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BMHP6029-Psychopathological Classifications and Provisions

Component 2: Written Assignment (Report)

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Classification and Diagnosis:

- Provide a detailed analysis of how the chosen condition is classified in ICD-11.

Dementia is a broad clinical condition rather than a single illness. Because the aetiology, course, and available treatments might vary greatly, it is crucial to appropriately classify it. Dementia is usually categorised by clinicians using a number of overlapping dimensions, including onset pattern, clinical symptoms, pathology, and cause (aetiology).

1 Classification by Cause (Neurodegenerative dementias)

These diseases typically irreversible and involve a progressive loss of neurones.

Alzheimer's

Most prevalent (~60–70%)

Tau tangles and amyloid plaques

Lewy body dementia

Lewy bodies, or abnormal α -synuclein deposits

Hallucinations and erratic thinking

Dementia frontotemporal

impacts the frontal and temporal lobes

Changes in personality and language

Parkinson's disease dementia

occurs when Parkinson's disease is advanced.

2 Classification by Underlying Pathology

This focuses on cellular processes:

Amyloidopathies, such as Alzheimer's disease (accumulation of amyloid- β)

Tauopathies: such as frontotemporal dementia (dysfunction of the tau protein)

Lewy body dementia (α -synuclein deposits) is an example of a synucleinopathy.

Vascular pathology: ischaemia and infarcts

Research and the creation of biomarkers benefit greatly from this classification.

3 Classification by Clinical Presentation

The predominant symptoms of various dementias vary:

A. Dementias of the cortex

impact higher order cognitive processes (language, memory)

For instance, Alzheimer's

Symptoms

Loss of memory

Aphasia (issues with language)

Apraxia (difficulty carrying out duties) (NIH 2026)

- Discuss the diagnostic criteria and processes associated with the condition.

1 Diagnostic Process

Medical Background
Timeline and symptoms of the patient
Family and carer input (essential)
History of medication, mental health, and health

2 Cognitive Testing

Short screening tools:

Mini-Mental State Examination

Montreal Cognitive Assessment

3 Neurological and Physical Examination
Coordination, reflexes, and gait
symptoms of Parkinson's disease, stroke, etc.

4 Tests in the Lab

To rule out causes that can be reversed:

Thyroid dysfunction
Lack of vitamin B12
An infection
imbalance of electrolytes

5 Imaging of the Brain

aids in locating structural or functional alterations:

Computed Tomography and Magnetic Resonance Imaging
PET scans for metabolic activity can occasionally

6 Functional Evaluation
Capacity to carry out Activities of Daily Living (ADLs)
ADLs that are instrumental (shopping, money, transportation)

7 Expert Evaluation
Memory clinics, neurologists, or geriatricians
Advanced diagnostics (such as cerebrospinal fluid biomarkers) may be included. (NICE 2026)

- Identify the language used in the classification (e.g., 'disorder,' 'condition,' 'illness').

Dementia is most frequently referred to as a "syndrome" rather than a single illness in academic and medical contexts. This is because it is a general word that encompasses a variety of underlying disorders that impact memory, thinking, and behaviour, such as Alzheimer's disease.

Condition – widely used and neutral; very common in healthcare and public information

Syndrome – more precise in clinical contexts

“Disorder” – still used, but can sound more technical or pathologizing

“Disease” – usually refers to specific causes (e.g., Alzheimer’s disease), not dementia as a whole

Labels that could be stigmatising have become less common in person-centred and advocacy language. Groups such as the Dementia Alliance and the Alzheimer’s Society Global encouragement:

Using the phrase "person living with dementia" rather than "dementia patient"

Steer clear of phrases like "victim" or "sufferer"

When feasible, use the word "condition" instead of harsher terms. (Alzheimer’s society 2026)

Treatment and Rehabilitation:

- Critically evaluate the standard treatment approaches for the condition.

The goals of standard dementia treatment strategies are to improve quality of life, control behavioural symptoms, and halt cognitive loss, but they are still unable to change the underlying trajectory of the illness. A critical analysis reveals both significant advantages and obvious drawbacks.

1 Pharmacological treatment

Inhibitors of cholinesterase

Galantamine, rivastigmine, and donepezil are a few examples.
They function by raising the brain's acetylcholine levels.

Strength

Modest gains in cognition and memory, particularly in the early to moderate phases can momentarily stabilise symptoms

Limitations

Once more, merely a symptomatic benefit
Limited effectiveness in the early stages of illness

2 Non-pharmacological interventions

Cognitive stimulation and therapy

Strength

enhances involvement and quality of life
No significant adverse effects
For certain results, they can be just as effective as medications.

Limitation

The effects vary and are dependent on compliance.
Don't change the course of the illness

3 Use of antipsychotics and sedatives

Strength

able to restrain risky behaviour during emergencies

Limitation

elevated mortality and stroke risk
Overuse-related ethical issues (sometimes known as "chemical restraint")
It should be temporary and a last resort.

Overall critical perspective

Symptom-focused model: Instead, then stopping the progression of the disease, the majority of existing treatments control its symptoms.

Modest efficacy: The advantages are usually fleeting and modest.

Equity concerns: There are disparities in access to modern medicines and high-quality care.

Risk of overmedicalization: Particularly when using antipsychotics for behavioural treatment.

