UNIT 1 CLASSIFICATION OF MENTAL DISORDERS: NEED, HISTORICAL PERSPECTIVE AND THE MODERN SYSTEM OF CLASSIFICATION

Structure

1.0 INTRODUCTION

There is one important difference between mental illness and physical illness. In most of the mental illnesses unlike the physical illnesses, the exact etiology is not known. For example, we know that hypertension, a physical illness, is a result of increased blood pressure due to various reasons. In acute bronchitis, another physical illness, there is inflammation of bronchi due to various causes. Ulcerative colitis and bronchial asthma, two common physical illnesses, are characterised by changes in the colon and lungs respectively. But we are not aware of the exact pathological changes accompanying the mental illnesses, though on advanced imaging studies some patients show changes in specified brain areas, but these are not uniform.

Mental illnesses are a result of disturbance of the psychological functioning due to various reasons, and hence the term 'disorder' is commonly used instead of disease, whenever we are referring to a mental illness. The term 'mental illness' and 'mental disorder' are used synonymously, but the current classification systems prefer the term 'mental disorder', indicating a disturbance of functioning.

In this Unit, we will discuss about the concept of mental disorder, need for classifying the mental disorders, historical developments in the classification of mental disorders, and the modern classification systems.

1.1 OBJECTIVES

After studying this Unit, you will be able to :

- define a mental disorder;
- explain the need and purpose of classification of mental disorder;
- describe the history of classification of mental disorders; and
- explain the modern systems of classifications of mental disorders.

1.2 DEFINITION OF MENTAL DISORDER

Before we proceed further, it is important to define mental disorder and distinguish it from normal. Whether or not a problem is considered a disorder has implications in terms of deciding treatment, legal aspects, and also for medical insurance reimbursements. In comparison to most medical illnesses, mental disorders are manifested by a quantitative deviation in behaviour, ideation, and emotion from a normative concept. The debate remains which behaviours, ways of thinking, or emotional states could be considered abnormal or deviant to indicate mental disorder.

The 10th edition of the World Health Organisation's International Classification of Diseases (ICD 10) does not define mental disorder, but refers to the term 'disorder', using it to imply the existence of a clinically recognisable set of symptoms or behaviours, associated with distress or interference with personal functions. It further mentions that social deviance or conflict alone, without personal dysfunction, does not constitute mental disorder (World Health Organisation, 1992).

The Mental Health Act of India does not define mental disorder or illness, but defines a mentally ill person as a person who is in need of treatment by reason of any mental disorder other than mental retardation.

American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV), defines mental disorder as a "clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom." The syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever be the original cause, the disturbance is considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (e.g., political, religious, or sexual) nor conflicts that are primarily between an individual and the society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above (American Psychiatric association, 2000).

Thus in simple words, mental disorder can be conceptualised as a disturbance in psychological functioning expressing itself in the form of psychological or behavioural disturbance, which is associated with significant distress to self or others or dysfunction in different areas of functioning.

Self Assessment Questions 1

***Note*:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Differentiate between mental disorder and mental illness.

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2) How do you define a mental disorder?

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1.3 NEED FOR CLASSIFICATION OF MENTAL DISORDERS

There is a wide range of mental disorders with different kinds of manifestations. Hence it becomes important to arrange them into specific categories, based on some established criteria for different purposes. The classification serves this purpose and can be defined as the process by which the complexity of phenomena is reduced by grouping them into categories as per some defined criteria.

The ultimate purpose of classification is to improve the treatment and prevention of illnesses. Ideally, a classification of any illness group should be based on its etiology or pathophysiology because this increases the likelihood of improving treatment and prevention. Since, exact etiology or pathophysiology of most of the mental disorders is not known; the disorders are grouped into various classes on the basis of some shared phenomenological characteristics.

Classification of mental disorders serves the purpose of communication, control, and comprehension.

- Communication refers to communicating information about the illness and the diagnosis. Thus when a clinician diagnoses a mental disorder as a specific category (e.g. generalised anxiety disorder) as per a particular classification system, and puts it on an outpatient prescription or the case records; another clinician would understand the clinical symptoms of the patient on seeing the diagnosis in the records. Thus it has served the purpose of communication.
- Control refers to developing the strategies for modifying the course of illness with treatment and also planning preventive strategies. A definition of disorder as per some classification would make it easy to develop control methods.
- Comprehension refers to understanding about the illness. Classification has a potential to improve understanding of an illness and hence also the causes and the processes involved in the development of illness and its maintenance.

Self Assessment Questions 2

***Note*:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What is classification?

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2) Why do we need to classify mental disorders?

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3) Describe the purposes of classification of mental disorders.

