itself, but the magnitude/duration of the behavior relative to the stimulus and relative to social norms.
- If you scream, swear and stomp your feet when your car breaks down in the middle of the expressway on the way to the most important job interview of your life, you're having a bad day!
- If you engage in the **same behaviors** when someone forgets to put the cap back on the toothpaste you've got *intermittent explosive disorder*.

How should behavior analysts look at mental illness?

- Sometimes it's a *stimulus control* problem, your laughing is not excessively loud nor long, but you laughed when someone told you that their dog got hit by a car (atypical responding).
- Sometimes a stimulus that should control a certain behavior produces a *very different behavior*, *no response* at all or a *very weak* response.
- Sometimes it may be a complete lack of a particular skill. The person does not show the behavior because it simply does not exist in their repertoire.

How should behavior analysts look at mental illness?

- Problems with *atypical reinforcers and aversives*. THESE ARE HUGE PROBLEMS!
- We might also speak of Neutralized Aversives and reinforcers
- If you love kittens and hate pain you're A-O.K., but if you hate kittens and love pain you've got some "issues!"
- Of course, if it doesn't interfere with work, home, vocation, cause restriction of freedom etc.. It should not be considered a bona fide "mental illness."

Categorizing disorders

- Here is a brief *technical* summary of some potentially useful categories for understanding different disorders and the commonalities between them.
- Most if not all of the disorders listed in the DSM-IV can be characterized by various combinations of the following problems:

Reinforcer/Aversive problems

- Atypical Reinforcers- Things that do not function as reinforcers for most individuals (personality disorders, anti-social).
- Atypical Aversives – Things that do not function as aversives for most individuals (phobias).
- Neutralized Aversives/Reinforcers – Things that previously controlled behavior but do not anymore.
- Reinforcer loss- Loss of potent reinforcers (precipitates some forms of depression)
- Introduction of severe one-time aversives or

Motivation problems

- Increased/decreased rate of behavior (implications for mania/depression)
- Increased/decreased duration
- Increased/decreased magnitude of response to a given stimulus

Stimulus Control Problems

- Changes in stimulus control exerted by private events. (Greater or poorer control or function altering effects)
- Changes in stimulus control exerted by public events. (Greater or poorer control or function altering effects)
- Chronic poor or absent stimulus control.
- Atypical responses

Repertoire problems

- Skill deficit (skill is totally missing)
- Poor skill development
- Skill Loss
- Reinforcement of aberrant behaviors
- Functional Impairment (how skill loss has affected the person's life)
- Verbal Behavior impairment (non-development or loss)

Unconditioned Responses/Reinforcer Problems

- Changes in eating
- Changes in sleeping
- Changes in sexual behavior
- General physiological disruption (increased heart rate, respiration, general arousal of the nervous system, as seen with “panic attacks”).

Some category notes…

- Note that for any of these categories we can be talking about either changes in status, or chronic problems that are present from birth or at least from very early ages.
- Chronic problems will most likely fall into one of the disorders of infancy and childhood e.g., If you stop talking at 21 you get the label schizophrenic If you never talked you get the label autistic or one of the other developmental disorders.

It's a matter of degree and context

- For any disorder in the DSM you can find smaller degrees of the primary symptoms in the general population
- One way to re-conceptualize these "disorders" is as normal behavior taken to an extreme
- You may be shy, but if you're PAINFULLY SHY you might have "social anxiety disorder"
- If a 4-year-old says he has an invisible friend that follows him everywhere it's cute…If a 40-year-old says the same thing it's disturbing

Degree and context

- If you believe that god spoke to you and told you to do good things, like build homes for the homeless then you are seen as a wonderful, deeply religious human being
- If you believe that god spoke to you and told you to kill all the non-believers then you are psychotic, schizophrenic, sociopathic, etc…
- It's not just that you believe that god is "speaking to you" for this is quite normal for the religious community (context). It's the behavior that (you say) God tells you to do that causes the problem

Degree and context

- If a child runs and yells and cheers and bounces off the walls on Christmas morning, it's just a Merry Christmas!
- If a child runs and yells and cheers and bounces off the walls on **most days**, it's time to go to the pharmacy and get that prescription for Concerta® filled again.
- If you killed 42 people, but you are a Navy Seal in Afghanistan, and those people were all "combatants" then you are proudly serving your country
- If you killed 42 people, who are not combatants and you are not a Navy Seal you're just in really really big trouble

Degree and context

- Sometimes it is not the degree or the context, but the **behavior itself** is primarily important. That is, there's never a proper context for putting a live kitten in the microwave, at least I hope there isn't.
- We all have bits and pieces of various "disorders" within our own repertoires, but they seldom grow in severity to the point that they disrupt social relationships, work, and activities of daily living.
- If you have excess stomach acid in your esophagus less than 3 times a week you have

How about a table?

- The following is a table that attempts to let the behavior analyst summarize the primary areas of concern with any presenting problem, irrespective of the actual diagnosis
- The table is based on the categorization scheme laid out earlier in this presentation
- The table is not based on facts or research, it is just a means of organizing and categorizing various kinds of problems to point the behavior analyst in some meaningful

	Motivation								SR+/Av.					Stim. Cont.			Repertoire						Physiological		
Disorder	Establishing Operations	Increased Rate	Increased duration	Incr. Magnitude of resp.	Abolishing Operations	Decreased Rate	Decreased Duration	Decr. Magnitude of resp.	Neutralized SR+/Av	Atypical Reinforcer	Atypical Aversive	Reinforcer loss	Introduction of Aversive	Changes in stim control by Priv. Ev*	Changes in stim. Contr. By Ext. Stim.	Chronic poor/absent stim. control	Skill Defecit (totally missing)	Poor Skill Development	Skill Loss	SR+ of Aberrant Behavior (social)	Functional Impairment	Verbal Behavior Impairment	Eating	Sleeping	General Physiological Disruption
Schizophrenia																									
Paranoid Type																									
Disorganized Type																									
Catatonic Type																									
OCD																									
Specific Phobia																									
Major Depressive Episode																									
Manic Episode																									
ADHD																									
inattention																									
hyperactivity																									
impulsivity																									
Intellectual Disability																									
Autistic Disorder																									

for example you normally might think about a conversation you had without talking out loud
but when hallucinating your observable behavior becomes consistent
with that behavior that is seen during a normal conversation with another person.
In essence the conditined hearing sets the occasion for different behavior