Chapter 3

CLASSIFICATION OF MENTAL DISORDERS

Mention was made in Chapter 1 that there is no clear, useful **definition of mental disorder.**

The WHO offers**: "Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others."**

The National Institute of Mental Health Strategic Plan (USA) offers the more promising, **"Mental illnesses are brain disorders expressed as complex cognitive, emotional and social behavioural syndromes".**

Why we need a Diagnosis/Classification System

The purpose of classification is to increase homogeneity and the validity of categories. Homogeneity facilitates communication leading to better science – it also means that a treatment which is effective in one disorder in a category will likely be effective across other disorders in that category.

The need for the current elaborate diagnostic system arises because psychiatry still lacks objective tests (blood tests, imaging etc). Now, when tests are used, the aim is to exclude 'organic' conditions, such as brain tumour, which may present with psychiatric features.

The current interview bases diagnosis/classification system has been described as a bridge between the clinic and research (Mitropoulos, 2018).

The Basis of Diagnosis/Classification

Proposed bases for categorization:

1. **Clinical description.** This method has been used for decades in DSM and ICD.
2. **Aetiology**. 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).
3. **Empirical data from genetics and neuroscience** (including neuroimaging).

Categorization vs dimensional approach to personality – historically DSM and ICD had used the **'categorical approach'** – using boxes – this accords with the clinical description approach (a patient goes in the 'borderline personality disorder' box or perhaps the 'avoidant personality disorder' box).

The **'dimensional approach'** has been discussed for more than a decade – it holds that personality features such as 'detachment' (the tendency to maintain social and interpersonal distance from others) - can be better described by using the 'degree' to which the feature is present rather than a categorical present/absent statement.

Leading Diagnostic Systems

As mentioned in Chapter 1, there of the two main systems of classification of mental disorders –

1. The Diagnostic and Statistical Manual - 5th Edition (DSM-5) (Developed by the American Psychiatric Association -released 2013).
2. International Classification of Disease -11th Edition (ICD-11) (Developed by the World Health Organization – released 2018).

Satisfaction with the Leading Diagnostic Systems

Satisfaction with the recent editions of DSM (-5) and ICD (-11) is low. Diagnostic validity has not been achieved (Mitropoulos 2018). It was not possible to move to aetiologically based or a genetic/neuroscience based system – because we do not yet possess enough knowledge to guide such a change.

"We know little about the aetiology of mental disorders…that's why we are stuck with our diagnostic categories." (Crocq, 2018)

The DSM-5 has been harshly criticised as the introduction of the dimensional approach to personality disorder was abandoned. However, the more recently released ICD-11 did deliver this approach (Tyrer et al, 2018; reed et al, 2019).

Other Diagnostic Systems

There are other diagnostic systems – mentioned here for the sake of completeness. These include, 1) Latin American Guide to Psychiatric Diagnosis – written in Spanish, 2) French Classification of Mental Disorders, and 3) the American Research Domain Criteria (RDoC). The RDoC is not a diagnostic system (at this stage) but a framework for organizing research, however, the aim is to eventually provide a classification system based on empirical data from genetics and neuroscience.

A Simplified System

The DSM-5 arranges the mental disorders under 22 major headings – the ICD-11 arranges the mental disorders under 21 separate headings.

Both are complicated – and some experienced clinicians have found them difficult.

A simplified system is offered. It was devised by the current author, who is responsible for its failings. The disorders are arranged under: "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-11. 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
- Amnesia
- Dementia

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

Other New Disorders (Not covered in this essay)
- Gambling disorder
- Paraphilic disorder
- Impulse control disorders

