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Editorial on Classification of Mental Disorders

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Editorial

The search for similarities and differences across patient groups has typically led to the classification of mental diseases. Its most common application nowadays is for administrative and reimbursement purposes. Researchers also utilise mental disorder categories to define homogenous groups of patient populations in order to investigate their features and potential causes of mental disease, such as the source, treatment response and prognosis. The use of mental illness categories as a teaching and clinical practise aid has grown in popularity. The introduction of operational diagnostics has demystified aspects of various practises: identification of a clinical feature should be defined, observed and if possible measured in a similar way independent of the assessor. Previously, psychiatry and behavioural medicine practise was primarily based on clinical judgement and speculative theories about aetiology; however, the introduction of operational diagnostics has demystified aspects of various practises. Understanding that mental disorders may be described as brain dysfunctions is one of the major breakthroughs of mental disorder categorization thus far. For example, schizophrenia was characterised as an integration of mental functions originating in the brain: errors in thought processing, for example, result in this mental condition, which was previously regarded to be a myth or a cultural term.

More attempts to categorise mental disease were made in the nineteenth century. Karl Kahlbaum proposed a method for classifying mental diseases based on their symptoms in his 'Classification of Psychiatric Diseases and Mental Disturbances' (1863) in Germany. He conceptualised psychiatric diagnoses as clusters of symptoms, rejecting the convention of labelling a symptom as a specific illness: mania as a symptom of a condition rather than a sickness in and of itself. Dysthymia, Cyclothymia, Catatonia, Paranoia and Hebephrenia are only a few of the words used by Kahlbaum that we still use today. Emil Kraeplin presented a method in the late 19th and early 20th centuries, based on Kahlbaum's concepts, in which a condition was characterised not only by the symptoms that comprised it, but also by the patterns and course in which it manifested. He famously distinguished between Psychotic Disorders and Affective Disorders, laying the groundwork for Schizophrenia and Bipolar Disorder as we know them today.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Categorization for Diseases (ICD) are the two most extensively used psychiatric classification systems today (ICD). The ICD and the DSM conceptualise and define mental diseases in distinct ways, despite the fact that they are both extensively used. Psychiatric nosology or psychiatric taxonomy are terms used to describe how mental diseases are classified. It is a significant problem for persons who may be diagnosed and is a vital part of psychiatry and other mental health professionals. There are presently two commonly used classification systems for mental disorders:

- Section V of the 10th International Classification of Diseases (ICD-10) delivered by the World Health Organization (WHO).
- The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) produced by the American Psychiatric Association (APA).

Both list categories of illnesses that are regarded to be separate kinds and subsequent updates have purposefully converged their codes such that the manuals are generally broadly equivalent, despite major discrepancies. Other categorization methods, such as the Chinese Classification of Mental Disorders, may be used more regionally. Other guides, such as the Psychodynamic Diagnostic Manual, have a limited utility among persons of different theoretical persuasions.

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