01 - 1. Approaches to Classification

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1. Approaches to Classification The two major contemporary classificatory systems are ICD 10 (1992) and DSM IV (1994). American Psychiatric Association produces the DSM system. WHO commissioned ICD 10? DSM-V was released in 2013 but there has been much criticism of this system, and as of yet it has not been adopted widely except by clinicians communicating with insurers in the USA. It is anticipated that ICD11 will be released in 2017 Both classificatory systems are categorical systems of classification based on clinical descriptions. While both ICD-10 and DSM-4 are diagnostic and classificatory systems and are meant to provide reliable diagnosis, they do not provide assessment plans, case formulations or treatment plans. Various terms are used to describe the characters of classificatory systems. The concept of operationalized criteria, atheoretical approach, hierarchical organisation and multi-axial classification are important for MRCPsych Paper A exam and are described below. Operationalised approach: In DSM-III operationalised diagnosis was first introduced. Operational criteria include the use of precise clinical description of disorders, together with predefined exclusion and inclusion criteria and details of the number and duration of symptoms required for diagnosis. It enables algorithm-based clinical diagnosis using intensity, duration of the symptoms and impairment tests. This more or less equates to using a checklist for diagnosis, but some rules are necessary while some are optional for a diagnosis. Characteristic symptoms are pertinent to the diagnosis, such as the symptom of depression, which is found in many different disorders. Discriminating symptoms, e.g. thought insertion, are necessary for diagnosis since they are not found in other diseases. Pathognomonic symptoms, if present, strongly favour one diagnosis over another. Thus, they are more specific to a condition than other symptoms (e.g. flashbacks of trauma and PTSD). Inclusion and exclusion criteria: A hierarchy of symptoms, arranged in order of importance (e.g. criterion A and B etc.) often accompanies diagnostic descriptions in operationalised systems. These form the core inclusion and exclusion criteria used in practice to establish a diagnosis.

Computerised scoring systems such as OPCRIT (for ICD10) facilitate the application of such operationalised diagnoses. The atheoretical approach means diseases are described according to the observed phenomenology; classification is NOT based on the understanding of what might be causing the disturbances. So various aetiological schools such as behaviourism or psychoanalysis, etc. are not employed in describing a disorder. No theory forms the basis of the classifications; only neutral observations are taken into account. The descriptive approach refers to classifying illnesses on the basis of what constitutes the illness rather than what causes it; Lack of pathogenetic knowledge of most psychiatric disorders makes this approach more rational. This forms the basis of any atheoretical classification.

© SPMM Course Categorical vs. dimensional approaches: The current classificatory systems entertain categorical diagnoses only; i.e. similar to medical diseases. In other words using current systems, we can only say whether an individual's clinical presentation either meets or does not meet the diagnostic criteria for a particular disorder. A patient either has or does not have pneumonia; she has or does not have schizophrenia, etc. Contrast this approach with measurement of blood pressure – we use a continuum from low to high along which measurement is made. (It only becomes categorical when we apply the label “hypertension” to indicate that a patient has clinically troublesome problem with high BP). Of all psychiatric disorders, the need to develop a dimensional system for description is said to be more urgent for personality disorders. Categorical approach Dimensional approach Traditionally doctors are accustomed to thinking in terms of categories – easy to understand. All existing knowledge base about the presentation, aetiology, epidemiology, course, prognosis, and treatment is based on these categories. Categories are easy to communicate with professionals Poor validity –vague categories such as ‘Psychosis - not specified’ are needed to include atypical cases.

More valid as most emotional and cognitive states exist as a continuum without clear cut-off point between ill and the well. Severity can be better indicated Need to entertain many comorbid diagnoses may be prevented. Research studies using dimensional scales as end points have much greater power to detect differences in groups than do studies focusing on changes in dichotomous categories Clinical utility is questionable, as dimensions cannot be directly mapped onto clinical decisions such as starting or stopping an intervention. Hierarchical organisation is largely abandoned in DSM and somewhat maintained in ICD-10 in its organisation of chapters. Hierarchy means that certain disorders take precedence over others while making a diagnosis. This follows Jasperian ideas (Karl Jaspers: see Introduction to Psychopathology for more details) – the ladder starts from organic disorders through to substance use issues, psychosis, affective and neurosis up to personality issues. If a disorder on top of the hierarchy can explain the observed symptoms, then a diagnosis should not be entertained from down below the hierarchy even if the constellation of symptoms are suggestive of such a diagnosis. To understand the concepts of hierarchy consider the following example. Dementia and other brain-based organic disorders can be associated with any type of psychiatric problem. But a separate diagnostic label is not used for each of these psychiatric syndromes. For example, ‘schizophrenic symptoms’ occurring in the course of Huntington's disease or temporal lobe epilepsy or severe learning disability do not change the diagnosis to ‘schizophrenia’ in these cases. Other examples include the co-occurrence of depression and agoraphobia, depression and OCD, organic delirium and psychosis – in all these cases the first diagnosis is primarily entertained instead of the second even if the symptoms could be explained by

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