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1.4 HISTORICAL PERSPECTIVE OF CLASSIFICATION OF MENTAL DISORDERS

Historically, there are evidences of description of some mental disorders as early as 3000 BC. The syndromes of melancholia and hysteria find mention in Egyptian and Sumerian literature of 2600 BC. Ayurveda, the Indian system of medicine had included a classification of psychiatric disorders under medical illnesses in 1400 BC. In the modern system of medicine, Hippocrates (460-370 BC) is generally credited for bringing the concept of psychiatric illnesses to medicine. He classified mental illness into delirium, mania, paranoia, hysteria, melancholia resulting from four basic temperaments.

In the modern psychiatry, the first major attempt of classifying mental disorders was made by Emil Kraepelin (1856-1926), who used three approaches towards classification of mental disorders: clinical-descriptive, the somatic, and the course. His primary classifications were manic depressive psychosis and dementia praecox. Thus, Kraepelin brought manic and depressive disturbances together into one illness, and distinguished it from the chronic deteriorating illness called dementia praecox, on the basis of its periods of remission. Later Eugen Bleuler renamed dementia praecox as schizophrenia, a diagnostic term which is in use even after 100 years of its introduction. Kraepelin also differentiated paranoia from dementia praecox, delirium from dementia, and, also introduced the concepts of psychogenic neuroses and psychopathic personalities. Sigmund Freud (1856-1939) made important contributions towards the classification of neuroses and personality disorders. Kraepelin's classification could be taken as a forerunner of the modern official classification system.

For the purpose of census, certain classification system had been in use in the 19th century and in the first half of the 20th century in the USA and certain other countries. In the current scientific world, there are two official classification systems: World Health Organisation's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). We will be discussing about these in detail.

1.5 PRINCIPLES OF CLASSIFICATION OF MENTAL DISORDERS

The development of classification system and their subsequent revisions reflect the contemporary understanding of the mental illness. The classification of psychiatric disorders has been primarily based on the clinical presentation of the illness and its course, since we are not aware of their exact etiology and pathophysiology. Clustering of different clinical symptoms in different areas of psychological functioning, their severity, and the course often form the basis of the categorisation, as also historically used by Kraepelin.

At the simplest, the mental disorders are divided into organic and functional, and then into psychotic and neurotic disorders. This dichotomy, though still used sometimes, is not valid in the current classificatory systems. But for historical reasons and for understanding purpose, it is important to understand these terms. If in a psychiatric patient there is an evidence of a structural or functional disturbance in brain on taking history, clinical examination or investigations, the disorder is termed as 'organic'. If there is no such evidence, the illness is called 'functional'.The functional illnesses are further broadly categorised into psychoses (psychotic disorders) and neuroses (neurotic disorders).

The term 'psychoses' refers to severe psychiatric disorders characterised by grossly disturbed behaviour, loss of contact with reality, lack of insight and inability to meet the general demands of life, whereas the 'neuroses' are psychiatric disorders of lesser severity, where anxiety is the predominant feature which may be experienced directly or on being altered into some other symptoms by mental defence mechanisms. The patient usually retains insight and contact with reality in neuroses. The traditional dichotomy between neuroses and psychoses is not followed in the current classificatory systems e.g. lCD 10 and DSM IV. In both, the disorders are arranged in groups according to major common themes or descriptive likenesses, making it more convenient to use.

Self Assessment Questions 3

***Note*:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What is Kraepelin's contribution to classification of mental disorders?

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2) What is the principle used in classification of mental disorders?

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3) What are the differences between psychoses and neuroses?

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1.6 MODERN SYSTEMS OF CLASSIFICATION OF MENTAL DISORDERS

As introduced earlier, there are currently two official classification systems which are recognised internationally. Both have been in use now for more than 60 years. The two systems are the WHO's International Classification of Diseases (ICD) and American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). Both the systems have undergone a number of revisions and also expansions since their initial introduction. Though initially, there were many differences between the two systems, their latest editions (ICD 10 of 1992 and DSM IV of 1994) with revisions in their respective editions over the years, the two are now quite similar in basic principle. Both are recognised internationally. DSM IV is the official diagnostic system of USA and its latest version is of 2000, called DSM IV-TR (DSM IV- Text Revision). WHO's ICD10 has got acceptance all over the world and is also the official diagnostic system in India. Both ICD 10 as well as DSM IV are in the process of a final revision to ICD 11 and DSM V, which are expected in another 2-3 years.

Let us now discuss both DSM and ICD classification.

1.6.1 Diagnostic and Statistical Manual (DSM)

The DSM-IV (TR) recommends clinicians to assess an individual's mental state across five factors or axes. Together the five axes provide a broad range of information about the individual's functioning, not just a diagnosis. The system contains the following axes.

