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Review

Psychiatric classification: Current debate and future directions

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ABSTRACT

Classification of health related conditions can be a complex task. This is particularly so in case of psychiatric disorders. The present paper reviews the fundamentals of psychiatric classification, including its basis, history, methods of evaluation, the journey so far and future directions. The various criticisms of current classificatory systems and possible solutions are discussed. Special reference to the research domain criteria (RDoC) approach has been made and implications discussed.

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1. Introduction

The third edition of the Diagnostic and Statistical Manual (DSM) stated that 2–4% of the general population had at some point suffered from an anxiety disorder (American Psychiatric Association, 1980). From these initial estimates during the late 1970s, the estimated lifetime prevalence has been quoted as 15% (Regier et al., 1998; Leaf et al., 1991) in the Epidemiological Catchment Area Survey (ECA) and 28.8% (Kessler and Waters, 2002) in the National Co-morbidity Survey – Revised (NCS – R). More recent epidemiological studies (Moffitt et al., 2009) suggested values as high as 49.5%. Do these differences indicate changes in actual prevalence or an artifact of the

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Box 1. Types of classification.

- Monothetic v/s polythetic
- Descriptive v/s etiological
- Natural v/s artificial
- Top-to-bottom v/s bottom-up
- Structured v/s listing
- Hierarchical v/s non-hierarchical
- Exhaustive v/s partial
- Idiographic v/s nomothetic

way psychiatric disorders are classified? In the present paper some of the most relevant debates surrounding psychiatric classification in scientific circles today and likely future developments are reviewed.

The following methods were used to review the pertinent literature. A Pubmed search was conducted using the broad MeSH term 'mental disorders classification' initially. Thereafter, additional words were added to the above – such as 'mental disorders classification schizophrenia', 'mental disorders classification bipolar disorder', 'mental disorders classification anxiety disorders' and so on. Although not a MeSH term, 'research domain criteria' was used to look for additional articles. Besides Pubmed search, the above terms were also entered into search boxes of leading psychiatry journals individually. The references cited in the articles so obtained were further reviewed. The chapters on classification from reputed psychiatry textbooks were also consulted, and cross references reviewed. The data so obtained was synthesized under various headings as shown below, for purposes of clarity.

2. Classification and its types

Classification is defined as the activity of ordering or arrangement of objects into groups, sets or categories. It consists of constructing groups and categories and assigning entities to the groups (Stengel, 1959). It provides a framework for understanding and communicating about various clinical conditions (Burke and Kraemer, 2015). Clinical conditions can be classified in many different ways from etiology, pathogenesis, symptoms, organ system involved, medical specialty concerned and so on. Similarly, several approaches can be used to classify psychiatric disorders as well (Berrios, 1999), as summarized in Box 1.

Clinical conditions represent entities about which variable amount of information are known. Some conditions are well understood in terms of etiology, pathogenesis, and clinical features as well as amenable to complete cure whereas others are poorly understood. The approach to classification varies significantly based on such understanding. Conditions are typically understood as either syndromes, disorders, diseases or illnesses (Horwitz and Wakefield, 2012). The defining features of these terms are summarized in Box 2.

3. History of psychiatric classification

The earliest descriptions of mental illness are commonly ascribed to senile deterioration of prince Ptah-Hotep in 3000 BC (Zimmerman and Spitzer, 2009). Sumerian and Egyptian literature described melancholic and hysterical presentations dating to 2600 BC while Ebers papyrus (1500 BC) describes alcoholism and senile deterioration. In India, Ayurveda elaborately described various forms of mental afflictions as early as 1400 BC. Hippocrates (4000 BC) described various forms of mental illnesses of acute or chronic nature with or without fever, besides hysteria. Felix Platter described conditions similar to dementia in the sixteenth century. The seventeenth century English physician, Thomas Sydenham was well ahead of his time when he suggested that each illness had a specific cause that must be carefully inquired into (Zimmerman and Spitzer, 2009). In the beginning of modern times (late eighteenth and early nineteenth century), Philippe Pinel described mania, melancholia, dementia and idiotism. The period from mid nineteenth century to the mid twentieth century saw classifications primarily geared toward public health concerns. From counting idiocy or insanity in the 1840s to failed attempts at consensus on a multiple category system in the 1880s, population level psychiatric census was abandoned at the turn of the nineteenth century. Surveys in mental hospitals, however continued though the categories used varied widely from hospital to hospital (Burke and Kraemer, 2015). With the advent of World War II and subsequent wars, classifications such as that of the United States army emerged followed by that of DSM I and International Classification of Diseases (ICD), first edition. This period from 1943–1980 saw classificatory systems primarily reflecting clinical practice. Meyerian psychodynamic terms such as 'reaction' were commonly suffixed to disorder categories. Further changes up to ICD-8 and DSM II continued along similar lines and were not widely followed. Diagnoses made in different parts of the world did not corroborate with one another. Feighner et al. (1972) published sets of diagnostic criteria for 15 disorders with emphasis on reliability. This and the subsequent Research Diagnostic Criteria (RDC) paved way for a shift in approach to psychiatric classification with emphasis on reliability resulting in the birth of ICD 9, and DSM III. The thrust has remained on the reliability of diagnoses in the present day classificatory systems of ICD 10, DSM IV and DSM 5 (Burke and Kraemer, 2015). Besides the ICD and DSM, the other classificatory system of relevance to Asia is published by the Chinese Society of Psychiatry – the Chinese Classification of Mental Disorders (CCMD). First published in 1979, it is currently in its third edition with deliberate similarities with ICD and DSM although it has additional culturally related diagnoses (Chen, 2002).

Box 2. Defining features of commonly used terms to indicate an abnormal state.

- **Syndrome** – A set of signs and symptoms that co-occur at a greater than chance frequency
- **Disorder** – Conjunction of a syndrome with a clinical course; A state considered intermediate between syndrome and disease
- **Disease** – Conjunction of etiology and pathology; true disease implies symptoms, pathology, pathophysiology and underlying causes as well as the relationship between them are known
- **Illness** – The psychosocial aspect of being sick

4. Psychiatric classification – fundamental challenges

Unlike many other branches of medicine, psychiatry faces certain challenges that are unique to this field. Classification based on cause or etiology is usually considered the standard way to classify conditions in the rest of medicine. But even with this approach, problems often arise due to variable clinical presentation of the same condition with the same cause. In psychiatry, to add to the woes, exact cause for most disorders are not known and are possibly multiple (Burke and Kraemer, 2015). Therefore, etiology based classification is extremely difficult to arrive at considering the current state of knowledge. It is impossible to reduce the available information to a one level explanation approach at the current time (Kendler, 2013). Current systems use a syndromal approach to psychiatric classification. But this approach, although convenient, is fraught with numerous conceptual problems (Horwitz and Wakefield, 2012). Plenty of historical examples from general medicine are a testament to this statement. Hydropsy, a blanket term that would today include various forms of edema, used to be a syndromal diagnosis. Foxglove leaves were a partially effective treatment for this syndrome (Ambrosy et al., 2014; Withering, 1941). However, with the availability of detailed knowledge of various causes of