



# Challenges in the Differential Diagnosis of Mental Health Disorders

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# Learning Objectives:

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After attending this presentation, participants will be able to:

1. Explain the core characteristics of the most prevalent categories of mental health disorders, including: mood disorders, personality disorders, anxiety disorders, substance use disorders, and trauma-based disorders.
2. Articulate some of the hallmark features of and distinctions between the specific mental health diagnosis within the categories listed above.
3. Understand the various gold standard mental health diagnostic tools available to help identify and distinguish between the most common mental health diagnoses.

# What is Differential Diagnosis?

The process of distinguishing between two or more conditions that share the same or similar symptoms.

# Challenges in Differential Diagnosis

Ruling out Medical Diagnoses

Categorical vs Dimensional Models

Overlap of symptoms

Frequency of multiple

diagnoses/co-morbidity



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# Medical Diagnoses Masquerading as Mental Health

**Key Takeaway #1:** Be certain the client has a full medical examination *before* making a mental health diagnosis.

- Depression: low Vitamin D, thyroid issues, sleep apnea, chronic fatigue syndrome, Lyme disease, infections, brain injury
  - Anxiety: cardiac problems, diabetes, hypoglycemia, endocrine tumors
  - Psychosis: delirium, dementia, epilepsy, infections
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# 5 P's Approach to Formulation



Presenting Issues	Statement of the behaviours.
Precipitating Factors	Proximal external and internal factors that triggered the current presenting issue.
Perpetuating Factors	The internal and external factors that maintain the current behaviours.
Predisposing Factors	External and internal factors that increase the person's vulnerability to their current problems.
Protective Factors	The person resilience and strengths & factors that help maintain emotional well-being.

# Case Example 1

- 55-year-old female who has no history of mental health episodes referred to outpatient psychotherapy by her PCP:
  - Two acute episode of anxiety (e.g., shortness of breath, difficulty concentrating, shaking) followed by an intense urge to die.
  - The episodes were brief (minutes to hours), and she recovered from it very quickly. When outside of the episodes, she denies any discontent with her life and suicidal thoughts. These episodes terrify her.

# Case Formulation

Presenting Problem	See Left
Precipitating Factors	• ?
Perpetuating Factors	• ?
Predisposing Factors	• Family history of diabetes • Currently has uncontrolled blood sugar
Protective Factors	• No previous history of any mental health conditions or suicidality • Reports having a “good life”

# Case Example 2

- 22-year-old female presents to an inpatient mental health facility:
  - A recent history of sexual assault (w/1 past 6 months)
  - Significant mood swings and “catatonia.”
  - On cognitive evaluation is scoring in the mildly impaired range across multiple measures.

# Case Formulation

Presenting Problem	See Left
Precipitating Factors	<ul style="list-style-type: none"><li>• Sexual assault (?)</li></ul>
Perpetuating Factors	<ul style="list-style-type: none"><li>• Decline in self-care and independent functioning</li><li>• Unable to implement self-regulation strategies</li></ul>
Predisposing Factors	<ul style="list-style-type: none"><li>• Not had any treatment for trauma</li></ul>
Protective Factors	<ul style="list-style-type: none"><li>• No previous history of any mental health conditions</li><li>• Above average academic and intellectual functioning</li></ul>



# Categorical

Yes or no?

Present or absent?

You have something, or you don't.

Traditional light switch



- Pros:
  - Most suitable for disorders other than personality disorders
  - In a clinical setting, helps to easily determine if does or does not need treatment
  - Necessary way for multiple providers to communicate with one another with ease
- Cons:
  - Does anyone really have no personality?
  - DSM-5 does not account for the relative importance of symptoms
  - Description of symptom criteria very broad, makes agreement difficult
  - Does not capture individual differences in disorder presentation (especially culture)
  - High levels of comorbidity
  - Diagnostic thresholds may be arbitrary

