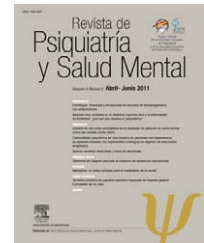


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### EDITORIAL

## Towards a more clinically useful International World Health Organisation classification of Mental Disorders<sup>☆,☆☆</sup>

### Hacia una clasificación Internacional de los Trastornos Mentales de la OMS de mayor utilidad clínica

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The descriptive approach based on diagnostic criteria that characterizes the ICD-10<sup>1</sup> and the DSM-IV<sup>2</sup> has led to marked improvement around the world in the identification and treatment of mental disorders. However, even those who developed these systems recognize that their primary accomplishment has been the improved reliability of diagnosis.<sup>3</sup> These benefits are most apparent in the research milieu, where explicit diagnostic criteria can be applied in the course of lengthy, complex, and costly standardized diagnostic interviews. There is no evidence of a parallel improvement in the reliability of diagnosis in daily clinical practice.<sup>4</sup> The WHO is looking upon the current revision of the ICD as an opportunity to address several major issues with the present classifications of mental disorders, but it is placing greater importance on making them more clinically useful for healthcare professionals.

Four decades of research have failed to demonstrate that the current nosology for mental disorders is based on valid disease entities.<sup>5,6</sup> The hope was that improved reliability, possibly through a symptom-based descriptive classification,

would pave the way for corresponding gains in validity based on the results of clinical research and contributions from neuroscience and genetics. This has not happened either as quickly or as extensively as the scientific community had hoped.

Advances in research to date have yielded neither a clear structure nor a coherent set of principles around which a standardized system of diagnosis could be organized, nor have they led to the validation of individual diagnostic entities or clarification of their criteria. Given the evidence currently available, it would be prudent to point out that any improvement in the validity of classifications in the ICD-11 and DSM-5 is going to be modest and gradual, as would be expected with a reiterative process of successive approximations. In fact, Hyman—president of the International Consulting Group for revision of the chapter on mental and behaviour disorders in the WHO ICD-10 and also a member of the DSM-5 task force—has recently stated that validity of the classification system cannot be achieved simply by refining the criteria for existing disorders or adding new disorders.<sup>3</sup>

Even if conclusive proof of the validity of current diagnostic symptoms remains elusive, experts are increasingly concerned about the fact that there are serious issues with these symptoms in terms of their clinical usefulness.<sup>7–9</sup> Several key issues stand out in the literature. First, a high proportion of diagnoses for mental disorders are recorded as “non-specific” (the term used in the ICD) or “not specified elsewhere” (the corresponding term in the DSM). This suggests that healthcare professionals find the present categories difficult to use or imprecise for

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describing their patients or that they do not find the nuances introduced by the diagnostic classification subtypes to be useful in clinical practice. Second, a high proportion of individuals with mental health problems meet the criteria for 2 or more disorders.<sup>10,11</sup> In the majority of cases, these multiple diagnoses may be considered an artefact of the classification system in that they identify separately different aspects of a single underlying disease. This suggests that the existing systems are not properly capturing the nature of mental disorders. At the same time, other diagnostic categories are characterized by considerable heterogeneity, which may have a significant impact on treatment.

Third, very often the same psychotherapy or pharmacotherapy is effective for different mental disorders.<sup>12,13</sup> This does not mean that the classification should be organized by response to treatment or that the existence of a specific treatment should be the acid test for inclusion of a category. It is clear, however that nowadays the classifications make numerous diagnostic distinctions that have no relevance to clinical practice.<sup>14–16</sup> In the case of some disorders, it is possible for 2 individuals to have the same diagnosis but have none of the clinical features in common. For example, the DSM-IV diagnosis of behaviour disorder requires that only 3 of 15 possible criteria be present, and the diagnosis of substance dependence requires that only 3 of 7 symptoms be present. Finally, the diagnostic categories are poor predictors of treatment needs—especially in the case of individuals with the more severe types of mental disorder. In other words, the current systems of diagnosis are of no help when it comes to efficient use of a clinic or community's limited treatment resources.

