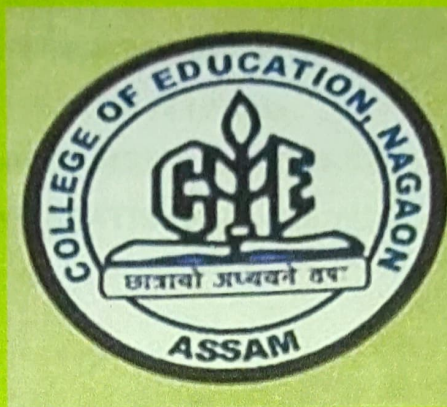


# COLLEGE OF EDUCATION, NAGAON



## ASSIGNMENT

**PAPER: (C-14)**

**TITLE: CLASSIFICATION OF MENTAL ILLNESS DSM II.**

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## **INTRODUCTION**

Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses can be associated with distress and/or problems functioning in social, work or family activities.

Mental illness is treatable. The vast majority of individuals with mental illness continue to function in their daily lives.

Mental health is the foundation for emotions, thinking, communication, learning, resilience, hope and self-esteem. Mental health is also key to relationships, personal and emotional well-being and contributing to community or society. Mental health is a component of overall well-being. It can influence and be influenced by physical health.

Many people who have a mental illness do not want to talk about it. But mental illness is nothing to be ashamed of! It is a medical condition, just like heart disease or diabetes. And mental health conditions are treatable. We are continually expanding our understanding of how the human brain works, and treatments are available to help people successfully manage mental health conditions.

Mental illness does not discriminate; it can affect anyone regardless of age, gender, geography, income, social status, race, ethnicity, religion/spirituality, sexual orientation, background or other aspect of cultural identity. While mental illness can occur at any age, three-fourths of all mental illness begins by age 24.

Mental illnesses take many forms. Some are mild and only interfere in limited ways with daily life, such as some phobias (abnormal fears). Other mental health conditions are so severe that a person may need care in a hospital. Similar to other medical illnesses, the optimal ways to provide care depend on the illness and the severity of its impact.

Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of biological, psychological, and environmental factors.

Many mental illnesses run in families. But that doesn't mean anyone will have one if his/her mother or father did.

Some conditions involve circuits in the brain that are used in thinking, mood, and behavior. For instance, if someone may have too much, or not enough, activity of certain brain chemicals called neurotransmitters within those circuits. Brain injuries are also linked to some mental conditions.

## **CAUSES OF MENTAL ILLNESS**

Some mental illnesses may be triggered or worsened by psychological trauma that happens when the person was a child or teenager, such as:

- Severe emotional, physical, or sexual abuse
- A major loss, such as the death of a parent, early in life
- Neglect

Major sources of stress, such as a death or divorce, problems in family relationships, job loss, school, and substance abuse, can trigger or aggravate some mental disorders in some people. But not everyone who goes through those things gets a mental illness.

It's normal to have some grief, anger, and other emotions when you have a major setback in life. A mental illness is different from that.

## **BIOLOGICAL FACTORS INVOLVED IN MENTAL ILLNESS**

Some mental illnesses have been linked to abnormal functioning of nerve cell circuits or pathways that connect particular brain regions. Nerve cells within these brain circuits communicate through chemicals called neurotransmitters. "Tweaking" these chemicals - through medicines, psychotherapy, or other medical treatments - can help brain circuits run more efficiently. In addition, defects in or injury to certain areas of the brain have also been linked to some mental conditions.

Other biological factors that may be involved in the development of mental illness include:

- **Genetics (heredity):** Mental illnesses sometimes run in families, suggesting that people who have a family member with a mental illness may be somewhat more likely to have one themselves. This susceptibility is passed on in families through genes. Experts believe that many mental illnesses are linked to abnormalities in many genes, rather than just one or a few, and that how these genes interact with the environment is unique for every person (even identical twins). That is why a person inherits a likeliness to have a mental illness and doesn't necessarily get the illness. Mental illness itself comes from the interaction of multiple genes and other factors – such as stress, abuse, or a traumatic event – which can influence, or trigger, an illness in a person who has an inherited likeliness to have it.
- **Infections:** Certain infections have been linked to brain damage and the development of mental illness or the worsening of its symptoms. For example, a condition known as pediatric autoimmune neuropsychiatric disorder (PANDAS) associated with the streptococcus bacteria has been linked to the development of obsessive compulsive disorder and other mental illnesses in children.
- **Brain defects or injury:** Defects in or injury to certain areas of the brain have also been linked to some mental illnesses.
- **Prenatal damage:** Some evidence suggests that a disruption of early fetal brain development or trauma that occurs at the time of birth – for example, loss of oxygen to the brain – may play a part in certain conditions, such as autism spectrum disorder.
- **Substance abuse:** Long-term substance abuse, in particular, has been linked to anxiety, depression, and paranoia.
- **Other factors:** Poor nutrition and exposure to toxins, such as lead, may play a role in mental illnesses.

