Neurotic, Psychotic or Just Plain Nuts?
A Primer of Mental Health Classification

Mental health clinicians---*all of us*, psychologists, psychiatrists, master's level practitioners---use the same classification system when diagnosing someone's mental health. DSM-IV (Diagnostic and Statistical Manual of Mental Disorders---4th Edition) is our "diagnostic Bible" intended to provide a *global picture* of the individual's functioning. A thorough mental health evaluation should include a classification on *each* of the five axes of DSM-IV: each axis represents a different aspect of functioning. DSM reflects a "biopsychosocial model," i.e. a conception of the individual as reflecting biological, psychological and sociological influences. And isn't that the way things really are? We're all the product of the *many* forces that impinge upon us. (By the way, DSM, although it is used by all mental health professions to make a diagnosis, is *not* universally acclaimed! See my article elsewhere on this website titled "Is Diagnosis Useless in Litigation?")

What IS DSM?

Each of the five axes of DSM is designed specifically to address one part of the biopsychosocial model:

Axis I is for all clinical (mental) disorders other than Personality Disorders (which are coded on Axis II). It includes such disorders as bipolar disorder, schizophrenia, the mood disorders, disorders usually diagnosed first in childhood, and also includes disorders of eating, sleeping, sexuality, impulse control, adjustment disorders and "V Codes." All these are described below. Axis I conditions generally occur at a given point in an individual's life, i.e. they are not lifelong styles, as are the disorders in Axis II.

Axis II is devoted to conditions that are generally life-long. These include personality disorders and mental retardation. These are not considered mental illnesses but may (in the case of personality disorders, for example) reflect maladaptive functioning that *could* have a bearing on the legal case.

Axis III reflects physical factors that affect emotional well-being. For instance, a diagnosis of cancer might cause someone to develop major depression.

Axis IV is concerned with any psychosocial stressors that may be impacting emotional well-being. Such stressors as unemployment, family problems, homelessness, lack of social support, and so forth, often co-exist with (and may even partially cause) emotional difficulties.

Axis V is where everything is put together. In other words, all things considered, how well did this individual function over the past year? This is known as a *Global Assessment of Functioning* or *GAF.* The score can range anywhere from 1 (indicating

"persistent danger of hurting self or others or persistent inability to maintain minimal personal hygiene") to 100 (which is "superior functioning in a wide range of activities…no symptoms") to any number in between. There are descriptions of typical behaviors at each increment of 10, but the precise number is a matter of clinical judgment.

It's important to be aware that an individual may have more than one disorder simultaneously. Someone may even have multiple diagnoses on each axis. These disorders are in no way mutually exclusive, and it is not uncommon at all for someone to have diagnoses on each axis. And DSM recognizes that it might not always be able to capture the essence of the individual's disturbance with one of its ready-made diagnostic categories. Therefore, most diagnoses include the option to specify it as being "NOS" which means "not otherwise specified." This indicates the person has a general presentation in this category but some details are missing or different from the usual clinical picture.

AXIS I Disorders

Axis I is subdivided into specific diagnostic categories. These are:

1) ***Substance-related disorders*** (which is further subdivided into issues of abuse or dependence of any substance. Generally, only alcohol and drugs are diagnosed in this manner, but in fact, DSM considers that one can have a diagnosable problem with even caffeine or nicotine!) And dependence and abuse problems are defined differently.

2) ***Schizophrenia and other psychotic disorders***
A psychosis is a mental illness that involves a break with reality. There are many kinds of psychoses, and most have subtypes. For instance, schizophrenia is a psychosis that can manifest as several different subtypes, each with its own set of symptoms. These subtypes have symptoms in common, and also have symptoms that are specific to that subtype. Common symptoms include problems with social functioning, disturbance in thinking, loss of emotional expression, delusions or hallucinations and other symptoms.

But schizophrenia is not the only mental illness characterized by a break with reality.   Other psychotic disorders include schizoaffective disorder (a combination of a thought disorder and mood problems), delusional disorder (the delusions here are *not* bizarre ones!), brief psychotic disorder (by definition, less than one month in duration), shared psychotic disorder (where two people share a delusional system) and substance-induced psychosis (a psychosis directly caused by use of a substance, such as alcohol or drugs).

