REVIEW ARTICLE

HOW MANY CATEGORIES IN A CLASSIFICATION OF PSYCHIATRIC DISORDERS DO WE NEED?

KOLIKO NAM JE KATEGORIJA U KLASIFIKACIJI PSIHIJATRIJSKIH POREMEĆAJA POTREBNO?

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ABSTRACT

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Communication among physicians requires a commonly accepted classification of diseases, which make it possible for them to undertake action that might prevent or control them. The psychiatric classifications, with over 300 different psychiatric disorders listed, are providing clinicians throughout the world with a free and accessible classification system that can be used with relative ease by mental health clinicians and scientists. However, such a classification will neither be used nor useful to other stakeholders, for example judges, policemen, patients family members, public health authorities, etc. All of them deal with the same diseases but from a different perspective. They will all develop their classifications of diseases, in harmony with the actions which they will have to take. This paper will attempt to make it clear that classifications – of objects, of concepts and of all other items with which we have to deal – will depend on their users. Understanding what classifications and diagnostic terms are used by others who see mentally ill people, will enable physicians to communicate with them and to create alliances, which will make it possible to provide adequate help to those who are ill, as well as their families, general population and all these who could influence the government to search for the best ways of implementing health care policies.

SAŽETAK

U međusobnoj komunikaciji lekara nužno je da postoji zajednički sistem klasifikovanja bolesti, na osnovu čega se preduzimaju odgovarajuće aktivnosti radi njihovog sprečavanja ili lečenja. Psihijatrijska klasifikacija, sa preko 300 postojećih dijagnoza, obezbeđuje kliničarima širom sveta slobodnu i dostupnu platformu koja je laka za primenu i, kao takva, služi svima koji se bave lečenjem ili proučavanjem mentalnih poremećaja. Takve klasifikacije će teško, međutim, koristiti ostalima, koji neretko imaju kontakt sa osobama sa mentalnim smetnjama, a nisu medicinari (na primer sudijama, policajcima, članovima porodica obolelih, različitim telima zaduženim za zdravstvenu zaštitu i slično) i koji u situacijama kada imaju kontakt sa mentalnim poremećajima njima pristupaju iz sasvim različitih pozicija u odnosu na zdravstvene radnike. Svaka od pomenutih grupa imaće potrebu da razvije svoju klasifikaciju bolesti, a ta klasifikacija biće, pre svega, uslovljena postupcima koje će oni morati da preduzimaju. Namera ovog rada je pojašnjenje činjenice da klasifikovanje objekata, koncepata i svega onoga što zahteva delovanje zavisi od pozicije iz koje je potrebno delovati. Kada se bude razumelo kako klasifikaciju i terminologiju dijagnoza razumeju i koriste svi oni koji na određeni način imaju kontakt sa osobama sa mentalnim smetnjama, lekarima će se značajno olakšati komunikacija. Kvalitetna komunikacija je neophodna da bi se uspostavila terapijska alijansa, da bi se činilo najbolje za pacijente, ali i za njihove porodice, za širu društenu zajednicu i za sve one koji će na najvišim nivoima donositi odluke u vezi sa zaštitom zdravlja stanovništva.

Introduction

Classification is a method of simplifying the environment. Objects which we have to deal with can be grouped by characteristics they share and thus it becomes easier to make decisions about action. There are hundreds, or maybe thousands, of races of dogs: recognizing that regardless of their size, color, name, length of tail, form of snout or running speed, they all bark – and if we hear the animal bark we know it is a dog regardless of how it looks - making it easier to talk about them and to avoid situations in which they could attack and bite us.

Diagnoses are names for state of the organism and they are made when certain characteristics, such as their causes, symptoms and reaction to treatment, are present. Physicians are trained to make diagnoses and to provide treatment in accordance with the evidence about effects of a particular treatment on the outcome of a particular disease. To make their action more simple, physicians and public health authorities also recognize the need for grouping diagnoses by various characteristics, for example by human body organ that is principally affected, or by the infectivity of a condition. This simplifies medicine, making it possible to train medical students in ways of recognizing diseases, and helping them to apply the right treatment for the condition they have recognized. Creating groups of diseases also expresses our knowledge about their relationship. Therefore, classifications of diseases will have to be regularly revised so we can keep up with the increased knowledge about them and with the improvement of our understanding of their relationships (1-3).

Specialists in different disciplines of medicine often have complex classifications of the diseases they deal with. These classifications have to be translated into a common classification that will serve public health purposes and enable all physicians, regardless of their specialties, to communicate (4). Most widely used common classification of diseases is the International Classification of Diseases (ICD). It has been introduced at the end of the 19th century when it became obvious that diseases do not respect human made borders; that health situation in different countries has to be compared; and that public health interventions in different countries will have to be similar to one another [1].