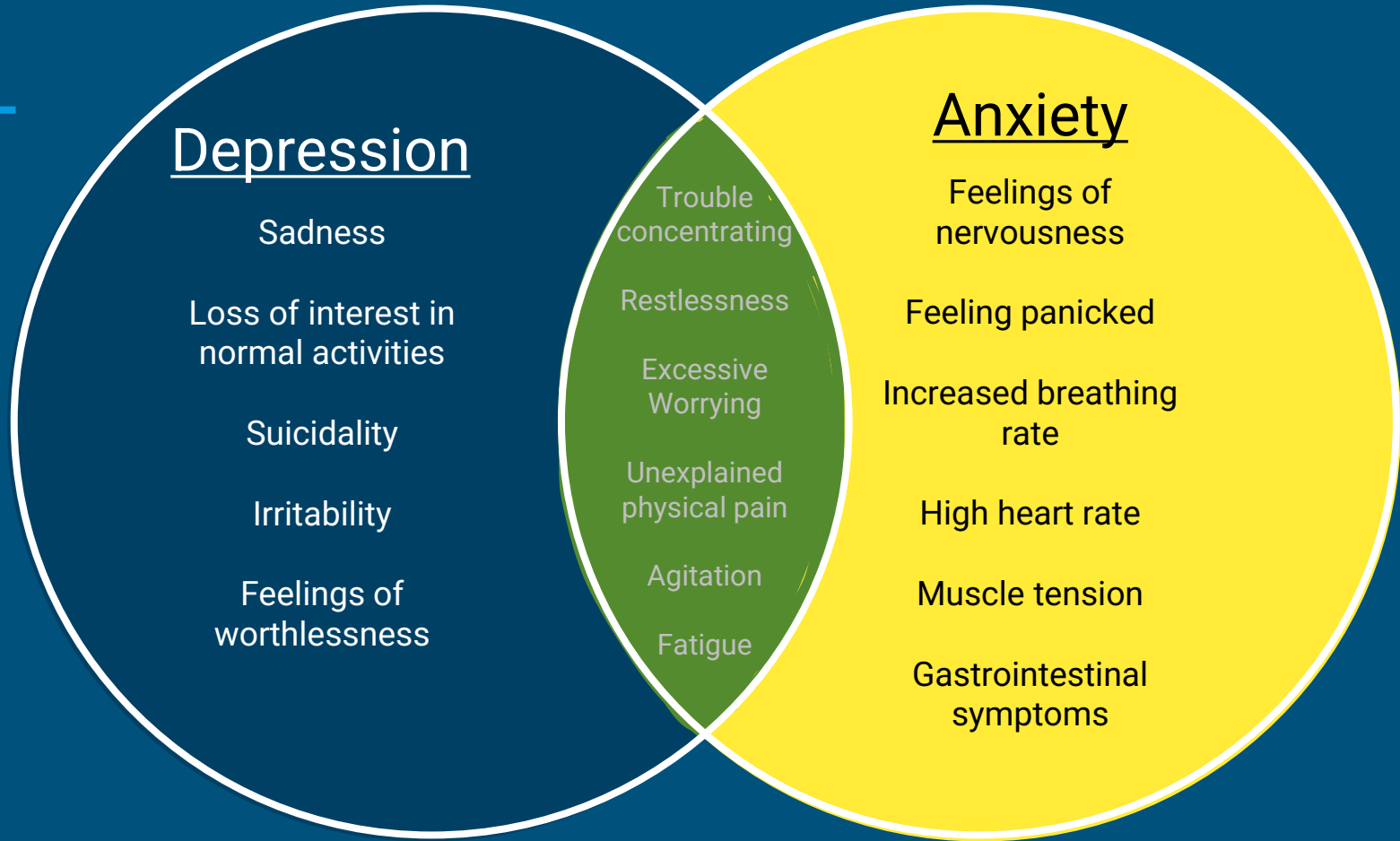
# Dimensional

Index or rank of disorder on a scale  
A light with a dimmer switch

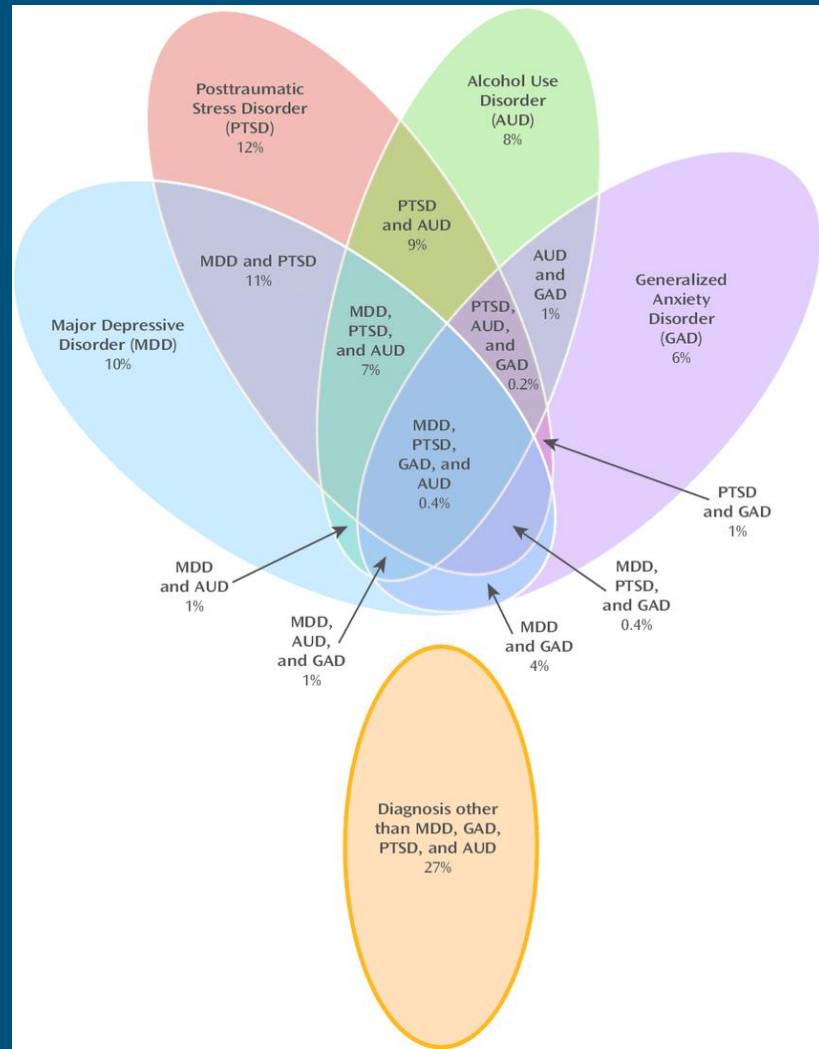
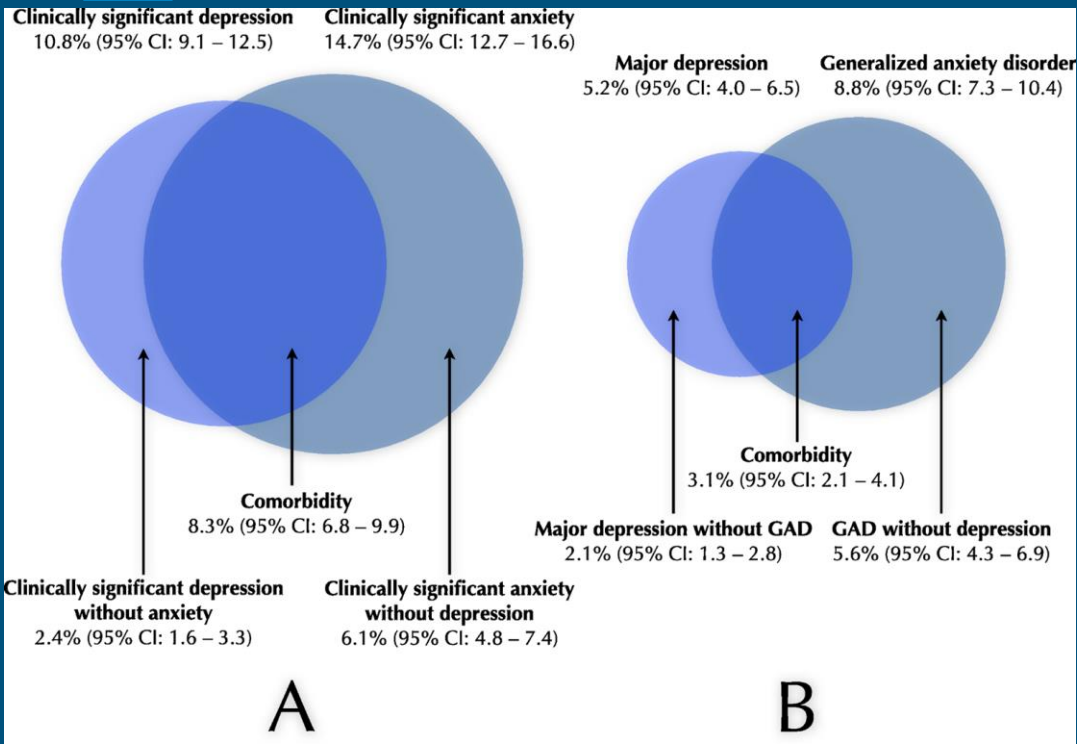


- Pros:
  - More accurately reflects the spectrum of personality presentations
  - Allows for individualization and specification in the assessment process
  - In a clinical setting, allows for consideration of full range, severity, and etiology of symptoms (Basically is a case formulation ,model)
- Cons:
  - Loses diagnostic simplicity
  - How many different dimensions do we need to consider? (Scientists will definitely argue about this)
  - Is there a diagnostic cutoff to establish the presence or absence of a disorder?

