CLASSIFICATIONS IN THE FIELD OF MENTAL HEALTH

Norman Sartorius

The development of proposals for the revision of sections of the International Classification of Diseases (ICD) dealing with mental disorders is the technical responsibility of the Mental Health Programme of WHO. The programme also has to revise the chapter on disorders of the nervous system and to collaborate in the development of certain other parts of the classification, e.g. the chapters classifying reasons for contact with health services, causes of suicide and ill-defined syndromes and symptoms. In fulfilling its mandate concerning these matters, the Mental Health Programme has traditionally relied on its collaborating centres located in some 40 countries, its advisory panels and results of research and literature reviews.

In the preparation of the "mental disorders" chapter of the Eighth Revision (which was adopted in 1968), the Organization had taken an additional step: it established a special group of experts representing different disciplines and psychiatric schools to assist in revising the classification. The group met annually in different parts of the world. Each time it met it was joined by groups of experts from the country in which the meeting took place and from neighbouring countries with whom it discussed different issues concerning the classification (1, 2). This method of work proved to be highly productive: it led to a significant improvement of the classification of mental disorders accompanied by a glossary giving a short definition for each category, numerous publications and a set of methods for the study of diagnosis and classification.

The most important outcome of this programme, however, was the heightened awareness of unresolved issues in the classification of mental disorders, which led to numerous studies and to changes in the manner of teaching psychiatry in many countries.

The preparation of the chapter on mental and behavioural disorders in the Tenth Revision of the ICD came at a very propitious moment in the history of the mental health programmes in WHO Member States and in the development of the Organization's Mental Health Programme (3, 4).

Firstly, in a number of countries mental health programmes began to receive higher priority than was previously the case. Several factors may have been responsible for this:

- In many countries the mental health programmes have been redefined and are now seen as covering behavioural and psychosocial problems as well as the treatment of mental disease. This usually means more visibility and priority. Drug abuse, juvenile delinquency, problems of adaptation in refugees, disintegration of families, and similar topics are all in the public eye and worry decision-makers.
- A new doctrine of mental health has emerged. It stresses the linkage of mental health to primary health care and the need for the active involvement of different social sectors in dealing with mental health problems. Such a doctrine is clearly more acceptable to public health authorities than the previous stand of isolated development and functioning of mental health services.
- The demonstration that the treatment of mental disorders, as well as the prevention of many of them, is now possible and can be done using effective low-cost technology has reduced resistance to building mental health programmes previously often seen in decision-makers.
- The growing awareness that mental disorders, as well as problems related to substance abuse, are increasing in numbers and have already assumed frightening magnitude in countries east and west, north and south, has added urgency to proposals to develop psychiatric care.
- Finally, in many countries and in the scientific community, it has become obvious that hopes which were placed in technological solutions to problems caused by disease in general, were not fulfilled and that it is therefore necessary to rely on behavioural and mental health approaches in preventing many such diseases and in coping with their consequences.

Secondly, the Mental Health Programme of WHO has, over the years, developed a network of collaborating centres willing and able to take part in international projects coordinated or stimulated by the Organization. This meant that proposals for the classification of mental disorders could be prepared in close collaboration with mental health experts from many lands and of many psychiatric persuasions.

Thirdly, the improvement of communication with psychiatrists from Third World countries, as well as an increase in the number of successful mental health programmes which they have developed, resulted in a better recognition of cultural differences in the presentation of mental disorders and made it easier to find new solutions for problems linked to the classification of conditions often seen in Third World countries, e.g. acute psychoses and the undifferentiated ailments often seen in patients contacting general health services.

Fourthly, in many countries national psychiatric associations have undertaken and completed revisions of their own classification (e.g. DSM-III and the Research Diagnostic Criteria in the United States of America). This growth of interest in classification has provided a fertile ground for the acceptance of proposals to test the sections of the International Classification of Diseases relevant to psychiatry.

* Director, Division of Mental Health, World Health Organization, Geneva.

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Fifthly, in the early 1980s WHO, in collaboration with the United States Alcohol, Drug and Mental Health Administration (ADAMHA), launched an international project which included multicentric studies producing assessment instruments for use in epidemiological studies (5), in clinical studies (6) and in the assessment of special areas of behaviour and disorders, e.g. personality disorder (7). This project has greatly facilitated the construction of transculturally applicable assessment instruments and led to joint research involving leading research centres worldwide.

These developments made it possible for WHO to launch a programme aiming at an intensive and extensive assessment of draft proposals for the chapter on mental and behavioural disorders in the Tenth Revision of ICD.¹

These proposals aimed at increasing reliability in the use of the classification; at ensuring that it contains categories for the classification of diagnoses used in different parts of the world and by different professions dealing with mental health problems; at making it possible to compare results obtained using the classification at different levels of health care; at creating a structure of the classification which will permit the correct interpretation of data obtained through studies on different types of mental disorders and in different countries; and at ensuring that the best of knowledge about mental disorders is taken into account in the construction of the classification.

