Chapter 3

CLASSIFICATION OF MENTAL DISORDERS

This chapter gives a bird's eye view of mental disorders, and introduces a system of classification. The purposes of classification, that is, the putting of apparently related items into categories (boxes) is to simplify large amounts of complicated information, and improve communication.

In Chapter 1, mention was made of the two main systems of classification of mental disorders (DSM and ICD). These systems arrange lists of mental disorders under a number of major headings (22 in the case of DSM5 and 9 in the case of ICD-10).

DSM5 and ICD-10 have acceptable reliability, but do not guide treatment. They are 'descriptive' (where internal medicine was in the 19th century). Francis (2009) says 'it would be wise for us all to accept that descriptive psychiatry is a tired old creature'. In the future, we may perhaps make diagnoses using objective means such as genetics and neuroimaging.

Others have emphasised the importance of a method of diagnosis based on etiology. McHugh (2005) describes an etiological diagnostic system of 4 clusters: 1) "brain disease", in which there is disruption of neural underpinnings (e.g., schizophrenia and melancholic depression), 2) "vulnerability because of psychological make-up" (e.g., sensitive individuals and the personality disorders), 3) the adoption of behaviour "that has become a relatively fixed and warped way of life" (e.g., alcoholism and anorexia nervosa), and 4) "conditions provoked by events that thwart or threaten" (situational anxiety and PTSD).

In this chapter a simplified classification system is presented. The mental disorders have been arranged under the following headings: "psychotic", "mood", "non-psychotic", "personality" and "organic mental disorders". A related classification is "substance use disorders". There has been debate as to whether substance use disorders are social or behavioural problems, or mental disorders. Currently they are included as mental disorders in DSM5 and ICD-10. However, in many jurisdictions, services are provided by separate, specialized treatment teams.

Psychotic Disorders
- Schizophrenia
- Delusional Disorder

Mood Disorders
- Bipolar Disorder
  (mania and depression phases)
- Cyclothymic Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder

Non-Psychotic Disorders
- Anxiety Disorders
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Phobic Disorders
- Obsessive Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Feeding and Eating Disorders
- Somatic Symptom and Related Disorders

Personality Disorders
- odd and eccentric
- anxious and fearful
- dramatic and emotional

Neurocognitive Disorders
- Delirium
- Major Neurocognitive Disorder (Dementia)
- Mild Neurocognitive Disorder

Substance-Related and Addictive Disorders
- Intoxication and psychosis
- Withdrawal

Gambling Disorder

T

Th
la
co
po

The main data the psychiatrist has is the appearance and behaviour of the patient and the words he or she uses to describe thoughts, feelings and other experiences. Other data comes from physical examination by which various medical conditions which may at first appear to be mental disorders, such as Huntington's disease or multiple sclerosis, and from psychological tests of memory and concentration, which help to identify organic mental disorders.