1) Axis I: *Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention*

   This axis incorporates a wide range of clinical syndromes, including anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, adjustment disorders, and disorders usually first diagnosed during infancy, childhood, or adolescence (except for mental retardation, which is coded on Axis II). Axis I also includes relationship problems, academic or occupational problems, and bereavement, conditions that may be the focus of diagnosis and treatment but that do not in themselves constitute definable psychological disorders. Also coded on Axis I are psychological factors that affect medical conditions, such as anxiety that exacerbates an asthmatic condition or depressive symptoms that delay recovery from surgery. The Axis I clinical disorder categories are as follows:

   1) Disorders usually first diagnosed in Infancy, Childhood, or Adolescence
   2) Delirium, Dementia, and Amnestic and other Cognitive Disorders
   3) Mental Disorders due to a General Medical Condition not elsewhere Classified
   4) Substance Related Disorders
   5) Schizophrenia and other Psychotic Disorders
   6) Mood Disorders
   7) Anxiety Disorders
   8) Somatoform Disorders
   9) Factitious Disorders
   10) Dissociative Disorders
   11) Sexual and Gender Identity Disorders
   12) Eating Disorders

13) Sleep Disorders
14) Impulse Control Disorders not elsewhere Classified
15) Adjustment Disorders
16) Other Conditions that may be a focus of Clinical Attention

2) Axis II: *Personality Disorders and Mental Retardation*

Personality disorders are enduring and rigid patterns of maladaptive behaviour that typically impair relationships with others and social functioning. These include antisocial, paranoid, narcissistic, and borderline personality disorders. Mental retardation, which is also coded on Axis II, involves pervasive intellectual impairment. People may be given either Axis I or Axis II diagnoses or a combination of the two when both apply. For example, a person may receive a diagnosis of an anxiety disorder (Axis I) and a second diagnosis of a personality disorder (Axis II).

This axis include following disorders:

1) Paranoid Personality Disorder
2) Narcissistic Personality Disorder
3) Schizoid Personality Disorder
4) Avoidant Personality Disorder
5) Schizotypal Personality Disorder
6) Dependent Personality Disorder
7) Antisocial Personality Disorder
8) Obsessive-Compulsive Personality Disorder
9) Borderline Personality Disorder
10) Personality Disorder Not Otherwise Specified
11) Histrionic Personality Disorder
12) Mental Retardation

3) Axis III: *General Medical Conditions*

All medical conditions and diseases that may be important to the understanding or treatment of an individual's mental disorders are coded on Axis III. For example, if hypothyroidism were a direct cause of an individual's mood disorder (such as major depression), it would be coded under Axis III. Medical conditions that affect the understanding or treatment of a mental disorder (but that are not direct causes or the disorder) are also listed on Axis III. For instance, the presence of a heart condition may determine whether a particular course of drug therapy should be used with a depressed person.

4) Axis IV: *Psychosocial and Environmental Problems*

The psychosocial and environmental problems that affect the diagnosis, treatment, or outcome of a mental disorder are placed on Axis IV. These include job loss, marital separation or divorce, homelessness or inadequate housing, lack of social support, the death or loss of a friend, or exposure to war or other disasters. Some positive life events, such as a job promotion, may also be listed on Axis IV, but only when they create problems for the individual, such as difficulties adapting to a new job. Table 1 lists examples from this axis.

Table 1: Psychosocial and Environmental Problems

Problem Categories	Examples
Problems with primary support group	Death of family members; health problems of family members; marital disruption in the form of separation, divorce, or estrangement; sexual or physical abuse within the family; child neglect; birth of a sibling
Problems related to the social environment	Death or loss of a friend; social isolation or living alone; difficulties adjusting to a new culture (acculturation); discrimination; adjustment to transitions occurring during the life cycle, such as retirement
Educational problems	Illiteracy; academic difficulties; problems with teachers or classmates; inadequate or impoverished school environment
Occupational problems	Work-related problems including stressful workloads and problems with bosses or co-workers; changes in employment; job dissatisfaction; threat of loss of job; unemployment
Housing problems	Inadequate housing or homelessness; living in an unsafe neighbourhood; problems with neighbours or landlord
Economic problems	Financial hardships or extreme poverty; inadequate welfare support
Problems with access to health care services	Inadequate health care services or availability of health insurance; difficulties with transportation to health care facilities
Problems related to interaction with the legal system/crime	Arrest or imprisonment; becoming involved in a lawsuit or trial; being a victim of crime
Other psychosocial problems	Natural or human-made disasters; war or other hostilities; problems with caregivers outside the family, such as counselors, social workers, and physicians; lack of availability of social service agencies

Source: Adapted from the DSM-IV-TR (APA, 2000)

5) Axis V: *Global Assessment of Relational Functioning (GARF)*

The clinician rates the client's current level of psychological, social, and occupational functioning using a 0-100 scale (see Table-2). The clinician may also indicate the highest level of functioning achieved for at least a few months during the preceding year. The level of current functioning indicates the current need for treatment or intensity of care. The level of highest functioning is suggestive of the level of functioning that might be restored. The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship (APA. 2000).