A classification of diseases, which all the clinicians dealing with these diseases accept, will make it possible for them to undertake action that might prevent or control them. However, such a classification will neither be used nor useful to other stakeholders who deal with the same diseases. They will develop their own classifications of diseases in harmony with the actions they will have to take. This paper will attempt to make it clear that classifications – of objects, of concepts and of all other items that we have to deal with – will depend on their users. The notion that the same classification can serve all of those who have to deal with the objects it is grouping – e.g. all the stakeholders who are dealing with health and disease - is only rarely valid. In order to serve everyone, classifications must have categories at such a high level of abstraction (for example grouping all people into "alive and well", "alive but affected by disease", and "dead") that they are rarely of great practical use.

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[1] The production of disease classification followed the decision of the First Statistical Congress in Brussels in 1853, when a request appeared to produce an outline of a classification for a "general" use. The classification was produced where all diseases were placed in 5 groups – epidemic, constitutional, local, developmental and those following violence. After that, the classification was reviewed and redrafted, until Bertillon in 1893 produced the grandfather of the International Classification of diseases, which has meanwhile gone through 10 major revisions (5,6).

Development of internationally used classifications of mental disorders

By the mid of the 20th century, different schools of psychiatry and different countries, used a variety of different classifications of diagnoses for mental disorders. A consultant invited by the World Health Organization (WHO) in the 1960's to review the situation, urged WHO to take urgent action. The classifications that were used in practice (and for reporting) had been so different and often incompatible with each other, that communication among psychiatrists was difficult and the data that they produced were impossible to interpret. Consequently, WHO has launched a major program and, after some 15 years of work, produced a classification of mental disorders (each of them with a brief definition). That classification was then included in the International Classification of Mental Disorders (ICD) and became the most widely used system of classifying (5,6).

During those years, the psychiatry in the USA was under psychoanalytic dominance and there was little interest in psychiatric diagnosis (7). However, during the next decade, on the basis of work from Feighner, Robins, Guze, et al. (8), a set of specific diagnostic criteria for adult psychiatric disorders was proposed, known as "the Feighner criteria". These criteria addressed diagnoses of primary affective disorders (depression and mania) and secondary affective disorder (depression only), schizophrenia, anxiety neurosis, obsessive-compulsive neurosis, phobic neurosis, hysteria, antisocial personality disorder, alcoholism, drug dependence, mental retardation, and anorexia nervosa, alongside "undiagnosed psychiatric illness" (9-11). All of this provided a key contribution to psychiatry: the recommendation to systematically use operationalized diagnostic criteria, paying attention to the course and outcome of diseases, promoting basing diagnostic criteria on empirical evidence (7). The Feighner criteria have been used in research in the USA. Its popularity had major influence on the decision to introduce it into the third revision of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 3) (11). Both the ICD and the DSM were twice revised since then and still exist as the DSM 5 and the Chapter of mental and behavioral disorders in the ICD 10.

Although the DSM 5 and the ICD 10 provided a classification which could be used by psychiatrists in all countries and settings, a number of papers have called attention to the problems still besetting the development of a universally usable psychiatric classification (12-14). Moreover, there is still a debate (mainly stimulated by psychologists) whether the same classification should be used everywhere or whether it should exist in parallel with country-specific classification. In 2013, Evans and colleagues (15), examined psychologists' views on the use of diagnostic classifications in mental health care and asked participants whether they feel that there is a need for country-specific classifications. One fifth of the overall sample responded "yes". Slightly more than half of the respondents from Latin America (51.3%) indicated that they saw a need for a national classification system, as did large minorities of respondents from Africa (42.9%), the Eastern Mediterranean (42.7%;), and Asia (24.8%). By contrast, very few European (9.7%) and American (10.5%) psychologists saw a need for a classification specific to their country. Approximately one-quarter (26.5%) of DSM-IV users indicated a need for a national classification in their country, compared to only 9.0% of ICD-10 users. Those who endorsed a national classification system were asked to explain why they felt so: the responses commonly mentioned cultural differences in psychopathology, culture-bound syndromes, and differences in mental health service delivery (15).

Can one classification serve all those who deal with mental illness and its consequences?

Both ICD and DSM classifications list over 300 different categories for the classification of psychiatric disorders and provide definitions for each of them. The ICD 10 has been produced in three versions: 1) one to be used by clinicians - psychiatrists; 2) one to define categories of the classification for use in scientific investigations; and 3) another for the use in primary health care. The DSM 5 exists in a single version for all users. Thus, psychiatrists have a tool which will allow them to communicate and work together.