# Overlap of Symptoms



# Frequency of Multiple Diagnoses



# Prevalent Categories of Mental Health Disorders

## Mood Disorders

- Depression
- Bipolar Disorder

## Personality Disorders

- Clusters A, B, and C

## Anxiety Disorders

- Generalized Anxiety Disorder
- Panic Disorder
- Specific Phobias
- Social Anxiety Disorder
- Agoraphobia

## Substance Use Disorders

- Mild, Moderate, Severe

## Trauma-based Disorders

- PTSD
  - Acute Onset Disorder
  - Adjustment Disorder
  - Other Trauma and Stressor Related Disorders
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# Depression

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- Feelings of sadness, tearfulness, emptiness, or hopelessness.
- Angry outbursts, irritability or frustration
- Loss of interest or pleasure in most all or normal activities
- Sleep disturbances
- Tiredness and lack of energy
- Change in appetite and weight
- Anxiety
- Slowed thinking, speaking, or body movements
- Feelings of worthlessness or guilt
- Trouble concentrating, making decisions, and remembering things
- Thoughts of death or suicide
- Unexplained physical problems (ex: headaches)

# Bipolar Disorder

- Bipolar I and Bipolar II
- Mania and hypomania
  - Abnormally upbeat, jumpy, or wired
  - Increased activity, energy or agitation
  - Euphoria
  - Decreased need for sleep
  - Unusually talkative
  - Racing thoughts
  - Distractible
  - Poor decision making
- Major depressive episode
  - Depressed mood
  - Loss of interest and pleasure in activities
  - Significant changes in weight without dieting
  - Insomnia or sleeping too much
  - Restlessness or slowed behavior
  - Fatigue and loss of energy
  - Feelings of worthlessness

# Personality Disorders

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Cluster A	<b>odd, eccentric thinking or behavior</b>	<ul style="list-style-type: none"><li>● Paranoid Personality Disorder</li><li>● Schizoid Personality Disorder</li><li>● Schizotypal Personality Disorder</li></ul>
Cluster B	<b>dramatic, overly emotional or unpredictable thinking or behavior</b>	<ul style="list-style-type: none"><li>● Antisocial Personality Disorder</li><li>● Borderline Personality Disorder</li><li>● Histrionic Personality Disorder</li><li>● Narcissistic Personality Disorder</li></ul>
Cluster C	<b>anxious, fearful thinking or behavior</b>	<ul style="list-style-type: none"><li>● Avoidant Personality Disorder</li><li>● Dependent Personality Disorder</li><li>● Obsessive-Compulsive Personality Disorder</li></ul>

# Case Example 3

- Kevin is a 40-year-old male who presented for treatment with complaints of:
  - Breakup of primary relationship about 18 months ago
  - First hospitalization for suicidal ideation with intent about 1 year ago
  - Periods of intense, negative affect in response to relational ruptures, particularly in intimate relationships
  - Binge-like episodes of alcohol, cannabis, and sometimes other substances
  - Expression of existential concerns (e.g., desire for partner, uncertain about profession, purpose of life) accompanied by intense expressions of affect
  - Periods of intense anxiety and panic attacks that are debilitating and lead to problematic coping

# Case Formulation

Presenting Problem	See Left
Precipitating Factors	<ul style="list-style-type: none"><li>• Breakup of relationship</li><li>• Suicidality 6 months later leading to psychiatric hospitalization</li></ul>
Perpetuating Factors	<ul style="list-style-type: none"><li>• Dissatisfaction at work</li><li>• Intermittent use of multiple substances</li><li>• Poor sleep habits</li><li>• Pattern of recent, intense romantic relationships</li></ul>
Predisposing Factors	<ul style="list-style-type: none"><li>• Paternal history of bipolar disorder</li><li>• History of moderate cannabis use intermittently since college</li><li>• Parents divorced in adolescence</li></ul>
Protective Factors	<ul style="list-style-type: none"><li>• High academic achievement and job performance</li><li>• Lack of previous psychiatric hospitalizations</li><li>• Strong family support system</li></ul>