Table 2: Global Assessment of Functioning (GAF) Scale

Code	Severity of Symptoms	Examples
91-100	Superior functioning across a wide variety of activities of daily life	Lacks symptoms, handles life problems without them "getting out of hand"
81-90	Absent or minimal symptoms, no more than everyday problems or concerns	Mild anxiety before exams, occasional argument with family members
71-80	Transient and predictable reactions to stressful events, or no more than slight impairment in functioning	Difficulty concentrating after argument with family, temporarily falls behind in schoolwork
61-70	Some mild symptoms, or some difficulty in social, occupational, or school functioning, but functioning pretty well	Feels down, mild insomnia, occasional truancy or theft within household
51-60	Moderate symptoms, or moderate difficulties in social, occupational, or school functioning	Occasional panic attacks, few friends, conflicts with co-workers
41-50	Serious symptoms, or any serious impairment in social, occupational, or school functioning	Suicidal thoughts, frequent shoplifting, unable to hold job, has no friends
31-40	Some impairment in reality testing or communication, or major impairment in several areas	Speech illogical, depressed man or woman unable to work, neglects family, and avoids friends
21-30	Strong influence on behavior of delusions or hallucinations, or serious impairment in communication or judgment, or inability to function in almost all areas	Grossly inappropriate behavior, speech sometimes incoherent, stays in bed all day, no job, home, or friends
11-20	Some danger of hurting self or others, or occasionally fails to maintain personal hygiene, or gross impairment in communication	Suicidal gestures, frequently violent, smears feces Largely incoherent or mute
1-10	Persistent danger of severely hurting self or others, or persistent inability to maintain minimal personal hygiene, or seriously suicidal act with clear expectation of death	Serious suicidal attempt, recurrent violence

Source: Adapted from the DSM-IV-TR (APA, 2000)

1.6.2 International Classification of Diseases (ICD)

ICD 10 is developed by WHO. The current version being followed is the 10th version of ICD (ICD-10) that was published in 1992. lCD10 follows an alphanumeric coding scheme, based on codes with a single letter followed by two numbers at the three character level (A00- - Z99). Further detail is then provided by decimal numeric subdivisions at the four character level.There are a total of 21 chapters in ICD-10, of which the fifth chapter, i.e. Chapter V (F) of lCD-10 deals with mental and behavioural disorders and has 100 categories F00-F99. On the other hand, DSM IV retained the coding of the earlier edition called International Classification of Diseases, Clinical Modification (ICD-CM) - 291.00 to 319. ICD 10 is the official diagnostic system in India.

The version of ICD 10 used by mental health professionals for clinical purposes is called the *Clinical Description and Diagnostic Guidelines version.* Other versions of the ICD-10, which are all mutually compatible, are depicted in the table below:

S.No.	ICD 10 Version	Description	Purpose
1	Clinical description and diagnostic guidelines	Contains basic description of each disorder	Mainly for clinicians
2	Diagnostic criteria for research	Each disorder contains specific criteria for diagnosis	Mainly for researchers
3	Primary care version	Contains only 27 main categories, with brief notes on management and referral	Mainly for general physicians who work in the primary care setting

As mentioned earlier, mental and behavioural disorders of ICD-10 are given code "F".

ICD 10 has grouped various mental disorders into 10 groups, coded as F00 to F99, as below.

Codes	Categories
F00-F09	Organic, including symptomatic, mental disorders
F10-F19	Mental and behavioural disorders due to psychoactive substance use
F20-F29	Schizophrenia, Schizotypal and delusional disorders
F30-F39	Mood (affective) disorders
F40-F49	Neurotic, stress related and somatoform disorders
F50-F59	Behavioural 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-F99	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Self Assessment Questions 4

***Note*:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Discuss briefly the international classification systems of mental disorders currently in use.

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1.7 CATEGORIES OF MENTAL DISORDERS

This section gives salient features of various mental disorders, as these are described in ICD 10. The categories are broadly similar to those of DSM IV, though there are minor differences in diagnostic guidelines or in the precise grouping or sub grouping of the diagnostic categories. All the disorders as enumerated below are discussed in details in subsequent chapters.

As mentioned earlier, the following mental disorders are included under ICD 10:

— Organic, including symptomatic, mental disorders

— Mental and behavioural disorders due to psychoactive substance use

— Schizophrenia, schizotypal and delusional disorders

— Mood [affective] disorders

— Neurotic, stress-related and somatoform disorders

— Behavioural syndromes associated with physiological disturbances and physical factors

— Disorders of adult personality and behaviour

— Mental retardation

— Disorders of psychological development

— Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

— Unspecified mental disorder

Characteristics of some important illnesses in each category are briefly discussed.