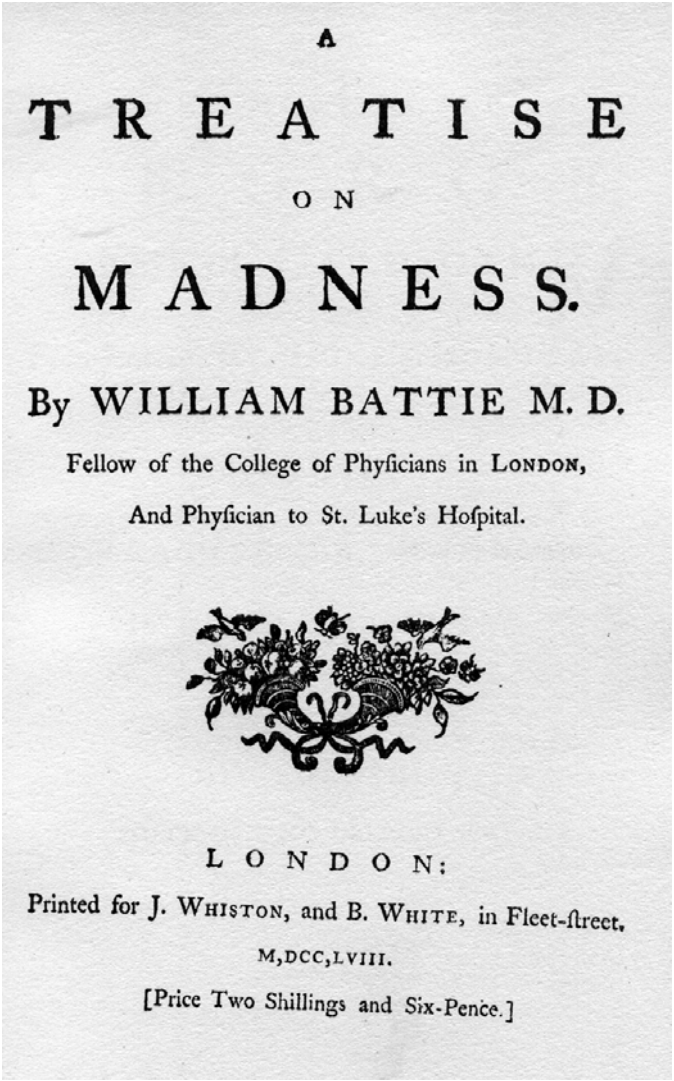
Madness

Madness was one of Shakespeare's favourite words. The English Dictionary offers three meanings. They are all in current use and this can cause misunderstandings. One meaning is senseless folly – as when the two young, unsuited, incompatible people have a wild love affair. Such undue enthusiasm appeared in the newspaper headline: "US Mad About Harry Potter".

Another meaning has to do with anger, as when the fathers of the young people mentioned above discover the affair, splutter, cancel credit cards and talk of rewriting wills etc. A bumper sticker used the angry meaning: "Cigarette companies – the truth will make you mad!" A recent newspaper headline used the word in describing a famous murder-suicide, which is believed to have been an angry outburst.

Illustration. Headlines in newspapers, dubbed Crown Prince Dipendra of Nepal, "The Mad Crown Prince". He is here holding the rifle he used to kill his mother, father, seven other royal relatives and himself. He wanted to marry a woman who was unacceptable to his parents. He was caught between two cultures and addicted to alcohol and illegal drugs. His murder-suicide was senseless and imprudent, it almost certainly involved anger and he may well have been mad (psychotic) due to the effects of illegal drugs. While there is some evidence that he Crown Prince Dipendra had suffered depression in the past, but there was no evidence that he was depressed at the time of the deaths, or that he had ever suffered a psychotic disorder.

The third meaning has to do with mental disorder. However, in this field, 'madness' has never been defined. It last appeared in medical books over a century ago. It had been used interchangeably with the words, delusion, delirium and mania. These words currently have separate and distinct meanings. Thus, madness has no precise meaning in either common English or medical lexicons.



A

TREATISE

ON

MADNESS.

By WILLIAM BATTIE M. D.

Fellow of the College of Phyſicians in LONDON,

And Phyſician to St. Luke's Hoſpital.

LONDON:

Printed for J. WHISTON, and B. WHITE, in Fleet-ſtreet.

M,DCC,LVIII.

[Price Two Shillings and Six-Pence.]

Illustration. Title page of a medical treatise on "madness", published in 1758. The author was a Dr Battie. In the recent past a person with serious mental disorder was colloquially described as "Bats" or "Batty" – which was a short form of saying the individual had "Bats in the belfry". Did this derive form Dr Battie?

For mental health professionals, 'mad' is sometimes used as a slang (picturesque, unconventional) word, roughly interchangeable with the term psychotic.