The classification of mental disorders will be produced in several versions. The first of these ICD-10 chapters on mental and behavioural disorders is used as are other parts of the International Classification of Diseases—mainly for statistical purposes. In view of difficulties experienced by coders and those who wish to use the chapter as a tool for reference, each category in this version is provided with a short glossary definition.

The second version is intended for the use of the practising clinician. Each category in this version has a detailed definition specifying the main features of the disorders which are to be categorized in a given rubric; this definition is followed by diagnostic guidelines and by a list of terms which should be included under the category.

The third version is intended for use in research. It is composed of the definitions and guidelines for each of the categories and contains diagnostic criteria for research, which are much stricter in their form than the guidelines for the clinician. Thus, while the guidelines may indicate that a particular disorder "usually starts in early adulthood", the criteria for research would specify that the diagnosis of that particular disorder "should not be made if the disease starts after the age of 30". The decision to separate the criteria for research from the classification which is to be used in clinical work was made because it was shown that clinicians in their daily work will not observe overly strict rules (which are of cardinal importance for research) and that the data obtained using the classification may therefore be misleading.

Previous experience and research showed also that the use of several "axes" in a classification may contribute to the improvement of clinical practice and provide more reliable information about the work of a service. In dealing with mental disorders in children for example, it is of considerable importance to record—in addition to the diagnostic impression—the level of intelligence of the child, factors which may have led to the development of the disorders and factors in the child's environment likely to have had an important impact on the child's health. This information usually gets lost in a system which requires only one diagnostic statement for the child's disorder. The multiaxial classification of mental disorders in children introduced and tested in WHO-sponsored studies (8) provides a possibility to record such information using one axis for the clinical syndrome and another for aetiological factors, another for psychosocial factors in the environment. The multiaxial versions of subsets of ICD-10 related to mental disorders—for use in work with adults and with the elderly—will use axes composed of categories contained in different parts of the ICD. These will serve to record disability caused by the disorder, the clinical syndrome and the environmental factors (e.g. marital breakdown or a bereavement) which in the opinion of the clinician have direct relevance to the appearance and course of the disorder.

An adaptation of ICD-10 for use in the provision of services for the mentally ill will also be produced. It will contain all the categories in the chapter dealing with mental disorders and a listing of other categories from the classification for other disorders often seen in psychiatric patients. This list will be followed by a series of "crosswalks" enabling a translation between the categories used in the Ninth Revision of the ICD and those used in the Tenth and the translation of categories used by national classification systems into the categories of ICD-10 and vice versa.

Finally, a special version will be produced for use in general health care. This will contain a smaller number of categories and put emphasis on categories frequently encountered in everyday practice.

All of these versions were produced simultaneously in languages spoken by the majority of the world's population—Arabic, Chinese, English, French, German, Portuguese, Russian and Spanish. They are also congruent and can be translated into each other.

The recommendation to use these versions of ICD-10 dealing with mental disorders had to be based on evidence that they would be reliable in practice, would fit the patients' diagnoses, could be employed in different types of service, etc.

Some evidence to that effect was available from previous studies, but it was necessary to obtain additional data in order to resolve some of the key questions. Categories with ill-defined limits, terms which have no equivalent in other languages, and other sources of error are usually discovered once the classification enters into use, and by that time it is often too late to change the classification. To prevent this from happening, WHO asked experts to jointly assess patients and their case histories and to classify the diagnoses which they made. The Organization moreover has carried out analyses of existing data about the validity and reliability of

classifications used in different countries; convened meetings of experts and consulted them by mail; and reviewed the literature about different classificatory issues and about ways in which different psychiatric classifications have overcome problems usually encountered in research and in other work involving the application of the classifications.

WHO has also carried out a series of field trials which aimed to assess whether the diagnostic guidelines provided were easy to understand and to use; whether the classification fitted the diagnoses given to the majority of patients and whether raters can agree in assigning a particular diagnostic category. The trials were coordinated by WHO headquarters in Geneva and its regional offices, in close collaboration with selected academic centres for different languages and geographical regions. In all, 107 centres in 40 countries participated in these trials: 16 field trial centres (FTCC) in 14 countries helped in setting up the trials, distributed data forms and case summaries, assisted in data analysis, accumulated suggestions for revisions, and organized national symposia on the development and testing of relevant parts of ICD-10.

These trials were one of the major sources of suggestions about improvements to the classification. A special committee of experts was regularly consulted by mail and in meetings, nongovernmental organizations were invited to provide comments and suggestions. Among the latter, a particularly useful source of comments and suggestions for improvement was the World Psychiatric Association which distributed the early drafts of the classification to its member societies, brought together their comments and reviewed them through a specially designated task force, thus providing the views not only of the academic community, but also of practising physicians working in different countries.