However, mental disorders are highly prevalent globally, affecting people in all parts of the world (16), and many members of the society meet people affected by mental illness. The question that therefore arises is how many classifications of mental disorders do we need as a society? Do judges and policemen need one too? Should members of the families and general public have another? Must public health authorities all have a different one? Do general practitioners feel comfortable with the complex classification used by the psychiatrist or do they need a different type of classification?

Scientists and their needs

Two of the science cornerstones are rigor and reproducibility. The value of scientific research depends on the reproducibility of research findings. Rigor refers to the strict application of an unbiased experimental design, to the use of scientific methods appropriate for the study of the matter under investigation, a well-structured analysis of the data obtained, and a reasonable interpretation of results: none of this is possible if the groups of subjects which are included in the investigation are not homogenous (i.e. similar in all characteristics except that which is being examined). For scientists, therefore, the main purpose of using a classification is to help them define homogenous groups thata classification must have clearly defined. For scientists a classification and a diagnostic system is seen as

useful if it allows the creation of groups sharing the same, well defined features. They are much less concerned with the grouping of the categories unless they also study the relations between factors that have been involved in the development of disorders placed into another category. Researchers working in the field of psychiatry and studying mental illness have therefore been strong supporters of the use of operational criteria and of the manner in which the DSM 3-5 and the ICD 10 were constructed.

Moreover, many of them wanted to go even further in the standardization of the grouping or assessment of mental disorders: a notable effort in this respect was the recently created framework for research into psychiatric disorders, proposed by the US National Institute of Mental Health (NIMH) - the Research Domain Criteria (RDoC) project. According to that proposal, five major RDoC research constructs should be considered as starting points that are not definitive and include: Negative Valence Systems (Fear, Anxiety, Loss, No reward), Positive Valence Systems (Reward valuation and learning, Habits), Cognition, Social Processes Systems (Communication, Self, Perception of others) and Arousal/Modulatory Systems (Sleep, Arousal, Circadian rhythm). In the RDoC, five 'domains' each reflect a brain system in which functioning is impaired to different degrees in different psychiatric conditions (17).

Authors who support the RDoC (18), believe that by doing so they are enabling a real paradigm shift using two steps. The first step is to inventory the fundamental, primary behavioral functions that the brain has evolved to carry out, and to specify the neural systems that are primarily responsible for implementing these functions. The second step then involves a consideration of psychopathology in terms of dysfunction of various kinds and degrees in particular systems, as studied from an integrative, multi-system point of view.

While of great interest, the RDoC idea will need to be tested in practice, which requires a sufficiently large database and more certainty about the best definition of the basic functions of the brain (the division used at present was made by consensus among leading scientists and is therefore also a subject of research to confirm its validity). It is difficult to estimate how long this project will have to continue before it produces results usable in practice and in research.

Practicing psychiatrists and their needs

For psychiatrists who work in in- or out-patient services, the main purpose of the classification is to help in decisions about treatment and other components of management of a disease. Thus, from their point of view, there should be as many categories as there are specific (and different) treatment interventions. For example, the fact that a number of medications seem to be effective in dealing with schizophrenia, as well as with bipolar disorder, leads to the re-emergence of the «Einheitspsychose»

(unitary psychosis) notion, introduced by Griesinger, who believed that schizophrenia, bipolar disorder and other psychoses are not different conditions, but different expressions of the same disease process (19).

In a study carried out in preparation for the ICD 10, World Health Organization (WHO) was testing a 22 category version of the ICD, to be used by general health care workers. Psychiatrists who participated in these studies said that they prefer this classification above all others, because it corresponds and it is useful in everyday work (NS, personal data). Primary health care workers who were offered the 22 category version, felt that they can do very well with 8 of the 22 categories. In a more recent survey, carried out by the World Psychiatric Association (WPA) in collaboration with the WHO, 4887 psychiatrists in 44 countries underlined that for them, the most important purpose of a diagnostic classification system is improving communication among clinicians and informing treatment and management decisions. When the participants were asked: "In clinical settings, how many diagnostic categories should a classificatory system contain to be as useful as possible for mental health professionals?", 40.4% responded that a classification system with 10 and 30 categories would be most useful, while 47.1% preferred a classification system with 31 to 100 categories (20).

The ICD 10 and the proposals for the ICD 11 still have a much larger number of categories and it is clear that many of the categories will not be used in everyday work. They may, however, be useful in scientific endeavors and necessary because, by definition, the ICD system must allow the coding of any diagnosis that psychiatrists make.