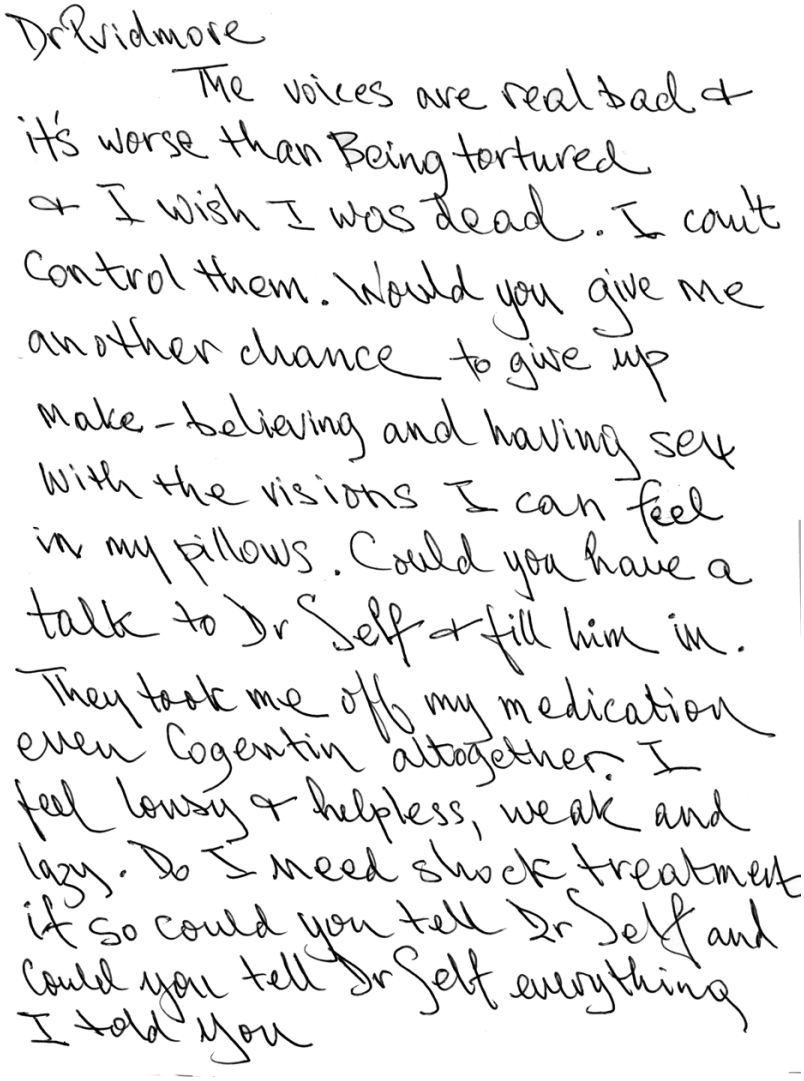
Psychotic disorders

The term psychotic describes particular symptoms, disorders and individuals. It is a term with many nuances.

Psychotic symptoms indicate a "loss of contact with reality", for example, when the individual believes something which has no basis in reality (delusions) or hears voices when no one has spoken (hallucinations).

However, similar symptoms can occur in healthy people. For example, some healthy people regularly hear their name called just as they are falling to sleep. These are called hypnagogic hallucinations. By definition, these people do hallucinate, but in the absence of additional symptoms, they are not suffering a psychotic disorder and cannot be described as being psychotic.

Illustration. This was written by a young Christian man who developed schizophrenia and began to believe that Satan had taken control in Heaven. He had not decided to change his religion, that is, he had not become a devil worshiper, and he was distressed by his new belief. Given this man's personal history and cultural group, this belief (that Satan had taken control in Heaven) was a delusion.
There is also thought slippage here. This man despised Satan, and it is unlikely that he would wish to apply the words "but beautiful" to him/her. It is probable that when he thought of heaven, he thought about the attributes of God, and stayed on that line of thinking while writing about Satan.


Dr Pridmore

The voices are real bad & it's worse than Being tortured & I wish I was dead. I can't Control them. Would you give me another chance to give up make-believing and having sex With the visions I can feel in my pillows. Could you have a talk to Dr Self & fill him in. They took me off my medication even Cogentin altogether. I feel lousy & helpless, weak and lazy. Do I need shock treatment if so could you tell Dr Self and Could you tell Dr Self everything I told you

Illustration. This letter was written by a man with schizophrenia. He had once been a patient of the author, but had not been seen by him for some years. He had been in a psychiatric hospital under the care of Dr Jeff Self. The patient writes that his hallucinations (voices) are worse than being dead or tortured.

For years he had experienced visual hallucinations of attractive women. He writes about having sex with his visions which he can "feel" in his pillows. It is very difficult to classify the information that he is having sex with his visions. If it is not possible to have sex with visions, then this is a false belief and could be classified as a delusion.