1) Organic, including symptomatic, mental disorders

Organic mental disorders, also known as organic brain disorders, are a group of disorders, characterised by a demonstrable etiology in the brain in form of a cerebral disease, brain injury or some other insult leading to cerebral dysfunction. The illness may be primary, where the pathology involves the brain directly or secondary, where the brain is affected as secondary consequence of another systemic disease, which has involved the brain as one of the multiple organs or systems. For example, the brain is the primary organ involved in Alzheimer's disease, Parkinson's disease, head injury or

cerebrovascular accidents, and secondarily involved in diabetes mellitus (ketosis, hyperglycemia), hyperthyroidism, hypothyroidism, HIV infection, nutritional deficiencies, cerebral anoxia due to any systemic cause, etc.

Common organic mental disorders include dementia, delirium, organic amnestic syndrome, organic delusional disorder, organic mood disorder, organic personality disorder, mild cognitive disorder, post encephalitic disorder, etc.

Dementia is a syndrome resulting from disease of brain, usually of chronic or progressive nature, which is characterised by a global impairment of higher mental functions, such as memory, intelligence, comprehension, cognition, learning capacity, judgement, reasoning, language, orientation and personality, occurring as a result of degenerative changes in the brain. Consciousness is not affected. Alzheimer's disease is the commonest type of dementia. Other types include vascular dementia, sub cortical dementia, dementia due to Parkinson's disease. A large number of neurological and systemic illnesses can lead to dementia.

Delirium is an organic mental disorder of acute onset, characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion and sleep-wake cycle. It is usually transient and runs a fluctuating course. Delirium is a result of some disturbance in the cerebral functioning, which can be due to a large number of cerebral and non cerebral systemic causes.

Organic amnestic disorder is characterised by an impairment of recent and remote memory. While immediate recall is preserved, ability to learn new material is markedly reduced, resulting in anterograde amnesia and disorientation in time.

Any kind of psychiatric symptomatology characterised by psychotic symptoms, mood symptoms, personality disturbances or others can occur due to an organic cause and comes under the broad category of organic mental disorders.

2) **Mental and behavioural disorders due to psychoactive substance abuse**

Abuse of various psychoactive substances like alcohol, opioids, stimulants or other such substances, can result in a wide variety of psychiatric conditions, such as acute intoxication, harmful use, dependence syndrome, withdrawal phenomena, amnestic syndrome and disorders resembling functional psychiatric conditions like schizophrenia, depression, mania, amnestic syndrome or others. Common substances that are abused include alcohol, opioids, cannabinoids, sedatives and hypnotics, hallucinogens, cocaine, stimulants, tobacco and volatile solvents.

Acute intoxication is a transient disturbance which occurs following the administration of a psychoactive substance and is characterised by disturbances in consciousness, cognition, perception, affect or behaviour, or in other psychophysiological functions and responses. The condition is usually transient.

Harmful use refers to a pattern of psychoactive substance abuse, which can cause damage to the physical or mental health of the person using the substance.

Dependence syndrome is characterised by a cluster of physiological, behavioural and cognitive phenomena, in which, the use of a substance takes on a much higher priority for an individual than other behaviours, which have a greater value. There is a strong desire or an urge (craving) to take the psychoactive substance, appearance of withdrawal symptoms on reducing or stopping the substance, need to take increasing amounts of the substance to achieve the desired effect, and persisting with substance use despite

clear evidence of overtly harmful consequences. Often there is accompanying impairment in various areas of psychosocial functioning such as personal neglect, neglect of family, and impairment in job performance.

Withdrawal syndrome refers to a group of symptoms of variable clustering and severity that occur on stopping or reducing the amount of intake of the psychoactive substance after repeated and prolonged use of that substance.

3) **Schizophrenia, schizotypal and delusional disorders**

This group includes schizophrenia, schizotypal disorder, persistent delusional disorder, acute transient psychotic disorder, schizoaffective disorder and other psychotic disorders.

Schizophrenia is characterised by disturbances in thinking, emotion, perception, behaviour and personality disorganisation, and often runs a chronic deteriorating course. The patient may present with delusions, hallucinations, disorganised thinking, disorganised behaviour, inappropriate and blunted affect, and personality deterioration.

Schizotypal disorder is characterised by eccentric behaviour and anomalies of thinking like odd beliefs, suspiciousness,vague circumstantial, stereotyped thinking inappropriate or constricted affect and occasional transient quasi-psychotic episodes. But characteristic symptoms of schizophrenia like delusions, hallucinations or disorganised behaviour are lacking.

In *delusional disorders*, the patient presents with long standing delusions in the absence of any other characteristic psychopathology suggestive of schizophrenia, mania or any other psychiatric disorder.

Schizoaffective disorders are characterised by the presence of prominent schizophrenic as well as affective symptoms within the same episode of illness. The illness has an episodic pattern and its relationship with schizophrenia as well as the mood disorders is still uncertain.

Acute and transient psychotic disorders are a group of disorders, characterised by symptoms of excitement, perplexity, confusion, irrelevant talk, delusions and hallucinations of acute onset. The clinical presentation may mimic schizophrenia or may have an affective colouring but the illness is mostly short lasting. Some cases may go on to develop into schizophrenia.