The general practitioners and their needs

Between countries, even within Europe, there are tremendous differences in the way primary health care services operate. For example, in some countries patients have a direct access to mental health specialists (21), whereas in others they require prior referral by a general practitioner (22). As evidenced by an international WHO study, about one third of GP consultations have a direct and explicit psychological component (e.g. a depressive syndrome or "medically unexplained symptoms") and 10% to 30% of patients have a clinically relevant mental disorder. This proportion may be considerably higher if the subthreshold conditions (e.g. subthreshold depression) are counted as well (22).

The training of general practitioners (GP) varies among countries, from an automatic designation as general practitioner after completing the obligatory internship, to the requirement of 5 years of post-graduate training in family medicine. The training which GP receive and the type of patients they usually see, affects the way in which they use the diagnosis and the classification of mental disorders seen in primary health care settings. WHO and WONCA (World Organization of National Colleges, Academies and

Academic Associations of General Practitioners/Family Physicians), both produced international classifications of mental disorders for use in primary health care - The WHO classification (Rev 1) of psychiatric disorders for use in Primary Health Care had 22 categories. These were selected because they are frequent and require specific treatment. The Revision 2 of that classification has more categories and is being tested (23). The WONCA proposed a classification of mental disorders included in International Classification of Diseases for primary health care (ICPC and ICPC 2), which is used in many countries. The information obtained using the ICD 10 version for primary health care is translatable and comparable with the information obtained by those using other versions of the ICD 10 classification of mental disorders: the ICPC data are only partly translatable or comparable with data obtained and recorded using the ICD.

The family members and their needs

The World Health Report (24) revealed that 1 in 4 families worldwide are likely to have at least one member with a behavioral or mental disorder. When a member of a family falls mentally ill, the family members will be upset and worried. Sometimes they, at first, do not accept the notion that their son, father or sister are mentally ill and ascribe the changes which they see to stress, to an extraordinary situation at work, to a physical illness or to bad behavior of the person. As the illness progresses their attitudes and comprehension of the situation may change and, at that point, their two main questions are: a) whether the condition they see is curable, and b) what will be the consequences for the family as a whole (e.g. because of the stigma of that the family, the expenses related to the treatment, the need to stay at home to look after the person, or because it will be necessary to tolerate the extraordinary behavior of the person who is ill etc.). Once these questions are answered, they will have classified their ill member into one of four categories:

• curable and harmless,
• curable but likely to be harmful,
• incurable but harmless, and
• Incurable and harmful.

Their behavior after that and the decisions they will take, will then be in line with the category they have assigned to the person with the illness.

The judges and their needs

Psychiatry is a branch of medicine that touches the interface between law and health, and psychiatrists frequently have to make decisions or give advice related to a variety of legal matters. When legal matters involve issues of general public, outside their expertise, lawyers and judges regularly seek advice from forensic psychiatrists. While they are interested in diagnoses in allied matters, their main concerns and questions are: a) is this person mentally ill, and b) was he or she able to understand the consequences of their action at the time when they took it.

Thus, for most of the judges, the classification of mental disorders can be reduced to advice about the placement of the individual's condition into one of the six boxes of the legally relevant classification. (**Table 1**).

Table 1. The classification used by judges and required from forensic psychiatrists

	Ability to understand the consequences of one's act		
	Fully able	Partially able	Not able
No mental illness			
Mentally ill			

The police and their needs

Many times, policemen are the first who see somebody with mental health problems and have to decide how to act, in order to avoid escalation of uncontrolled behavior and resolve problems. For them, it is important to decide immediately whether: a) the person before them is mentally ill (and unable to understand or rationally modify his or hers behavior) and therefore needs health care attention, or b) the person is dangerous to self or others.

The assessment of the individual on those two dimensions helps the policeman to decide what to do next – call an ambulance, talk to the person in question, try to calm down the situation or arrest those creating problems and leave the decision about further action to judges.

The policy makers and their needs

The public health authorities need to look at the field of mental illness in terms of large number of people, budget, health care resources and ethical requirement imbedded in their countries' constitutions. For them, the main issue is to assess the "true" mental health needs (3) and they can go about this matter in three ways:

1. They can decide that the mental health service will be decided based on an estimate of the total number of persons with a particular disease. If they accept this position, they will need to carry out epidemiological studies and express the results, in terms of frequencies of different types of mental disorder.

2. Public health authorities may also consider that the mental health service should be decided by counting the total number of persons who request mental health care (regardless of whether they suffer from a well- defined mental illness). If they decide to use this definition of needs, they shall have to do a research (mainly qualitative), to find out the expressed needs of the people living in that area.