But, was this man having visual hallucinations of himself having sex with the attractive women who appeared in his earlier visions? Insufficient details are available about his experience for firm conclusions to be reached. This patient had difficulty with logical thought, so he was unable to describe things better, even when specifically asked.

By convention, **psychotic disorders** are those in which there are psychotic symptoms, PLUS significant impairment of the capacity to function effectively in everyday life. It is possible to have a mental disorder, and a psychotic symptom, but not to have a greatly reduced capacity to function in everyday life. Thus, it is possible to have a psychotic symptom without having a fully developed psychotic disorder.

Consider a person who has suffered an acute psychotic disorder, who with treatment has returned to work and normal life, but who still hears a voice a few of times a day. This person may have full insight, meaning that he or she knows this 'voice' is an hallucination and recognises the need for ongoing treatment. Such an individual experiences occasional psychotic symptoms, but the full psychotic disorder is in remission, and he/she would not be described as being psychotic.

Consider a person with anorexia nervosa who purposefully restricts food intake and exercises excessively because of a fear of being fat, who is emaciated to a dangerous degree, but who nevertheless believes he/she is overweight. By strict criteria, this person is experiencing something at least very similar to a delusion. Further, when such patients see themselves in a mirror, they frequently "see" themselves as fat, a phenomenon which suggests mistakes of perception. This condition is often disabling (although, some people with anorexia nervosa can perform rewarding work and maintain stable relationships). In spite of apparent "delusions" and mistakes of perception, and some reduction in the ability to conduct a social and working life, by convention, anorexia nervosa is not classified as a psychotic disorder, and patients suffering this condition are not described as psychotic. (Mountjoy et al, 2014, raise questions on this point.)

As there may be some confusion, let us briefly consider the most common "psychoses", or psychotic disorders. These are schizophrenia and delusional disorder.

Schizophrenia is the archetypal psychosis. The symptoms of this disorder include hallucinations, delusions, reduced ability to think logically (thought slippage), behavioural signs such as the holding of bizarre postures, the loss of the ability to experience emotions and spontaneity, social withdrawal, and personal neglect. During acute episodes, hallucinations, delusions and thought slippage are the most prominent symptoms. With treatment or natural remission these symptoms are less prominent and the loss of spontaneity, social withdrawal and personal neglect become more noticeable.

Delusional disorder, in contrast, only manifests (one or more) delusions. Usually the delusion is of a paranoid type, and the patient believes he/she is being watched and is in danger from spies, organised crime, etc. The patient may be able to work and appear normal to others. As there is only one symptom and the patient may appear to function reasonably well outside the home. However, in most instances, the individual's life is severely damaged by this disorder. Suspiciousness or frank delusions result in conflict at work and the patient is usually finally placed on some form of pension. The social life is also severely impaired, the patient eventually withdrawing to live behind reinforced doors with an array of locks, in a state of constant apprehension.

Mood disorders

The Oxford English Dictionary defines mood as "1, a particular sate of mind or feeling, and 2, a prevailing feeling, spirit or tone". Thus, feelings are the central issue, and under this heading one might expect to include fear, jealousy or love. However, from a clinical perspective, the term 'mood disorders' usually refers to conditions in which the prominent feeling of sadness or elation.

Bipolar disorder (once called manic-depressive psychosis) is the most dramatic form - characterised by mood elevated (manic) and lowered (depressed) phases. These phases may last for months or even become chronic. For a given patient, swings may predominantly occur in one direction, alternatively, about equal numbers of swings may occur in each direction. In the **mood elevated phase** the patient is often over confident, grandiose, irritable and disinhibited, with rapid thoughts, reduced need for sleep and abundant energy. Delusions may occur about possessing exceptional importance or skills; hallucinations (often of being spoken to by God or adoring others) less commonly occur. In such cases the term 'psychotic' is appropriate – illustrating the difficulty of trying to divide the severe mental disorders into separate "psychotic" and "mood disorder" categories.

In **depressed phases** the mood and energy are low, thinking is slowed and the ability to concentrate is reduced. Sleep is disrupted, the patient often waking in the early hours and unable to return to sleep. There is loss of interest in food, sexual or any other activity, and weight loss is a frequent feature. In severe cases, the individual may develop delusions (usually of being guilty of something), in which case the term 'psychotic' is appropriate.

