Classification & Diagnosis

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The Purposes of Psychiatric Diagnosis

1. To define clinical entities, so that clinicians have the same understanding of what a diagnostic term means

2. To determine treatment

How well a diagnosis defines a disorder and guides treatment depends on it's validity and reliability

Classification is needed in psychiatry for several purposes:

- to enable clinicians to communicate with one another about the diagnoses given to their patients
- to aid patients and their families, by allowing clinicians to provide a framework for them to understand their symptoms and difficulties, and for proposed treatments
- to understand the implications of these diagnoses in terms of their symptoms, prognosis, and treatment, and sometimes their aetiology
- to relate the findings of clinical research to patients seen in everyday practice
- to facilitate epidemiological studies and the collection of reliable statistics

Two Diagnostic Approaches

1. Descriptive – diagnoses based on relatively objective phenomena that require little clinical inference (signs, natural history, etc.) – focus on what
2. Psychological (or dynamic) – diagnoses based primarily on inferred causes and mechanisms, with symptoms frequently being seen as superficial manifestations of a more profound underlying process – focus is on why

Diagnoses, diseases, and disorders

The term ‘diagnosis’ has two somewhat different meanings.

It has the general meaning of ‘telling one thing apart from another’, but in medicine it has also acquired a more specific meaning of ‘knowing the underlying cause’ of the symptoms and signs about which the patient is complaining.

The lack of clear disease categories, in a medical sense, has led to the use of the more general term ‘disorder’. The definition of a psychiatric disorder in ICD-10 is:

…a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here. (World Health Organization, 1992b, p. 5)

- The DSM-5 definition of a mental disorder is longer but similar:
- …a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.
- Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally acceptable response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (American Psychiatric Association, 2013a, p. 20

- Despite the similarity, there is an important difference between the two definitions. ‘Interference with personal functions’ in ICD-10 refers only to such things as personal care and one’s immediate environment, and does not extend to interference with work and other social roles.

- In DSM-5, as in the extract above, impairment refers to all types of functioning. Both definitions illustrate that most psychiatric disorders are based not upon theoretical concepts, or presumptions about aetiology, but upon recognizable clusters of symptoms and behaviours. This reliance explains much of the debate about the reliability and validity of the categories being classified

- The early Greek medical writings contained descriptions of different manifestations of mental disorder— for example, excitement, depression, confusion, and memory loss. This simple classification was adopted by Roman medicine and developed by the Greek physician Galen, whose system of classification.
- Interest in the classification of natural phenomena developed in the eighteenth century, partly stimulated by the publication of a classification of plants by Linnaeus, a medically qualified professor of botany who also devised a less well-known classification of diseases in which one major class was mental disorders
- Many classifications were proposed, notably one published in 1772 by William Cullen, a Scottish physician. He grouped mental disorders together, apart from delirium, which he classified with febrile conditions. According to his scheme, mental disorders were part of a broad class of ‘neuroses’, a term that he used to denote diseases which affect the nervous system (Hunter and MacAlpine, 1963). Cullen’s classification contained an aetiological principle—that mental illnesses were disorders of the nervous system

In the early nineteenth century, several French writers published influential classifications. Pinel's Treatise on Insanity, which appeared in English in 1806, divided mental disorders into mania with delirium, mania without delirium, melancholia, dementia, and idiocy. Pinel's compatriot, Esquirol, wrote another widely read textbook, which was published in English in 1845, and added a new category, 'monomania', characterized by 'partial insanity', in which there were fixed false ideas that could not be changed by logical reasoning (i.e. delusions). Like other psychiatrists of the time, Pinel and Esquirol did not discuss neuroses (in the modern sense), because these conditions were generally treated by physicians

Categories, dimensions, and axes

- Traditionally, psychiatric disorders have been classified by dividing them into categories that are supposed to represent discrete clinical entities. As already noted, in the absence of knowledge of underlying pathology, these categories can only be defined in terms of symptom patterns and course. Such categorization facilitates the decisions that have to be made in clinical work about treatment and management, but presents two problems. ● Although definitions and descriptions can be agreed upon (to improve reliability; see page 29), there is uncertainty about the extent to which these categories represent distinct entities or 'carve Nature at her joints' (validity; see page 30). ● A significant proportion of patients do not closely match the descriptions of any disorder, or meet criteria for two or more categories (comorbidity; see page 29). These are all significant points, and they are addressed further in the following sections. However, a more satisfactory and practical alternative system has not yet been devised.