Table. A simplified classification system

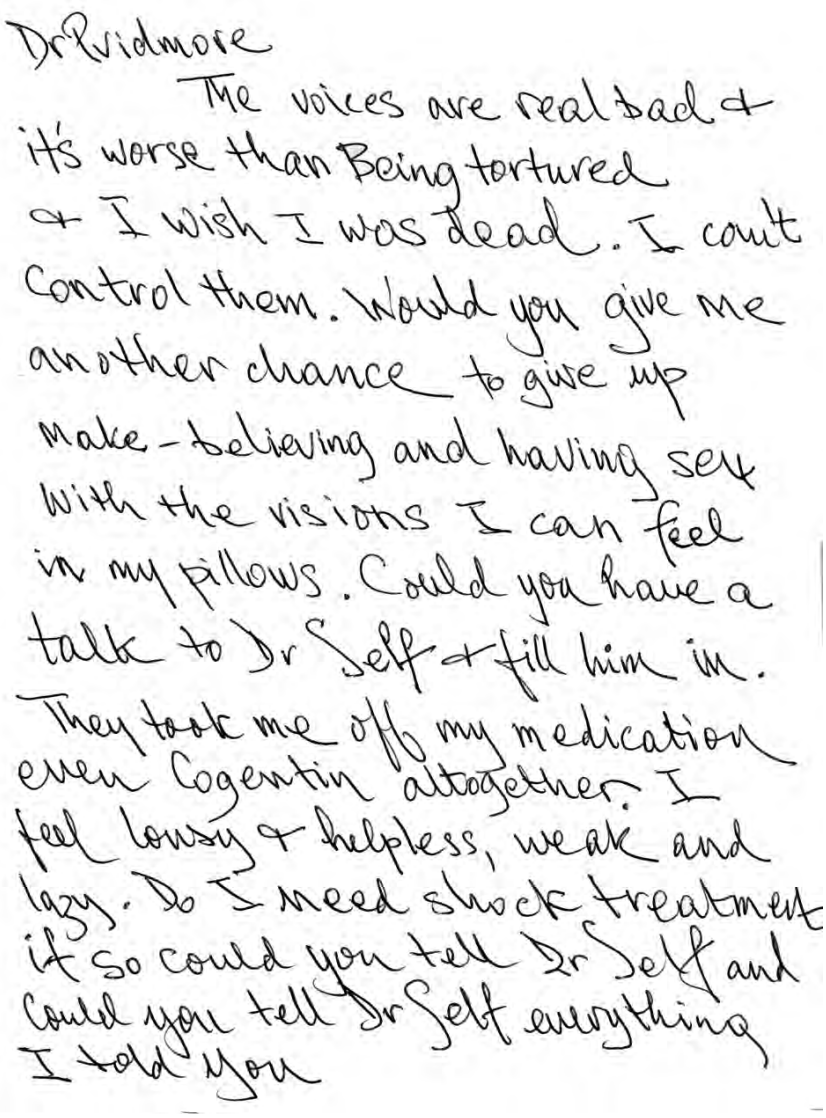
Psychotic disorders

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 are not described as psychotic.

In some psychotic disorders (particularly schizophrenia, but also mania) the individual's thoughts become disconnected from each other – there is thought slippage and the logic is difficult to follow.

Illustration. This was written by a young Christian man who developed schizophrenia and began to believe that Satan had taken control in Heaven. Given his 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.

P**sychotic 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 week. This person may have full insight, meaning that he/she knows this 'voice' is an hallucination and recognises the need for ongoing treatment. Such an individual experiences occasional psychotic symptom, but the full psychotic disorder is in remission, and he/she is not described as 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 are capable of rewarding work and maintain stable relationships). Despite 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.)

The most common psychoses, or psychotic disorders are **schizophrenia** and **delusional disorder**. **Mania** involves high elevation of mood and may have psychotic symptoms (hallucinations, delusions and thought slippage) – but, it is generally placed under the heading of mood 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 more 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 often 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

While fear and love might be considered moods, clinically, "mood disorders" is usually restricted to conditions in which the prominent feeling is sadness or elation.

Low or **depressed mood** occurs in a variety of disorders – **unipolar depressive disorder**, the **depressed phase of bipolar disorder** and **dysthymic disorder**. In addition to low mood there may be low energy, thinking may be 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.

High or **elevated mood** occurs in one phase of **bipolar-disorder**, and in **cyclothymia**. The higher elevation termed **mania** occurs only in **bipolar disorder 1** and 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.

A lower elevation of mood is termed **hypomania** and occurs in both **bipolar disorder 1 & 2**.

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.

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.

Non-psychotic disorders

This is a mixed bag of conditions. Symptoms of the non-psychotic disorders are known to us all, at least to some degree. For example, anxiety is similar to worry and fear – and these are 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, or the leaving of the home.
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.
Social anxiety disorder is the fear of negative evaluation by others
Separation anxiety has been described in adults (ICD-11.).

Obsessive-compulsive disorder (OCD) is a curious, disabling condition. **Obsessions** are repetitive thoughts which make no sense. Patients accept that these are their own thoughts - but they 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, such 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.

In the ICD-11 4 other conditions have been placed with OCD

1. **Body dysmorphic disorder** – preoccupation with defects of body appearance which are not noticeable to others
2. **Olfactory reference disorder** – belief one is emitting an offensive body odour
3. **Hoarding disorder** – accumulation of possessions
4. **Hypochondriasis** – health anxiety disorder.

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. Despite 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.

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. The unjustified fear that one has a disease, in the absence of organic (physical examination and imaging) findings is listed under OCD and related disorders in the ICD-11.

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 causes distress to the individual and frequently, to those associated with the individual.

Until 2018, personality disorder was classified using categories. There were/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.

Before the release (2013) of DSM-5 it was anticipated that the next edition would abandon the categorical and move to a dimensional approach to the classification of personality disorder. However, that did not happen, and there was disappointment. The DSM-5 has remained with the categorical as the official personality classification method - however, it also provides an introduction to the dimensional approach under the heading of “Emerging Models”.