## **SYMPTOMS OF MENTAL ILLNESS**

If several of the following are occurring, it may be useful to follow up with a mental health professional.

- **Sleep or appetite changes** — Dramatic sleep and appetite changes or decline in personal care.

- **Mood changes** — Rapid or dramatic shifts in emotions or depressed feelings, greater irritability.
- **Withdrawal** — Recent social withdrawal and loss of interest in activities previously enjoyed.
- **Drop in functioning** — An unusual drop in functioning, at school, work or social activities, such as quitting sports, failing in school or difficulty performing familiar tasks.
- **Problems thinking** — Problems with concentration, memory or logical thought and speech that are hard to explain.
- **Increased sensitivity** — Heightened sensitivity to sights, sounds, smells or touch; avoidance of over-stimulating situations.
- **Apathy** — Loss of initiative or desire to participate in any activity.
- **Feeling disconnected** — A vague feeling of being disconnected from oneself or one's surroundings; a sense of unreality.
- **Illogical thinking** — Unusual or exaggerated beliefs about personal powers to understand meanings or influence events; illogical or "magical" thinking typical of childhood in an adult.
- **Nervousness** — Fear or suspiciousness of others or a strong nervous feeling.
- **Unusual behavior** — Odd, uncharacteristic, peculiar behavior.
- **Changes in school or work** — Increased absenteeism, worsening performance, difficulties in relationships with peers and co-workers.

## CLASSIFICATION OF MENTAL ILLNESS

From the Latin term "insania" for insanity to the use of "mania" and "melancholia" in Greek to denote a chaotic frenzy and depression, there has been a rich vocabulary used to discuss mental illness since ancient times. But the first attempt to classify such afflictions was by the Greek physician Hippocrates in 400 BC, who believed that mental illness stemmed from imbalances of a person's black bile, yellow bile, phlegm, and blood. Different imbalances resulted in particular symptoms which could be split into the following categories: Mania, Melancholy, Phrenitis (brain inflammation), Insanity, Disobedience, Paranoia, Panic, Epilepsy, and Hysteria.

Inspired by botanical taxonomy (the classification of plants), a French physician called François Boissier de Sauvages de Lacroix published a system of classifying

illness in 1763. This classification included mental illnesses, subdivided into four categories: 1) Hallucinations, 2) Morositates, 3) Deliria, and 4) FoliesAnomales. Within these categories were some familiar symptoms including induced vomiting, mania, amnesia, hypersexuality, panic, and insomnia. Other symptoms, like "the uncontrollable impulse to dance" and "non-aggressive delirium with accompanying sadness caused by the devil" are a world away from the Western psychiatric manuals we know today.

The 19th century saw more attempts to classify mental illness. In Germany, Karl Kahlbaum published his 'Classification of Psychiatric Diseases and Mental Disturbances' (1863), positing a system which classified mental illnesses by their symptoms. Rejecting the tradition of labelling a symptom as a particular illness, he conceptualised psychiatric diagnoses as clusters of symptoms: mania as a symptom of a disorder instead of a disorder in itself. Kahlbaum employed many terms that we still use today including Dysthymia, Cyclothymia, Catatonia, Paranoia, and Hebephrenia. Inheriting Kahlbaum's ideas, Emil Kraepelin, in the late 19th and early 20th century, proposed a system in which a disorder was defined not only by the symptoms that constitute it, but also by the patterns and course in which it presents. Famously, he differentiated between Psychotic Disorders and Affective Disorders, providing the foundations for what we now refer to as Schizophrenia and Bipolar Disorder.

Today, the two most widely established systems of psychiatric classification are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification for Diseases (ICD). Despite each being as widely used as the other, the ICD and the DSM conceptualise and classify mental disorders in different ways.

## **DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS**

The DSM is published by the American Psychiatric Association, America's main professional organisation of psychiatrists. It is the world's largest psychiatric organisation, with upwards of 38,500 members in over 100 countries. Given that the DSM only includes Mental Disorders, it is used primarily by Psychiatrists but also by other mental health professionals. The beginnings of the DSM arose before the APA went by its current name, then called the Committee on Statistics of the American Medico-Psychological Association. In 1917, it published the 'Statistical Manual for

the Use of Institutions for the Insane' which outlines the symptoms of 21 disorders. All the disorders were, bar two, psychotic in nature.

Reformulated as the DSM, the first edition was released in 1952 and contained 128 categories. It differentiated between organic brain syndromes and functional (physically undetectable) disorders. Functional disorders were further divided into Psychotic Disorders, Neurotic Disorders (distress without psychosis), and Personality Disorders. Descriptions were short, leaving it up to the diagnosing clinician's discretion to interpret meaning, focusing on the cause of disorders rather than their symptoms. In this way, the manual honoured the psychodynamic tradition. Whilst the first DSM- seemed to be aimed at diagnosing patients in psychiatric hospitals, the DSM-2 (1968) was thought to have more relevance to outpatients. The sections on Depressive Disorders, Anxiety Disorders, and Personality Disorders were expanded in this edition, and disorders specific to children and adolescents - as well as a miscellaneous category - were introduced. The seventh printing of DSM-2 saw homosexuality depathologised, reflecting a departure from mental illness as being a deviation from accepted social values.