4) **Mood (affective) disorders**

Mood disorders are characterised by a primary disturbance of mood or affect. Most of theother symptoms are secondary and can be easily understood in the context of the primary mood disturbance. Most of these disorders run an episodic course. The episodes can be of mania, depression or of mixed type. In inter episodic periods the patients may not have any symptoms.

The patient in mania is euphoric or elated, excited, overenergetic, grandiose, and has increased libido and decreased need for sleep. There is pressure of speech or flight of ideas. The patient may make extravagant and impractical schemes, spend money recklessly, or may become paranoid, aggressive and violent.

In the depressive phase, the patient feels sad, dejected and low. There is loss of interest in day to day activities, decreased sleep, decreased appetite and lack of energy. Psychomotor activity is usually decreased, but sometimes agitation may be present. Ideas of guilt, hopelessness, helplessness, worthlessness and suicide are often present.

Sometimes, there occur mixed kind of episodes with a mixture of manic and depressive symptoms.

Hypomania and dysthymia are relatively milder forms of manic and depressive episodes respectively. Cyclothymia is a condition, in which there occur alternating phases of hypomania and dysthymia.

5) **Neurotic, stress related and somatoform disorders**

The group of neurotic, stress related and somatoform disorders includes a large number of conditions, which were earlier included under the broad group of neuroses, and stress related symptoms. Most such patients present with anxiety symptoms, or somatic symptoms without an organic basis. Stress related disorders like post traumatic stress disorder and dissociative disorders also grouped in this broad category.

Neurotic disorders include phobic anxiety disorder, panic disorder, generalised anxiety disorder, obsessive compulsive disorder and dissociative disorders.

The central feature in *phobic anxiety disorder* (earlier known as phobic neurosis) is phobia. Phobia is a persistent, unrealistic and intense fear of an object, activity or a situation, which is considered irrational by the person. Common types of phobia are agoraphobia, social phobia and specific phobias.

Generalised anxiety disorder is characterised by the presence of generalised and persistent anxiety. The presenting symptoms include feelings of nervousness, muscular tension, sweating, light-headedness, palpitations, dizziness, epigastric discomfort and tremulousness.

In *panic disorder*, there occur recurrent brief episodes of severe anxiety (panic). The episodes occur suddenly and spontaneously and are not restricted to any particular situation or set of circumstances (unlike phobias), and usually last for minutes, though may be longer in some cases.

Obsessive compulsive disorder is characterised by obsessions and compulsions. An obsession is a persistent and recurrent idea, image or impulse, which enters the individual's mind against one's wish, is considered absurd by the person, is anxiety provoking and cannot be eliminated from the consciousness by any amount of reasoning or logic. It is recognised as one's own thought or impulse. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. The individual often views them as preventing some objectively unlikely event or performs it in response to an obsession. Behaviour is considered purposeless by the person and person may feel compelled to perform it.

Dissociative (conversion) disorders are characterised by the presence of psychological or physical symptoms, presumed to result from partial or complete loss of normal integration (dissociation) between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. The term conversion refers to the mechanism by which an unpleasant affect, resulting from a conflict is transformed into the symptoms. Psychological presentations include amnesia, fugue states, stupor, possession states, multiple personality, etc. Physical presentations include disorders of movement and sensation, convulsions and dissociative anaesthesia or loss of sensation. The conversion disorder with presentation of physical symptoms is grouped under somatoform disorders in DSM IV.

In *somatoform disorders*, the patient presents with physical symptoms suggesting a physical illness, though there is none. Even if a physical pathology is present, it is not

sufficient to explain the symptoms. The patient repetitively requests for medical investigations, in spite of repeated negative findings and reassurances from the doctors that the symptoms have no physical basis. Psychological factors are responsible or are presumed to be responsible for the symptoms. Even when the onset and continuation of the symptoms bear a close relationship with unpleasant life events or with difficulties or conflicts, the patient usually resists attempts to discuss the possibility of psychological causation. The category of somatoform disorders includes somatization disorder, hypochondriacal disorder, undifferentiated somatoform disorder, somatoform autonomic dysfunction and persistent somatoform pain disorder.

In *stress related disorders*, the genesis of illness is related to stress. The illness may occur either immediately following the stress or with a delayed onset.These include acute stress reaction, post traumatic stress disorder and adjustment disorders.

Acute stressre action is a transient disorder occurring in response to exceptional physical or mental stress, which usually subsides within hours or days. The clinical picture is often changing, starting with a daze and later characterised by depression, anxiety, anger, despair, overactivity or withdrawal. Stressor may be an overwhelming traumatic experience posing serious threat to the security or physical integrity of the person (e.g. a criminal assault, natural catastrophe, rape, accident, etc.)