The ICD-11 (released, 2018) presented a dimensional approach to personality disorder classification – to broad approval (Tyrer et al, 2019). The first step in diagnosis is to decide on a level of personality disorder (5 levels - from none to severe). The second step is to score the 5 traits (negative affectivity, obsessive compulsiveness, detachment, dissociality and disinhibition).

It also includes a category of personality difficulty – this is less severe than personality disorder and is not considered to be a personality disorder – so, why it appears here is unclear.

Neurocognitive Disorders

Major Neurocognitive Disorders are acquired conditions is characterized by prominent cognition (memory and intelligence) symptoms. Individual disorders include **delirium, amnestic disorder and dementia**. There may also be hallucinations, delusions and mood changes.

Substance use disorders

The essential feature **substance 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.

APPENDIX

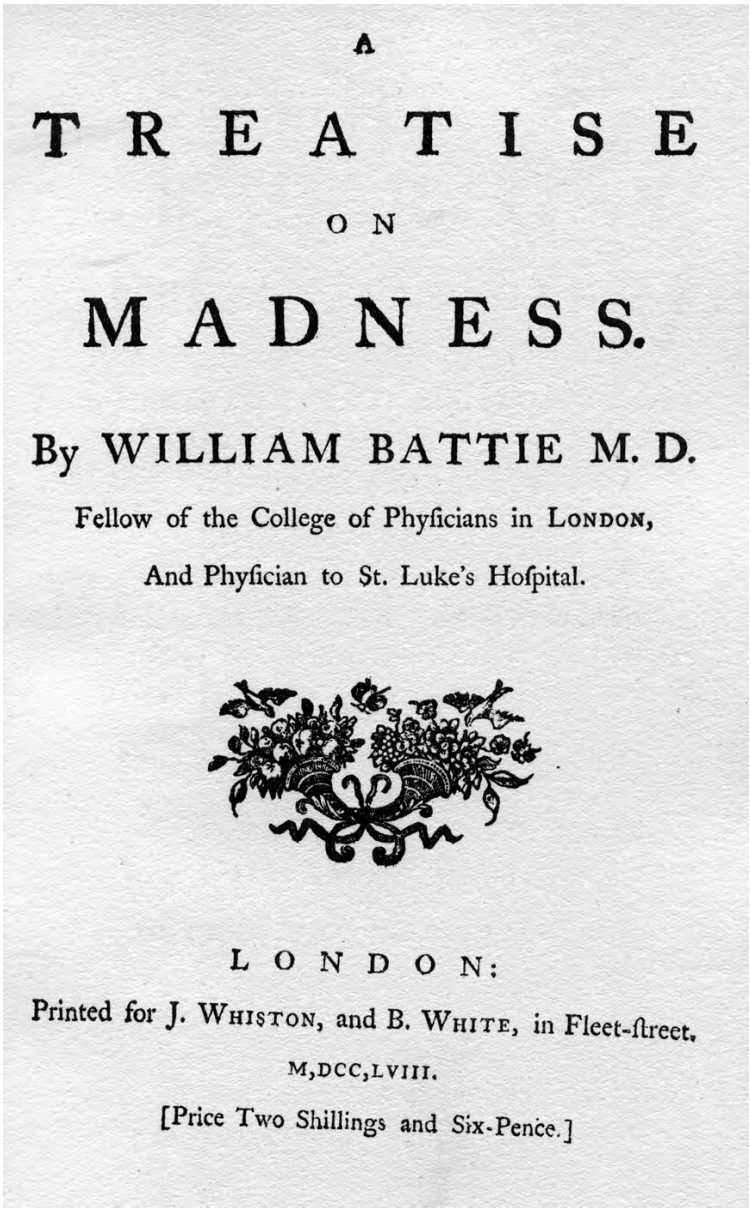
Madness

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. 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.

References

Crocq M-A. Can psychopathology and neuroscience coexist in psychiatric classifications? Dialogues in Clinical Neuroscience 2018; 20: 155-160.
First M. The problematic DSM-5 personality disorder proposal: options for plan B. Journal of Clinical Psychiatry 2011; 72:1341-1343.
McHugh P. Striving for coherence: psychiatry's efforts over classification. Journal of the American Medical Association 2005; 293:2526-2528.
Mitropoulos G. The DSM-ICD diagnostic approach as an essential bridge between the patient and the "big data". Psychiatriki 2018; 29: 249-256.
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.
Reed G et al. Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders World Psychiatry 2019; 18: 3-19
Tyrer P et al. The development of the ICD-11 classification of personality disorders. Ann Rev Clin Psychol 2019; 15: 7.1-7.22.