3) Mood Disorders

There are several types of mood disorders, but two are the most frequently encountered: One of these is **bipolar disorder** (which used to be called manic depression) in which the individual experiences alternating periods of depression and elation, called mania. (There is also a variation of bipolar disorder that includes depression and a much subtler form of mania that is not as flamboyant as the usual mania.) The interval between the moods varies widely, and the shift can be very subtle. While manic, the person might spend a great deal of money s/he does not have, do socially inappropriate things, and act self-destructively and very impulsively. When depressed, that same person might be unable to get out of bed, lose all appetite (or eat non-stop), have difficulty sleeping (or sleep constantly). The individual bounces back and forth between two opposite poles of extreme emotion. And it's important to know that bipolar <u>can</u> be so severe (although it certainly is not always) that it can involve a break with reality.   This can be a tricky diagnosis to make, because in its more subtle forms, the individual may appear quite "normal."

Another extremely common mood disorder is **major depression**.   This   illness is different from the "blues" that has been called the common cold   of mental health. Major depression is incapacitating and can be life-threatening. The sufferer experiences major changes in appetite and   sleep, becomes socially isolated and may neglect personal hygiene. Well-meaning friends and family may tell the individual to "snap out of it" but the individual cannot do so without professional intervention.

There are other forms of depression as well. One of the more serious variants is major depression with psychotic features. This is depression in which the individual may be hearing voices or having some other sort of experience that indicates a disconnection from reality.

Anxiety disorders are yet another kind of mood disorder. They have several variations, including **panic disorder** (in which the individual experiences discrete episodes of panic, accompanied by specific physical symptoms and may or may not be afraid to leave home for fear another attack will occur) and **phobias** of all sorts (defined as "a marked and persistent fear that is excessive and unreasonable, cued by the presence or anticipation of a specific object or situation" such as flying, dogs, fear of small, enclosed spaces, etc. It is theoretically possible (though uncommon) to develop a phobia about anything.

Generalized anxiety disorder refers to marked worry, occurring daily for 6 months or longer, about a *variety* of subjects. The individual has at least 3 symptoms from the list provided in DSM. A separate diagnosis is **anxiety disorder due to a medical condition.** Also separate is the diagnosis of **substance-induced anxiety disorder**, which is what its name implies.

One anxiety diagnosis that is probably quite familiar to those of you involved in personal injury litigation is that of **PTSD** (Post Traumatic Stress

Disorder). Few diagnoses are cited so frequently and yet are so poorly understood. PTSD is discussed in depth in my paper elsewhere on this website: "PTSD: The Misunderstood Diagnosis."

Also included in Axis I are "other conditions that may be a focus of clinical attention." These are things that may cause the individual some distress, but which are not considered mental illnesses by themselves. Examples include malingering, antisocial behavior, bereavement and problems with acculturation. There are many more such examples in DSM and they're called "V Codes."

4) **Impulse Control Disorders** People with these problems have great trouble reining in their impulse for behaviors that are destructive. Included are behaviors like fire-setting, stealing, compulsive gambling, explosive temper, hair-pulling and that old stand-by, Impulse Control NOS.

5) **Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence** Here you will find disorders like Learning Disabilities, Communications Disorders, and disorders which affect the individual's entire functioning, such as autism.

6) **Somatoform Disorders** are those disorders in which emotional problems are manifested by physical symptoms. The individual is <u>not</u> consciously aware of the underlying emotional issue.

7) **Factitious Disorders** are similar to Somatoform Disorders in that they involve emotional problems expressed by physical symptoms. The key differentiation is that with a Factitious Disorder, the individual is <u>intentionally</u> feigning the illness. S/he <u>wants</u> to assume the role of an ill person, but there is <u>not</u> any clear benefit (e.g. litigation).

8) **Dissociative Disorders** is the correct name for the over-used and very poorly-understood term "multiple personality disorder." This is an <u>extremely rare</u> condition that involves some form of disassociation from one's identity.

9) **Sexual and Gender Identity Disorders** do <u>not</u> include homosexuality, which is not considered to be any form of a mental illness. Note, however, that the individual may be experiencing depression or anxiety due to his/her sexual orientation, but that diagnosis focuses on the symptoms, not on the homosexuality per se. The illnesses in this category include various disorders of sexual functioning (e.g. erectile dysfunction), paraphilias (disturbance re: the object of one's sexual desire, such as sadism, exhibitionism, fetishism, etc.)

10)   Eating Disorders include anorexia and bulimia and, of course, Eating Disorder NOS.