One of the factors that limit the clinical usefulness of the current systems of diagnosis is their extraordinary complexity—each revision including more categories and subtypes focused on increasingly finer distinctions.<sup>17</sup> What has spurred this increasing level of definition and complexity in the current systems of diagnosis for mental disorders is partly the very nature of the revision process—that it is incremental, within the framework of the existing system of diagnosis, and centred around the participation of researchers who have experience in specific diagnostic categories. As Watson and Clark<sup>18</sup> point out that clinical usefulness is not taken into account by some psychopathology experts because they do not face the daily decision-making involved in treating individual patients. They have access to increasingly more sophisticated multivariate statistical techniques, which can fit complex hierarchical models with a wide range of predictor variables. They do not wish to give up the prospect of having the power—eventually, through the development of a more nuanced system—to explain the mechanisms and pathways of diseases and to address the comorbidity and heterogeneity issues. The nature of current approaches to diagnosis has been of benefit in certain aspects of research—in particular, trials of specific pharmacotherapies for an increasingly greater number of well-recognized mental disorders<sup>19</sup>—but it has been a limitation in other areas of research, such as the study of mechanisms common to different psychopathologies or studies on the efficacy of treatments across a cluster of disorders.<sup>3,20</sup>

One of the consequences of using classifications that introduce detailed specifications into the definition of a disorder is that, to diagnose a mental disorder, healthcare professionals typically have to consider 20–35 pieces of information.<sup>21</sup> As different studies have discovered, however, there are very few resident and primary care physicians who are able to remember the key symptoms of mental disorders.<sup>22,23</sup> Perhaps it could be expected that mental health professionals would have more detailed knowledge of the symptoms of mental disorders. However, as evidenced by the extremely low frequency, worldwide, of specialized treatment consultations for the majority of individuals with mental disorders,<sup>24</sup> in most healthcare settings, it is much more important that the office time available be spent on choosing and explaining the most suitable therapeutic management strategy than on conducting detailed diagnostic interviews. In fact, there are studies showing that the level of detail in the definitions of and criteria for mental disorders may not actually be required. Two recent studies have shown that almost half of the existing criteria for major depression could be eliminated, with its explanatory power almost fully preserved.<sup>21,25</sup> Similar results would probably be obtained for other disorders, but a systematic program of clinical and epidemiological research would be required for this.

In view of the issues described, the WHO has decided that improving clinical usefulness should be a guiding principle for the current revision of the ICD-10. Clinical usefulness is important to healthcare professionals because it impacts their daily practice.

Mental and neurological disorders represent a higher proportion of the disease and disability burden than any other category of non-communicable disease.<sup>26</sup> More than 75% of the morbidity burden from mental disorders falls on low- and middle-income countries, who face the toughest dilemmas in prioritising and assigning healthcare resources. The great majority of individuals with mental disorders receive inadequate treatment or no treatment at all. The World Mental Health Survey found that, in developing countries, 35.5%–50.3% of individuals with severe mental disorders had received no treatment during the previous year, while in the developed world, this figure was 76.3%–85.4%.<sup>27</sup> The existing disparity between those who need treatment and those who receive it varies from 32% to 78%, depending on the disorder.<sup>28</sup>

The public health implications of clinical usefulness have shaped the WHO approach to revising the ICD in several important respects. First, development of the ICD-11 must be an international endeavour. Ensuring the strong participation of developing countries is both a challenge and a requirement. Creating a system of diagnosis that, for these countries, is clinically useful and may be a means of reducing the disease burden is not simply a matter of modifying classifications previously elaborated by and for mental health specialists working in the developed world.

A second, closely related issue is that the revision process and the products it yields must be multilingual. Many specific cultural traits and national perspectives are embodied in language, and if there is no attention to translation and linguistic equivalence throughout the classification development process, reduced clinical usefulness is a predictable

result for the non-English versions. WHO activities related specifically to development of the ICD-11 classifications for mental and behaviour disorders are being carried out in more than 20 languages. Field studies that have been completed thus far aiming to identify the general structure of the classification have been conducted entirely in 2 languages, simultaneously: English and Spanish.

Third, the revision must be a multidisciplinary endeavour. As mentioned above, the great majority of individuals around the world who have mental disorders will never see a psychiatrist. If the purpose is to make the ICD-11 classification for mental and behaviour disorders a tool that contributes to reducing the disease burden worldwide, it will have to be one that a wide range of healthcare professionals can use—in particular, the staff of primary care teams.

For the WHO-driven ICD-11 development process, taking all the above into consideration, clinical usefulness will be defined by the following factors:

- its role as a means of communication (between clinicians and patients, family members, and healthcare administrators)
- the features required for it to be implemented in clinical practice, such as the precision of its descriptions, its ease of use, and its feasibility in different healthcare settings
- its usefulness in choosing interventions and its role in decision-making for clinical management

We also believe that consideration should be given to whether the proposed changes in diagnostic categories will contribute to improving clinical results in terms of both the individual and the population.

For the WHO, this classification revision project should lead to the development of a new instrument oriented more to the needs of daily clinical practice in different healthcare settings and should lay the foundation for an integrated model of mental health care in the future.

## Conflicts of interest

The authors have no conflicts of interest to declare.

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