The patient in a manic phase is clearly acting out of character, and with mood elevation as a springboard, problems arise when patients engage in risky behaviour such as unwise investments, fast driving, ill-advised sexual liaisons or audacious activities.

The patient in a depressive phase may also act out of character, becoming inactive and withdrawn. However, not infrequently, the patient thinks about death and regrettably, suicide is more common among significantly depressed individuals than among the healthy population.

Major depressive disorder or unipolar depression is the term applied when severe episodes of depression occur, but the individual has never experienced a manic or hypomanic episode.

There are also less severe mood disorders. **Cyclothymic disorder** manifests both depression and elevations, but severity is insufficient for the diagnosis of bipolar disorder. **Persistent depressive disorder** is a chronic condition of depressed mood; this may indicate a major depressive disorder which has incompletely resolved, or a long term condition which has never reached the diagnostic criteria for major depressive disorder.

Non-psychotic disorders

The non-psychotic disorders are, in general, what Freud referred to as the **"neuroses"**. A mixed bag of conditions. The symptoms of the psychotic disorders such as hallucinations and delusions are largely unknown to healthy individuals. However, the symptoms of the non-psychotic disorders are known to us all, at least to some degree. These include anxiety, which is similar to worry and fear - in a mild form, this is familiar to everyone who has taken an exam or been out on a first date.

Generalized anxiety disorder is characterised by continuous, unprovoked anxiety. **Panic disorder** is characterized by sudden attacks of extreme anxiety during which the patient may struggle to get enough air, feel the heart thumping as if to burst, and fear that he/she may collapse or die. The **phobic disorders** (or phobias) are characterized by episodes of anxiety which is out of proportion to the danger of a particular situation. In **agoraphobia**, anxiety is triggered by the thought of leaving the home, and this may worsen if the home is left. In **special phobias**, anxiety increases at the thought of meeting a feared, specific agent or circumstance (spiders or lifts, for example), and life may be disrupted by the steps taken to avoid those agents or circumstances.

Obsessive-compulsive disorder (OCD) is a curious, disabling condition. **Obsessions** are repetitive thoughts which make no sense. Patients (usually) accept that these are their own thoughts, but are unable to stop them. For example, the patient may have the irrational and unwelcome thought that his/her hands are contaminated by dirt or germs, alternatively, the patient may be dogged by the irrational thought that he/she "killed God". The patient is distressed by the loss of control and the "silliness" of his/her thought. **Compulsions** are repetitive actions or urges in which the patient engages. Sometimes the compulsions relate to obsessions, as when the thought is that the hands are dirty and so the hands must be washed. But the compulsion may be that the hands must be washed 10 times, when washing once would be enough. In other cases, compulsions may have no relationship with obsessions, as for example, when the patient feels anxious or uncomfortable until something is performed "correctly"; it may be that when walking into a room, night or day, the light switch must be flicked a certain number of times.

The **Trauma- and Stressor-Related Disorders** include the well-publicised **Post traumatic stress disorder (PTSD)** which follows exposure to a traumatic event, particularly protracted traumatic events such as involvement in war, but sometimes following briefer, severe stress, such as rape.

The **Feeding and Eating Disorders** is a puzzling group of conditions, the best known being anorexia nervosa and bulimia nervosa. In **anorexia nervosa** there is purposeful weight loss through restriction of eating, excessive exercise and sometimes purging and vomiting. In spite of emaciation and threat to life, there may be the conviction of being fat, which cannot be dispelled by the use of scales, mirrors or photographs. In **bulimia nervosa** there are episodes of binge eating and compensatory behaviour to prevent weight gain, such as purging and vomiting.

The **Somatic Symptom and Related Disorders** present with somatic symptoms associated with significant distress and impairment. They include conditions in which there are physical symptoms, such as pain, limb paralysis or anaesthesia, or the unjustified fear that one has a disease, in the absence of organic (physical examination and imaging) findings. These conditions are more commonly encountered in primary care and other medical settings than in psychiatric practice.