11)   Sleep Disorders envelope a wide variety of sleep problems, from garden-variety insomnia to night terrors and many other diagnoses in between.

12)   Adjustment Disorders are very important to understand, because not infrequently conditions which *should* be given this diagnosis are misdiagnosed as being something else. An adjustment disorder is the development of emotional problems *in response to an identifiable stressor, occurring within 3 months of the onset of that stressor.* If someone, for instance, becomes depressed because s/he has been fired, a diagnosis of "adjustment disorder with depressed features" would be the correct diagnosis unless the individual meets other requirements that would indicate a diagnosis of Major Depression.

AXIS II Disorders

Axis II is comprised of two categories: mental retardation and personality disorders. The first category is probably familiar to you: it refers to persons whose intelligence falls below a specific level, referred to as an Intelligence Quotient or IQ. A personality disorder is an **enduring and pervasive style of interacting** with the world that "deviates markedly from the individual's culture."   This behavior must lead to "clinically significant distress or impairment in social, occupational, or other important areas of functioning." Typically, persons with personality disorders do not believe that they themselves have a psychological problem: they generally think the rest of the world ought to shape up, however! In other words, they think that all the problems they encounter in their daily interactions are due solely to the other person's behavior. Because they don't see their own responsibility for the problem, people with personality disorders are usually not too amenable to treatment; instead, it generally takes a crisis of some sort to get them into therapy.

There are 3 main "clusters" of personality disorders: avoidant/fearful, dramatic/emotional.erratic, and odd/eccentric.. And within those clusters, there are several specific types:

Cluster A (Anxious/fearful): These are marked by avoidant or fearful symptoms, and include these disorders:

Paranoid: pervasive mistrust and suspiciousness of others. This person is always quick to impute the most sinister motivation to others' behaviors.

Avoidant: Like the Schizoid and Schizotypal person, the individual with Avoidant Personality Disorder feels uncomfortable around other people. But unlike the other types, the Avoidant personality is hypersensitive to any criticism, and really wants to interact with others; s/he is just too worried and inhibited.

Dependent: This individual is defined by his/her preoccupation with being taken care of, and thus, clings and is submissive to others. Decisions are very difficult, disagreements are rare, and being alone leads to feelings of discomfort.

Obsessive-Compulsive: Here's the individual who is preoccupied with order and cleanliness and control, to the point where all flexibility is lost.

Cluster B (dramatic, emotional, erratic): In this group are the more flamboyant personality disorders:

Antisocial: this individual has no regard for the rights and needs of others and disregards them in favor of his own wishes. There is a tendency towards deceitfulness, irresponsibility,   nonconforming behavior and a complete lack of remorse for any problems his behavior may cause

Borderline: The person with this disorder does not have a solid core sense of personal identity and often displays wildly fluctuating moods, with anger and fear of abandonment being among the most prominent.

Narcissistic: The narcissist is known by his or her excessive need for admiration, overblown feelings of importance, sense of entitlement and a deficit of empathy for others' feelings and needs.

Cluster C (Odd, eccentric): The people in this group are more easily spotted due to their obvious peculiarities.

Schizoid: detachment from others and a reduced range of feelings. This is the classic "loner" who really does not enjoy either people or most activities, and who rarely shows any emotions.

Schizotypal: Like the Schizoid personality disorder, the Schizotypal person does not feel comfortable around others and indeed, has a reduced capacity for human relationships. But the Schizotypal person displays eccentricities in dress, behavior or thinking and may have some clearly "odd" beliefs.

AXIS III

On this axis, we code any medical conditions that might be important to the understanding or management of the individual's mental health. For example, if a person has an AIDS-related dementia, the diagnosis of AIDS goes on Axis III.

AXIS IV

We all know that the events around us help to shape how we feel. For instance, the day you get a big promotion, you're likely to be in a pretty good mood. Conversely, if you're homeless and have few friends, you're just as likely to feel pretty lousy. Those *psychosocial or environmental stressors* which have been present during the past year are listed on this axis. These stressors can be many types, including occupational problems, economic problems, problems related to the legal system, etc.

AXIS V

This is the individual's GAF score: Global Assessment of Functioning. It is a numerical value which can range from 0 (Inadequate information) to 50 ("Serious symptoms or any serious impairment in social, occupational or school functioning") to 100 ("Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms. Any number in between may be assigned, and while the specific number chosen is up to the clinician's opinion of the client's overall functioning, the number chosen should reflect what has been learned from the first 4 axes.