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Dimensional classification

Dimensional classification does not use separate categories, but characterizes the subject by means of scores on two or more dimensions. In the past, Kretschmer and several other psychiatrists advocated it, and subsequently it was strongly promoted by the psychologist Hans Eysenck, on the grounds that there is no systematic objective evidence to support the existence of discrete categories. Eysenck (1970b) proposed a system of three dimensions—psychoticism, neuroticism, and introversion–extroversion.

The dimensional view of psychiatric disorder is comparable to that of hypertension and other medical diagnoses that are really extremes of a normal distribution, and this view reflects the nature of the underlying genetic predisposition and presumed neurobiology

Two Diagnostic Approaches

Both approaches are valuable – each addresses a different aspect of psychopathology

Ex: delusions

Descriptive – Are they fixed? Vague? Paranoid? Circumscribed?

Dynamic – inner mechanism (e.g., projection) that produces the delusion

Dimensions of Diagnosis

- Categorical vs. dimensional
- Monothetic vs. polythetic

- Categorical diagnosis – all persons assigned to the same category are alike with respect to some attribute
- Dimensional – all persons rated on pre-determined dimensions

Dimensional Approaches to Diagnosis

- All persons are rated on a pre-determined, quantitatively-based dimensions
- Ex: Axes IV and V of DSM-IV-TR

- In dimensional approaches, there is no assumption of behavioral discontinuity – psychopathology is seen as falling on a continuum
- “more this or less that” not “either/or”

- Monothetic diagnosis – each category is associated with specific criteria, all of which are considered essential to that category's definition (also called classical categorization)

- Effects:
- 1. comparatively few persons will met the criteria of any one category
- 2. for those who do, they will show a high degree of behavioral similarity

- Polythetic (prototypal) diagnosis – each category is associated with a number of criteria, only some of which are necessary for a diagnosis to be assigned.

Two advantages over the categorical approach

- 1. requires fewer categories to classify the great variety of behavioral variation (greater simplicity)
- 2. more reliable – clinicians do not have to agree on every criterion to arrive at the same diagnosis

Disadvantage: individuals with the same diagnosis may bear little resemblance to each other, in terms of presenting complaints

- There is a third, mixed approach, in which some criteria are considered necessary for a diagnosis, while other criteria may or may not be met.

- Ex: Criteria A & B are essential to this diagnosis, while any combination of 2 of the 4 of criteria C, D, E & F will do.

Historical Overview of Psychiatric Classification

The science of classifying abnormal patterns of behavior and experience is called nosology.

The root of nosology can be traced back to Hippocrates, who established a classification scheme that remained influential throughout ancient Greece and Rome

Diagnostic categories included mania, melancholia and hysteria

The International Classification of Diseases (ICD), Chapter V

The International Classification of Diseases (ICD) is produced by the World Health Organization (WHO) as an aid to the collection of international statistics about disease. The current version is the 10th edition (ICD-10). Of the 21 chapters, Chapter V is devoted to psychiatry. Mental disorders were included for the first time in 1948, in the sixth revision (ICD-6), but neither ICD-6 nor ICD-7 were widely used because they consisted merely of a list of names and code numbers by which national statistics could be tabulated, with no glossary to indicate suggested meanings of the constituent terms. As noted, the survey of Stengel in 1959 was an important first step in much-needed improvements in this regard, setting the stage for an extensive and ongoing WHO programme geared towards achieving a ‘common language’. ICD-9, published in 1978, was the first satisfactory and widely used version.

ICD 10

CD-10 was endorsed in May 1990 by the Forty-third World Health Assembly. It is cited in more than 20,000 scientific articles and used by more than 100 countries around the world.

A version of ICD-11 was released on 18 June 2018 to allow Member States to prepare for implementation, including translating ICD into their national languages. ember States will start reporting using ICD-11 on 1 January 2022.

Box 2.2 The main categories of ICD-10 Chapter V (F)

F0 Organic, including symptomatic, mental disorders

F1 Mental and behavioural disorders due to psychoactive substance use

F2 Schizophrenia, schizotypal, and delusional disorders

F3 Mood (affective) disorders

F4 Neurotic, stress-related, and somatoform disorders

F5 Behavioural syndromes associated with physiological disturbances and physical factors

F6 Disorders of adult personality and behaviour

F7 Mental retardation

F8 Disorders of psychological development

F9 Behavioural and emotional disorders with onset usually occurring in childhood or adolescence

Source: data from The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines, Copyright (1992), World Health Organization.