Future prospects are promising but uncertain: while disease-modifying treatments represent advancements, they are not yet revolutionary. (The Lancet 2026)

- Examine the rehabilitation measures included in ICD-11 and in practice

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- Assess the effectiveness and limitations of these approaches.

Over the past few decades, approaches to dementia care have changed dramatically, shifting from strictly medical management to more comprehensive, person-centred models. Depending on the person, the stage of dementia, and the regularity with which the techniques are used, their efficacy varies. Nevertheless, each strategy has significant drawbacks.

1 Person-Centered Care

Effectiveness

Enhances emotional health and quality of life
Lessens irritation and discomfort
keeps one's feeling of autonomy and dignity intact

2 Cognitive Stimulation and Therapy

Effectiveness

Can halt early to moderate stages of cognitive deterioration.

Improves mood and social engagement

Aids in preserving communication abilities (Cambridge University 2024)

Current Debates and Emerging Issues:

- Discuss the ongoing debates surrounding the classification and treatment of the condition.

1 Problems with classification systems (DSM vs ICD and beyond)

When it comes to who is eligible for a diagnosis, systems such as DSM and ICD can differ. The DSM-5 even changed definitions by substituting "major neurocognitive disorder" for "dementia."

Some claim that traditional classifications are overly limited because they mostly rely on memory loss.

Debate:

Do the present criteria miss early disease because they are too late-stage?

Do they oversimplify complicated brain disorders?

2 Overlap between different types of dementia

Alzheimer's and vascular disease are examples of "mixed dementia," which is highly prevalent.

Diagnosis is problematic since clinical and pathological characteristics frequently overlap between kinds.

Debate:

Should we maintain separate classifications (Lewy body, Alzheimer's, etc.)? or shift to a multi-factor or continuum model?

3 The rise of biomarkers vs clinical diagnosis

Alzheimer's-related alterations can be identified by biomarkers prior to symptoms. However, clinical decision-making still lacks precise thresholds.

Debate:

Should symptoms or biology (biomarkers) be used to define dementia?
What happens if a person has aberrant biomarkers but no impairment?

(House of common library 2023)

- Critically assess the role of neurodivergence and any relevant reclassification issues.

1 Neurodivergence vs. Dementia: the core difference

Neurodivergence is a general idea that describes the inherent differences in brain function. Dyslexia, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, and other disorders are frequently linked to it.

Current from the beginning of development
Lifelong thought and behaviour patterns
Not degenerative by nature

In contrast, dementia—such as Alzheimer’s disease—is:

Typically, acquired later in life
marked by a steady deterioration in cognitive function
caused by neurodegeneration, which is the gradual loss and destruction of brain cells

Because dementia includes degeneration rather than a stable variation, it has historically not been categorised as neurodivergence.

2 Diagnostic classification systems

Major classification systems like:

The International Classification of Diseases (ICD) of the World Health Organization
The DSM of the American Psychiatric Association

still categorize dementia under neurocognitive disorders, not neurodevelopmental conditions.

For example:

Dementia is grouped as a Major Neurocognitive Disorder

Autism and ADHD are grouped as Neurodevelopmental Disorders (Taylor and Francis 2023)

- Consider the impact of these debates on practice and policy.

Recommendations:

- Provide well-reasoned recommendations for improving the classification, diagnosis, treatment, or rehabilitation of the selected condition.

1 What to improve:

Transition to classification based on biomarkers

Instead of focusing only on symptoms, characterise disease biology using frameworks such as the ATN framework (amyloid, tau, neurodegeneration).

Identify mixed pathologies

Alzheimer's, vascular, and Lewy body abnormalities coincide in many cases. Rather than imposing a single label, classification systems ought to take this into account.

Integrate genetics selectively

Incorporate risk markers like APOE ϵ 4 where clinically relevant, without over-medicalizing low-risk individuals.

It matters because better classification leads directly to more targeted therapies and avoids “one-size-fits-all” treatment mistakes.

What to improve:

Scale biomarkers based on blood

PET scans and lumbar punctures are increasingly being replaced with blood tests for tau and amyloid.

Make use of digital cognitive tools

Compared to clinic visits, passive monitoring (speech patterns, typing, walking) can identify modest decrease earlier.

Intelligently combine modalities

Instead of using binary labels, a probabilistic diagnosis is made using cognitive testing, imaging, biomarkers, and clinical history.

Reduce diagnostic inequity

Many tools are biased toward highly educated or Western populations—this needs correction.

It matters because earlier diagnosis is only useful if it leads to intervention—so it must be paired with treatment pathways (The kings fund 2026)

- Consider the implications of these recommendations for practice, policy, and further research.

Conclusion

In summary, dementia is still a complicated and progressive illness that has a big influence on those who have been diagnosed as well as their families, carers, and the larger community. Early diagnosis, suitable interventions, and person-centred care can significantly enhance quality of life and help preserve independence for as long as possible, even though there is presently no cure.

Ongoing research continues to advance understanding of the causes, risk factors, and potential treatments for dementia, offering hope for more effective prevention and management strategies in the future. Equally important is the need for increased awareness, reduced stigma, and stronger support systems to ensure individuals living with dementia are treated with dignity, respect, and compassion.

Ultimately, addressing dementia requires a collective effort from healthcare professionals, policymakers, communities, and individuals to create environments that are inclusive, supportive, and responsive to the needs of those affected.

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