A prefinal version of the clinical guidelines of the Classification is available now. The final version of the clinical descriptions and diagnostic guidelines will be published by the end of 1990 and the criteria for research will appear shortly after that. The version for use in general practice will be tested during 1990. These three versions of the classification together with other materials, e.g. training materials, glossaries, lexicons, etc., will compose a “family” of ICD-10 psychiatric classification instruments available for use in a multitude of languages and shown to be applicable and reliable.

A classification is a way of seeing the world. It is the reification of an ideological position, of an accepted stand of theory and knowledge. Classifying means creating, defining or confirming the boundaries of concepts. These in turn define ourselves, our future and our past, the territory of our discipline, its importance and its exclusiveness. The new provisions that will form a part of ICD-10 provide a framework for world psychiatry today. They are a product of the work of psychiatrists and other mental health professionals from many lands. The classification reflects their views and is the result of a careful scrutiny of existing scientific data obtained both from special trials and from numerous other studies dealing with classificatory issues.

A classification can remain alive and be improved only if it is constantly reexamined in the light of new knowledge. It is hoped that WHO’s Mental Health Programme will continue to serve as the channel through which new views and knowledge about psychiatric disorders can be reflected in the ICD and that the Classification will be the bridge helping to arrive at a better understanding between researchers, clinicians, public health decision-makers and all the others concerned with the improvement of the fate of the mentally ill worldwide.

**SUMMARY**

For the first time in the Ninth Revision of the International Classification of Diseases (ICD-9) the chapter on mental disorders contained short glossary definitions for each category.

A number of changes in attitudes and policies at the international and national levels, particularly the reorientation of mental health programmes to include behavioural and psychosocial problems, came at an opportune time and had a positive influence on the development of proposals for the chapter on mental and behavioural disorders in the Tenth Revision (ICD-10).

This in turn enabled WHO to undertake an intensive and extensive assessment of international needs in the classification of mental disorders and, where the situation was not unequivocal, to organize field trials to provide the empirical data necessary for problem solution.

The result is a series of compatible classifications of mental and behavioural disorders based on ICD-10. The first, produced mainly as a reference tool for statistical purposes, will be included in ICD-10 with short glossary definitions as was the case for ICD-9. Other versions will be published for practising clinicians (with enhanced glossary definitions followed by diagnostic guidelines), for research (with full definitions, diagnostic guidelines and diagnostic criteria); for use in the provision of services to the mentally ill; and for use in general health (primary) care. There will also be a multiaxial classification of mental disorders in children to identify the clinical syndrome, resulting disability and environmental factors. It is hoped that these versions tailored to the needs of different groups working in the field of mental health will result in further improvements in communications between those responsible for the provision of services and care.
Résumé

Classifications dans le domaine de la santé mentale

Pour la première fois, la Neuvième révision de la Classification internationale des maladies (CIM-9), chapitre des troubles mentaux, contenait de courtes définitions de chaque catégorie de troubles.

Un certain nombre de changements d’attitude et de politique aux niveaux international et national, notamment la réorientation des programmes de santé mentale dans lesquels on a inclus le traitement des problèmes comportementaux et psychosociaux, ont intervenus opportunément et ont eu une heureuse influence sur l’élaboration de propositions pour le chapitre de la Dixième révision (CIM-10) concernant les troubles mentaux et comportementaux.

Ainsi l’OMS a-t-elle pu entreprendre une évaluation intensive et à grande échelle des besoins internationaux en matière de classification des troubles mentaux et, dans les cas où la situation donnait lieu à équivoque, organiser des essais sur le terrain pour obtenir les données empiriques nécessaires à la solution des problèmes.

Le résultat est une série de classifications compatibles des troubles mentaux et comportementaux basées sur la CIM-10. La première, qui joue essentiellement le rôle d’un outil de référence à des fins statistiques, sera insérée dans la CIM-10 avec de brèves définitions des termes, comme dans la CIM-9. D’autres versions seront publiées à l’intention des cliniciens praticiens (avec des définitions développées suivies d’indications pour le diagnostic), des chercheurs (avec des définitions complètes, des indications pour le diagnostic et des critères diagnostiques), des personnes qui soignent les maladies mentaux et de ceux qui dispensent des soins de santé généraux (primaires). Il y aura aussi une classification multiaxiale des troubles mentaux chez l’enfant qui permettra d’identifier les syndromes cliniques, les invalidités qui en résultent et les facteurs de l’environnement. On espère que les versions adaptées aux besoins des divers groupes de personnels travaillant dans le domaine de la santé mentale permettront d’améliorer encore la communication entre toutes les personnes responsables des prestations de services et de soins.

Références — Références