3. The authorities might also consider that mental health service have to be calculated, by considering the availability of an effective treatment for one, or more, of the conditions which are affecting the population. If they decide to use this definition, they will have to examine the scientific literature concerning treatment effectiveness. Consequently, they will have to write the regulations concerning the provision of treatment, to a proportion of patients whose illness responds to that treatment.

A more advanced way, that is gradually being accepted by public health officials, is to consider focus on estimating the needs for treatment of those who:
(i) Suffer from well-defined diseases,
(ii) Request treatment, and
(iii) Whose illness will respond to currently available treatments.   In the above considerations, the diagnostic categories are of interest and relevance to doctors who make the diagnoses. However, patients who require treatment use a different language to describe their ailment, while public health authorities speak in terms of percentage of inhabitants in an area whose treatment has to be covered.
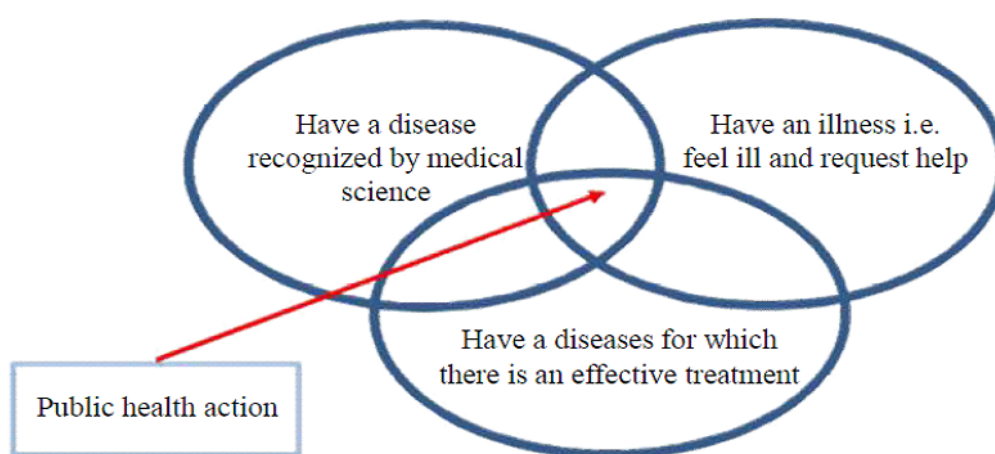

Figure 1. The policy makers and their needs

The general public and their needs

How people acquire knowledge and beliefs about mental health is relatively unknown. It is likely that personal experiences and anecdotal evidence from family and friends are an important source (25). Nevertheless, the majority of the public is unable to distinguish different mental disorders and does not understand the meaning of psychiatric terms used to describe people with a mental illness. In most of the settings, general public uses a classification that is similar to the classification used by policemen, with only a few categories:
•   A harmless madman,
•   A dangerous madman,
•   An eccentric.
This simple classification of people „suspected" to have some mental disorder will make it easier for the general public to talk about them, to make quick decisions in daily life situations and to react accordingly.

Conclusion

The main purpose of this paper was to remind the readers of the variety of classification that are used by many groups of people who have to deal with mental illness, or people who suffer from them. The task of the psychiatrists does not end at the production of a classification of diagnoses which they make and the skillful use of that classification. In addition, they have to know what classifications and diagnostic terms are used by others who see mentally ill people, to be able to communicate with them, to create alliances, that will make it possible to provide adequate help to those who are ill, to collaborate with their families, to educate the general public, to communicate with societies' agents (such as judges and policemen), and to inform the government about the best ways of implementing health care policies.

Psychiatrists also have to know the language that patients use about their illness and their symptoms. Patients make diagnoses of their condition and place them into some category of their own classification: unless psychiatrists understand this, they will not be able to raise their patients self-esteem, create a therapeutic alliance, jointly decide on the treatment that is best under the circumstances, or do any other therapeutic intervention in a maximum useful way.

What is true for psychiatrists is also true for other

medical practitioners. They often get caught in the universe of technical terms and complex schemes which were main content of their medical education. They think that they can speak with patients in those terms and that their patients will understand (and benefit from) suggestions they make, following the schemata by which physicians organize their knowledge. There is much evidence that things do not work this way: learning how to communicate, therefore, should be a lifelong task of all the doctors, from their first contact with people who are asking for medical care, to decision making and follow up of people whom they have treated. The word "doctor" has its origin in docere, meaning to teach (thus communicate!), not in any other word that speaks about a medical intervention.

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