Post traumatic stress disorder (PTSD) is characterised by a delayed or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature(e.g., natural or man-made disasters, serious accidents, wars, torture, terrorism) which is likely to cause pervasive distress in almost all the affected population. Symptoms include repeated reliving of the trauma in flashbacks or dreams, sense of numbness, detachment from other people, unresponsiveness to others,a state of hyper arousal with hyper vigilance and avoidance of activities and situations reminiscent of trauma.

Adjustment disorders are characterised by subjective distress and emotional disturbance, occurring in the period of adaptation to a significant life change. Symptoms usually interfere with social functioning and performance, and include a range of depressive, anxiety or behavioural disturbances.

6) **Behavioural syndromes associated with physiological disturbances and physical factors**

This group includes eating disorders, non organic sleep disorders, sexual dysfunctions, mental and behavioural disorders associated with puerperium (not classified elsewhere), psychological and behavioural factors associated with disorders and diseases classified elsewhere and abuse of non dependence producing substances.

Eating disorders include anorexia nervosa, bulimia nervosa, overeating and others. Anorexia nervosa is characterised by deliberate weight loss, induced and/or sustained by the patient and is usually seen in adolescent girls and young women, and is associated with body image distortions and endocrine disturbances like amenorrhea. In bulimia nervosa, there occur repeated bouts of overeating and an excessive preoccupation with the control of body weight, leading to episodes of self induced vomiting, purgative abuse, diuretics or appetite suppressants.

Non organic sleep disorders include non organic insomnia, non organic hypersomnia, disorder of sleep wake schedule, sleepwalking, sleep (night) terrors and nightmares.

Sexual dysfunctions (not caused by organic disorder or disease) or psychosexual disorders include a range of dysfunctions like failure of genital response (erectile impotence in males), premature ejaculation, retarded ejaculation, excessive sexual drive,

lack or loss of sexual desire, orgasmic dysfunction, vaginismus, dyspaerunia and sexual aversion.

7) Disorders of adult personality and behaviour

This group includes personality disorders, habit and impulse disorders, gender identity disorders, disorders of sexual performance, factitious disorder and other related disorders.

Personality disorders are deeply ingrained and inflexible lifelong maladaptive patterns of behaviour, generally recognisable by adolescence and continuing throughout most of the adult life. There is significant functional impairment and the patient may be subjectively distressed, but denies his or her problems and refuses psychiatric help.There are many types of personality disorders, which include paranoid personality disorder, schizoid personality disorder, dissocial personality disorder, histrionic personality disorder, narcissistic personality disorder, avoidant personality disorder and others.

Habit and impulse disorders are characterised by repeated performance of certain acts, generally of harm to one's and others' interests. There is no clear rational motivation, but the behaviour is associated with impulses which cannot be controlled. The group includes pathological gambling, pathological fire setting (pyromania), pathological stealing (kleptomania), trichotillomania and others.

Gender identity disorders are characterised by persistent feelings of discomfort with one's biological sex or gender role of one's biological sex.These include transsexualism and transvestism.

Disorders of sexual preference include deviant sexual practices like sadism, masochism, fetishism,transvestism, voyeurism, exhibitionism, paedophilia, zoophilia, etc. The key feature is that the deviant sexual behaviour is often the preferred sexual practice by the person.

Factitious disorder is characterised by repeated feigning of physical or psychological symptoms. The patient may even self inflict cuts or abrasions to induce bleeding or self inject toxic substances to produce pathology. There is no apparent motivation except for an unconscious desire to assume a sick role or to be ill.

8) Mental retardation

Mental retardation is a developmental condition, characterised by significantly subaverage general intellectual functioning in various areas like cognitive, language, motor and social abilities, resulting in or associated with concurrent impairment in adaptive behaviour. The condition is usually manifested during the developmental period. The cause may lie in arrested or incomplete development of the mind due to a congenital or hereditary cause or brain insult due to a birth injury, pre or post natal event or in the early childhood. Depending on the IQ or the severity, it is categorized as mild, moderate, severe or profound.

9) Disorders of psychological development

These include specific developmental disorders of speech and language, scholastic skills and motor function, mixed specific developmental disorders and pervasive developmental disorders.

Specific developmental disorders of speech and language are characterised by a delay in the normal patterns of language acquisition from the early stages of development.

The delay is not a result of any neurological or speech mechanism abnormalities, sensory impairment, mental retardation or environmental factors. There could be a delay in speech articulation, expressive language, receptive language, acquired aphasia with epilepsy (Landau Kleffner syndrome) or other related disorders.

Specific developmental disorders of scholastic skills are characterised by delay in the normal patterns of development of a specific skill acquisition, which may include reading, writing, spellings or arithmetic skills.Conceptually, it is similar to the specific developmental disorder of speech and language. The disorder is thought to result from some abnormalities in cognitive processing because of some biological dysfunction, and is not simply a consequence of a lack of opportunity to learn or some acquired brain trauma or disease.

Specific developmental disorder of motor function is characterised by serious impairment in the development of motor coordination, which cannot be explained in terms of general intellectual retardation or some neurological disorder.