Diagnostic and Statistical Manual (DSM)

In 1952 the American Psychiatric Association (APA) published the first edition of the Diagnostic and Statistical Manual (DSM-I) as an alternative to the widely criticized ICD-6.

DSM-I was strongly influenced by the views of Adolf Meyer and Karl Menninger, and its simple glossary reflected the prevailing acceptance of psychoanalytic ideas in the USA.

DSM-II was published in 1968, and combined psychoanalytic ideas with those of Kraepelin.

DSM-III was published in 1980, and was an important step forward, containing five main innovations.

● Operational criteria were provided for each diagnosis, with explicit rules for inclusion and exclusion (Feighner et al., 1972). This was the first complete classification to do so, and the first to be based on criteria that had been field-tested.

Innovations of DSM-III

1. Provided a definition of the term “mental disorder”
2. Presented diagnostic criteria for each disorder
3. Introduced the multiaxial diagnostic format
4. Redefined a number of major disorders (e.g., elimination of “neurosis”)
5. Added new diagnostic categories (e.g., personality disorders)
6. Presented a hierarchical organization of diagnostic categories
7. Presented a systematic description of each disorder

Innovations of DSM-III

8. Provided decision trees for differential diagnosis
9. Provided a glossary of technical terms
10. Published reliability data from field trials
11. Utilized a descriptive, a theoretical approach
12. A multiaxial classification was adopted, with five axes (Axis I: Clinical syndromes; Axis II: Personality disorders; Axis III: Physical disorders; Axis IV: Severity of psychosocial stressors; Axis V: Highest level of adaptive functioning in the last year).

DSM-III-R

Published in 1987, as a result of on-going research and resulting progress in the understanding of the diagnostic categories.

Represented a number of changes, including a revision of the multiaxial system (especially Axis II, which was broadened to include mental retardation, and Axis V, which introduced a more comprehensive rating scale).

The next full revision, DSM-IV, followed in 1994. It contained some revisions and additions to diagnostic categories, but retained the basic structures and features from DSM-III.

DSM-IV-TR

- Published by the American Psychiatric Association
- Primarily used in the United States
- Includes information only on mental illnesses
- Classifies mental illnesses into different types of disorders (Mood disorders, psychotic disorders, eating disorders, etc.)

DSM 5

- The DSM 5 May 2013.
- Research started in 1999.
- The DSM makes the American Psychiatric Association over $5 million a year, historically adding up to over $100 million.

Goals for Improving the DSM

- Changes should be based on empirical research rather than clinical consensus.
  - Behavioral science
  - Neuroscience
  - Molecular genetics
- Move toward a classification based on etiology.

DSM-5 Structure

- Section I: Basics
- Section II: Diagnostic Criteria and Codes
- Section III: Emerging Measures and Models
- Appendix

Section I: Basics

- Introduction
- Use of the Manual
- Cautionary Statement for Forensic Use

Section I: Basics: Introduction

- DSM-5 has better reliability than DSM-IV.
- Research to validate diagnoses continues.
- The boundaries between many disorder categories are fluid over the life course.
- Symptoms assigned to one disorder may occur in many other disorders.
- DSM-5 accommodates dimensional approaches to mental disorders.

- DSM-5 provides explicit diagnostic criteria for each mental disorder, supplemented by dimensional measures when appropriate.
- Many mental disorders are on a spectrum with related disorders that have shared symptoms.
- The boundaries between disorders are porous.

- For example, suppose a client has significant depressive symptoms but does not meet all the criteria for a major depressive episode.
- The diagnosis would be “Other specified depressive disorder, depressive episode with insufficient symptoms.”

Two Clusters of Disorders

- Internalizing group

  Disorders with prominent anxiety, depressive, and somatic symptoms

- Externalizing group

  Disorders with prominent impulsive, disruptive conduct, and substance use symptoms

Disorders within these clusters are adjacent in the DSM-5.

Organization of Disorders

- Disorders are organized on developmental and lifespan considerations.
- DSM-5 begins with diagnoses that manifest early in life, then adolescence and young adulthood, then adulthood and later life.

Cultural Issues

- Culture shapes the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis.
- Section III contains a Cultural Formulation.
- The Appendix contains a Glossary of Cultural Concepts of Distress.
- More information on culture and diagnosis is online at www.psychiatry.org/dsm5

Cultural Issues, cont.