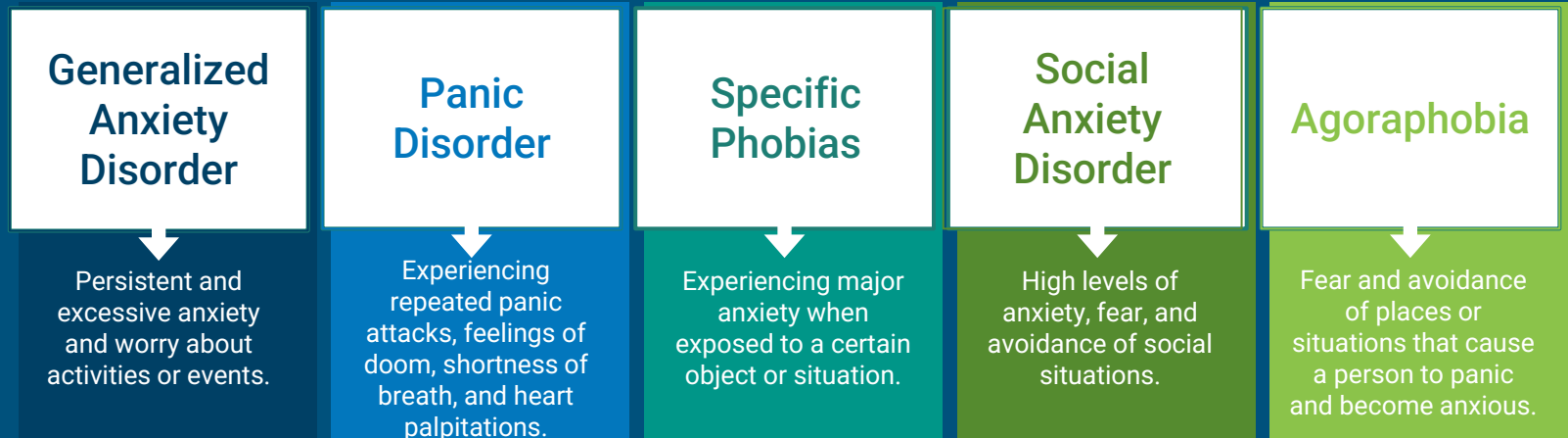


# Anxiety Disorders

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There are many types of anxiety disorders.

They are different, but share symptoms such as: feeling nervous, restless, or tense and uncontrollable worry.



# Substance Use Disorders

Regardless of the substance, a person's disorder can be classified as mild, moderate, or severe.

## DSM-5 Criteria for Substance Use Disorder

Criterion	Severity
Use in larger amounts or for longer periods of time than intended	Severity is designated according to the number of symptoms endorsed: 0-1: No diagnosis 2-3: Mild SUD 4-5: Moderate SUD 6 or more: Severe SUD
Unsuccessful efforts to cut down or quit	
Excessive time spent using the drug	
Intense desire/urge for drug (craving)	
Failure to fulfill major obligations	
Continued use despite social/interpersonal problems	
Activities/hobbies reduced given use	
Recurrent use in physically hazardous situations	
Recurrent use despite physical or psychological problem caused by or worsened by use	
Tolerance	
Withdrawal	

*SUD, substance use disorder*

*Adapted from Diagnostic and Statistical Manual of Mental Disorders, fifth edition.<sup>23</sup>*

# Trauma Disorders

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## PTSD

- Intrusive memories
- avoidance
- negative changes in thinking and mood
- changes in physical and emotional reactions

## Acute Onset Disorder

“Development of specific fear behaviors that last for 3 days to 1 month after a traumatic event.” (DSM-V)

## Adjustment Disorder

- Experiencing more distress than what is expected to a specific event or stressor.
- Disruption to normal activities and functioning
- Symptoms usually last less than 6 months after onset.

## Other Trauma and Stressor Related Disorder

- For when we know a trauma or stressor is impacting functioning, but doesn't meet the criteria above.

# Case Example 4

- Bradley was a 40-year-old male who presented for treatment with complaints of:

# Case Formulation

Presenting Problem	See Left
Precipitating Factors	<ul style="list-style-type: none"><li>Breakup of primary relationship, resulting in loss of housing</li></ul>
Perpetuating Factors	<ul style="list-style-type: none"><li>Moved back home with his family</li><li>Began drinking heavily and lost his job</li></ul>
Predisposing Factors	<ul style="list-style-type: none"><li>Repeated mental health hospitalizations starting his 20's</li><li>Emotionally abusive father</li></ul>
Protective Factors	<ul style="list-style-type: none"><li>Mother</li></ul>

# Gold Standards for Diagnostic Assessment

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- **Structured Clinical Interview for the DSM-5 (SCID)**
  - Has a screening tool that assesses for all the most common disorders
  - Anything that screens positive is assessed further through detailed modules
  - They have several different version of the SCID that can assess for different things:
    - SCID-CV assesses for major clinical syndromes
    - SCID-PD assesses for personality disorders
  - Requires significant training
  - Can be time consuming to administer
  - Has very good validity and reliability