In *pervasive developmental disorders*, qualitative abnormalities are seen in reciprocal social interactions and in patterns of communication, accompanied by restricted and stereotyped repetitive repertoire of interests and activities. The developmental problems are mostly evident starting from infancy and the condition becomes manifest in the first 5 years of life. The group includes autism, Rett's syndrome, childhood disintegrative disorder, Asperger's syndrome and other related disorders.

10) **Behavioural and emotional disorders with onset usually occurring in childhood and adolescence**

This group includes hyperkinetic disorders, conduct disorders, mixed disorders of conduct and emotions, emotional disorders with onset specific to childhood, disorders of social functioning, tic disorders, enuresis, encopresis and other related disorders.

Hyperkinetic disorders (Attention deficit hyperactivity disorder in DSM IV) have onset usually in the first five years of life and are characterised by overactivity, impaired attention, and behavioural disturbance, which are manifest in different situations.

Conduct disorders are characterised by a repetitive and persistent pattern of dissocial, aggressive and defiant behaviour, which is more than the usual childish mischief or adolescent rebelliousness. Such behaviours include excessive fighting or bullying, cruelty to animals, severe destructiveness to property, fire setting, stealing, truancy from school, repeated lying, etc.

Emotional disorders specific to childhood include separation anxiety disorder, phobic anxiety disorder, social anxiety disorder and sibling rivalry disorder.

Disorders of social functioning are characterised by some abnormalities of social functioning with onset during developmental period. These include elective mutism, reactive attachment disorder and disinherited attachment disorder.

11) **Unspecified mental disorder**

This includes conditions which cannot be diagnosed under any of the above categories.

Self Assessment Questions 5

***Note*:** i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the different major diagnostic categories under the section of mental disorders in ICD 10?

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2) Discuss the main difference between schizophrenia and mood disorder?

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3) What are disorders of psychological development?

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1.8 LET US SUM UP

- Mental disorder is conceptualised as a disturbance in psychological functioning expressing itself in form of psychological or behavioural disturbance, associated with significant distress to self or others or dysfunction in different areas of functioning.
- Classification serves the purpose of communication, control and comprehension.
- ICD 10 and DSM IV are the two official classification systems used for classification of mental disorders.
- ICD 10 is the official classification system of India.

1.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Mental disorder and mental illness are used synonymously; however, the current classification system prefers the use of the term 'mental disorder', indicating a disturbance of functioning.

2) Mental disorder can be defined as a disturbance in psychological functioning, expressed in the form of psychological or behavioural disturbance, and that is associated with significant present distress or disability or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.

Self Assessment Questions 2

1) Classification is the process by which a phenomena is grouped into categories as per some defined criteria.

2) We need to classify mental disorders in order to provide for better treatment and prevention of illnesses.

3) The purposes of classification of mental disorders are three-fold: communication, control and comprehension.

Self Assessment Questions 3

1) Kraepelin was the first psychiatrist to classify mental disorders, and used three approaches towards the classification of mental disorders, namely (i) clinical-descriptive, (ii) the somatic, and (iii) the course.

2) The classification of mental disorders is primarily based on the clinical presentation of the illness and its course.

3) The difference between psychoses and neuroses lies in the severity of the disorder. Psychoses refer to severe psychotic disorders characterised by grossly disturbed behaviour and loss of contact with reality; whereas neuroses are of milder form with anxiety being the predominant feature.

Self Assessment Questions 4

1) Currently there are two types of international classification systems of mental disorders that are in use. These are Diagnostic and Statistical Manual (DSM – IV – Text Revision) and International Classification of Diseases (ICD – 10). The former is the official diagnostic system of USA whereas India follows the latter classification system.

Self Assessment Questions 5

1) The major diagnostic categories under the section of mental disorders in ICD 10 are as follows:

   i) Organic including symptomatic, mental disorders

   ii) Mental and behavioural disorders due to psychoactive substance use

   iii) Schizophrenia, schizotypal and delusional disorders

   iv) Mood, affective disorders

   v) Neurotic, stress related and somatoform disorders

   vi) Behavioural syndromes associated with physiological disturbances and physical factors

   vii) Disorders of adult personality and behaviour

   viii) Mental retardation

   ix) Disorders of psychological development

   x) Behavioural and emotional disorders with onset usually occurring in childhood and adolescence.

2) Schizophrenia is characterised by disturbed thought and perception with delusions and hallucinations; whereas mood disorders are characterised by a primary disturbance of mood or affect.

3) Disorders of psychological development include specific developmental disorders of speech and language, scholastic skills and motor function, mixed specific developmental disorders and pervasive developmental disorders.

1.10 UNIT END QUESTIONS

1) What are the purposes of classification?
2) What is the basis of classification of mental disorders in the modern classification systems?
3) Discuss historical development of classification of mental disorders.
4) What are the different major diagnostic categories in the mental disorder section of the ICD 10?

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