- DSM-5 replaces the construct of the culture-bound syndrome in DSM-IV with 3 concepts:
  - Cultural syndrome: a cluster of invariant symptoms in a specific cultural group
  - Cultural idiom of distress: a way of talking about suffering among people in a cultural group
  - Cultural explanation or perceived cause for symptoms, illness, or distress

DSM-5 is Non-Axial

- DSM-IV axes I, II, and III have been combined.
- Continue to list relevant medical conditions.
- The GAF in DSM-IV has been eliminated. Instead, use the World Health Organization Disability Assessment Schedule (WHODAS).
- The WHODAS-2.0 is on page 747 of the DSM-5 and is also available online.

Section I: Basics: Use of the Manual

- Clinical Case Formulation
  - Making diagnoses requires clinical judgment, not just checking off the symptoms in the criteria.
  - The client's cultural and social context must be considered.
  - The DSM-5 does not include all possible mental disorders.

Definition of a Mental Disorder

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

There is usually significant distress or disability in social or occupational activities.

- The diagnosis of a mental disorder should have clinical utility; it should help clinicians to determine prognosis and treatment plans.

- The diagnosis of a mental disorder is not equivalent to a need for treatment.

- Until etiological or pathophysiological mechanisms are identified to validate specific disorders, the most important standard for the disorder criteria will be their clinical utility.

- The etiology of most mental disorders is unknown.
- The pathological physiological mechanisms for most mental disorders are unknown.
- Until such factors are identified, it will be difficult to fully validate specific disorders.

- In the absence of clear biological markers for mental disorders, it has not been possible to completely separate normal and pathological symptom expressions contained in diagnostic criteria.
- Therefore, a generic diagnostic criterion is “the disturbance causes clinically significant distress or impairment . . . .”

- Diagnoses are made on the basis of
  - The clinical interview
  - DSM-5 text descriptions
  - DSM-5 criteria
  - Clinician judgment

Steps in Making a Diagnosis

- Administer cross-cutting assessments
- Administer WHODAS 2.0
- Conduct clinical interview
- Determine whether a diagnostic threshold is met
- Consider subtypes and/or specifiers
- Consider contextual information, disorder text, distress, clinician judgment
- Apply codes and develop a treatment plan

Section I: Basics: Cautionary Statement for Forensic Use of DSM-5

- The diagnosis of a mental disorder does not imply that the person meets legal criteria for the presence of a mental disorder or a specific legal standard for competence, criminal responsibility, disability, etc.
- Having a diagnosis does not imply that the person is (or was) unable to control his or her behavior at a particular time.

Section III: Emerging Measures and Models

- Optional Assessment Measures
  - Level 1 Cross-Cutting Symptom Measure
    - To measure depression, anger, mania, anxiety, etc.
    - To screen for important symptoms; self-administered by patient; brief (1-3 questions per symptom domain).
  - Level 2 Cross-Cutting Symptom Measure
    - To be done when a Level 1 item is endorsed at the level of “mild” or greater.

Emerging Measures, cont.

- Diagnosis-Specific Severity Measures
  - To document the severity of a specific disorder.
  - Some are clinician-rated, some are patient-rated.

Emerging Measures, cont.

- WHO Disability Assessment Schedule 2.0
  - Replaces the GAF Scale in DSM-IV
  - Is recommended but not required.
  - Has 36 self-administered questions.

- Cultural Formulation
  - Outline for Cultural Formulation
  - Cultural Formulation Interview

Conditions for Further Study

- Attenuated Psychosis Syndrome
- Persistent Complex Bereavement Disorder
- Caffeine Use Disorder
- Internet Gaming Disorder
- Suicidal Behavior Disorder
- Nonsuicidal Self-Injury

Suicidal Behavior Disorder

- A suicide attempt within the past 24 months.
- The act is not nonsuicidal self-injury.
- Suicidal ideation does not qualify.

Nonsuicidal Self-Injury

- In the last year the person has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body . . . with the expectation that the injury will lead to only minor or moderate physical harm (i.e. there is no suicidal intent).
- Five additional criteria.

Table 2.1 Differences between ICD-10 and DSM-5

	ICD-10	DSM-5
Origin	World Health Organization	American Psychiatric Association
Usage	Official global classification, for use by all health practitioners in all health settings	Mainly American psychiatrists, and psychiatric researchers
Presentation	Different versions for clinical work, research, and use in primary care	A single document
Languages	Available in all widely spoken languages	English version only
Structure	Part of overall ICD framework	Stand alone
Content	Clinical descriptors and guidance used Guidelines and criteria do not include social consequences of disorders	Operational criteria used Diagnostic criteria usually include significant impairment in social functions