The DSM-3 marked a paradigm shift: a move away from vague descriptions mostly concerned with a disorder's origin, instead embracing the clinical specificity of diagnostic criteria. With the DSM-3 (1980) came the introduction of the multi-axial system.

Published in 1994, the DSM-4 built upon the clinical research generated for its predecessor, with most diagnoses being grounded in at least some research. DSM-4 was revised in 2000, with corrections made to factual errors and research updated to reflect that which was most recently published.

The DSM-5, published in 2013, is the most up-to-date manual. Like the DSM-4, it is based upon the work of expert study groups and makes use of large sets of data. The DSM-5 is a polythetic system in that lists of symptoms are given and diagnostic labels are assigned to patients based upon whether the specified symptoms or sometimes number of symptoms are met.



## DSM II

The American Psychiatric Association published a second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1968. This revision of the original DSM was prompted by a desire to increase the compatibility of the American and international diagnostic systems and address inconsistencies in criteria between the DSM and the World Health Organization's International Classification of Diseases (ICD) that was in its 8th edition at the time. DSM-II expanded the number of diagnostic sections from two to ten and it added a child/adolescent section. Because the first DSM was designed to generate population statistics, it did not permit diagnostic comorbidities. DSM-II reversed the original manual's prohibition against diagnostic comorbidity. It retained the psychodynamic nomenclature and etiologically-based classification of the first DSM, but the term "reaction" was removed, possibly representing an initial step toward an atheoretical etiologic orientation in future versions of the diagnostic criteria.

To compensate for perceived inadequacies of the *DSM-I*, the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* was published in 1968, and was still largely reflective of the psychodynamic tradition, although this school of thought was already on the decline by the end of the 1960s, and subtle amendments made to *DSM-II* hinted at such change. Two major trends can be noted in the content modifications to the *DSM-II*. The first was a further expansion of the definitions of mental illness that was arguably in line with a broadening of psychodynamic theory to be more inclusive of milder conditions seen in the general population. This was indicated by the addition of diagnostic categories such as "Conditions Without Manifest Psychiatric Disorder" for "individuals who are psychiatrically normal but who nevertheless warrant examination by a psychiatrist", and "Transient Situational Disturbances" for "disturbances of psychotic proportion when they are considered clearly transient reactions to overwhelming environmental stress". The second trend was an increased systematic categorization and specificity that suggested a return to the Kraepelinian tradition. This was evidenced by multiple subdivisions of former disorder categories, such as the addition of eight new "alcoholic brain syndromes", an increased number of "qualifiers" from four in the *DSM-I* to nine in the *DSM-II* - namely,

"acute; chronic; not psychotic; mild; moderate; severe; in remission", and the explicit advocacy that clinicians "diagnose every disorder that is present, even if one is the symptomatic expression of another". Yet another alteration in the *DSM-II* was the removal of the psychodynamic term "reaction", referring to the maladaptive response of an individual to socio-environmental sources of distress. A disclaimer accompanied the announcement of such modification:

"Some individuals may interpret this change as a return to a Kraepelinian way of thinking, which views mental disorders as fixed disease entities. Actually this was not the intent of the APA Committee on Nomenclature and Statistics: "The Committee tried to avoid terms which carry with them implications regarding either the nature of a disorder or its causes. In the case of diagnostic categories about which there is current controversy concerning the disorder's nature or cause, the Committee has attempted to select terms which it thought would least bind the judgment of the user."

While significant discrepancies existed between the classification schemes of the *DSM-I* and the *International Classification of Diseases, 6<sup>th</sup> revision (ICD-6)* of the World Health Organization (WHO), The *DSM-II* And the *ICD-8* were more closely aligned, reflecting a collaborative effort between the WHO and American psychiatrists sent to Europe prior to the publication of both the *ICD* and *DSM* manuals that same year.

## CONCLUSION

The DSM classification systems in psychiatry have value and, in particular, the high profile of DSM since 1980 has stimulated much more interest in nosology and heightened awareness of both the limitations and advantages of current classification.

DSM has been productive in promoting research, but has handicapped advances in some respects by giving credibility to diagnoses which probably do not exist, and has generated much needless research into issues such as comorbidity of disorders which share much more than they differ by.

ICD has been poorly resourced and has not been able to generate the same degree of research data as DSM, but has steadily improved over the years and, with better descriptions and definitions, is likely to be used not only widely, but more seriously and accurately.

Diagnostic practice remains fluid and it is uncertain which of these three approaches DSM, ICD or RDoC will dominate in the end. None of these classification systems are going to be able to overcome the fundamental problems outlined at the beginning of this article until we have independent measures of disease, but for some mental conditions this will never happen. Without a well-functioning classification system we would be blind, deaf and stupid in the practice of our craft and so need to spring to its defence whenever it is mindlessly assaulted.



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