Personality disorders

Personality has been described as the predictable responses of the individual to the environment (other people and the world in general). If we know people well, we know what they like and dislike, how far we can rely on them in tough times, whether they spend or save their money, in short, we know their personality (characteristic responses).

Personality disorder is present when features of the personality (responses) cause subjective distress to the individual or significant impairment in his/her social or occupational function. Impaired social or occupational function involves others, thus, personality disorder frequently causes distress to the individual and frequently, to those associated with the individual.

There are three groups of personality disorders, 1) an odd and eccentric group in which a prominent feature is the absence of close relationships, 2) an anxious and fearful group in which a prominent feature is self doubt, and 3) a dramatic, emotional and erratic group in which prominent features are stormy relationships and sudden excessive anger.

Neurocognitive Disorders

Major Neurocognitive Disorder (Dementia) is characterized by prominent cognition (memory and intelligence) symptoms. There may also be hallucinations, delusions and mood changes.

Substance use disorders

The essential feature s**ubstance use disorder** is the cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Different substances are associated with different symptom profiles. The DSM5 focuses on intoxication and withdrawal states, and with some substances, persisting neurocognitive disorder.

Problems include the immediate effects of acute intoxication (including psychosis), and longer term effects of addiction, withdrawal states and physical damage (including brain damage).

Acute intoxication with alcohol may result in aggression or dangerous driving. Symptoms of distorted reality, including visual hallucinations and distortion to time are the desired effects of those taking "hallucinogens" such as LSD. Drug induced psychotic disorders are not sought after, but are common with amphetamine use. They feature delusions and auditory hallucinations and may persist for days after the drug has been ceased.

With frequent drug use, **tolerance** develops. This means that the body adjusts to the effect of the substance and greater quantities are needed to produce the same effect. When this adjustment has occurred, the body may "need" the substance to function roughly normally, and withdrawal symptoms (sweating, trembling, body pain) may occur when the drug is not taken. Withdrawal states, particularly with alcohol, may include disorientation (being unaware of the time and place), inability to concentrate and understand what is happening in the environment, and hallucinations (particularly seeing spiders, snakes and other scary creatures).

Physical damage to body and brain results from the toxic effect of the substances and/or nutritional neglect. Using alcohol as an example, the toxic effects lead to liver failure and the nutritional neglect (vitamin B deficiency) leads to irreversible brain failure (dementia).

In addition, substance abuse leads to mood and sexual problems, destruction of the family, loss of employment and income, and legal problems. The police become involved because of violence or driving offences during the intoxication phase, or due to theft, prostitution or drug dealing, as the user needs to raise money to support the habit.

Categorical and Dimensional Systems

The current diagnostic systems are descriptive and categorical (they place conditions/disorders into categories/boxes which are distinct from normality). This is suitable for schizophrenia (hallucinations, delusions and thought slippage are distinct from normal). However, some disorders such as generalized anxiety disorders have features which are continuous with normality (we all have some anxiety from time to time, and some have it continuously, but not at the level sufficient to make a diagnosis). Thus, a case can be made that some mental features should be graded dimensionally – that is, along a spectrum (for example, we would all sit somewhere along the anxiety dimension/spectrum).

There was speculation that DSM5 would provide a 'hybrid' model for the diagnosis of personality disorder, which would include both categorical and dimensional components (First, 2011). When published, DSM5 retained the previous categorical system. However, an **Alternative DSM5 Model for Personality Disorders** - a proposed research model of personality was also presented – with a view to moving further in this direction in the future. The suggested dimensions include, **Identity, Self-direction, Empathy** and **Intimacy.**

Strong criticisms of the DSM5 has been expressed (Frances, 2013).

References

First M. The problematic DSM-5 personality disorder proposal: options for plan B. Journal of Clinical Psychiatry 2011; 72:1341-1343.
Frances A. Saving Normal. New York: HarperCollins, 2013.
McHugh P. Striving for coherence: psychiatry's efforts over classification. Journal of the American Medical Association 2005; 293:2526-2528.
Mountjoy R, Farhall J, Rossell S. A phenomenological investigation of overvalued ideas and delusions in clinical and subclinical anorexia nervosa. Psychiatry Res 2014; 220: 507-512.