

Editorial

Towards innovative international classification and diagnostic systems: ICD-11 and person-centered integrative diagnosis

A new cycle is starting in the development of international classification and diagnostic systems. The World Health Organization (WHO) Department of Mental Health organized in January 2007 the first meeting of an Advisory Committee for the preparation of the Mental Disorders Chapter of the Eleventh Revision of the International Classification of Diseases (ICD-11), to be consistent with the overall ICD-11 plan coordinated by the WHO Classification Office. Of relevance, there has been an active process of collaboration between the World Psychiatric Association (WPA) and WHO since 2001 to explore new classification and diagnostic paths. Also presently, the American Psychiatric Association (APA) is preparing the bases for its Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V). Furthermore, other active national and regional psychiatric bodies such as the Chinese Society of Psychiatrists and the Latin American Psychiatric Association are researching and refining, respectively, their Chinese Classification of Mental Disorders, 3rd Edition (CCMD-3) and Latin American Guide for Psychiatric Diagnosis (GLADP), which represent ICD adaptations to local realities and needs.

As health professionals and institutions consider and undertake these important activities on central topics for clinical care and public health, it may be wise to reflect carefully on their fundamental purposes so that their conceptualization can be optimized. A full international revision of classification and diagnostic systems takes place only every 10–20 years, and therefore this represents an opportunity as well as a responsibility not to be missed to advance our field.

What is diagnosis?

The term *diagnosis* has a widely accepted central position in the process of medical care. Feinstein (1) has noted that diagnostic categories provide the

locations where clinicians store the observations of clinical experience and the diagnostic taxonomy establishes the patterns according to which clinicians observe, think, remember and act.

But, what is diagnosis? The eminent historian and philosopher of medicine, Laín-Entralgo (2), has pointed out that ‘diagnosis is more than identifying a disorder (nosological diagnosis) or distinguishing one disorder from another (differential diagnosis); diagnosis is really understanding what is going on in the mind and body of the person who presents for care’.

In an attempt to delineate the nature and scope of that ‘understanding’ required to achieve a proper diagnosis, we may find the following reflections helpful. As health professionals, our natural area of concern is health. In Sanskrit, the mother of all Indo-European languages, the term for health is *hal*, meaning ‘wholeness’. Ancient Greek philosophers pointed out that if the whole is not well, it is impossible for the part to be well (3). Furthermore, WHO (4) has enshrined in its Constitution that ‘health is a state of complete physical, emotional, and social well being and not merely the absence of disease’.

As we know, medicine at large and psychiatry in particular are professions committed to helping people restore and promote their health. In fact, health promotion, in addition to health restoration (disease cure, alleviation or management), is increasingly recognized as a proper and important task of clinical care (5, 6).

From the above reflections, it should be possible to accept that *diagnosis* would fulfill better its fundamental role as informational basis for clinical care if it were to have a scope broad enough to describe the overall health status of the person presenting for care. And this means covering both ill health (or disease) and positive health, the latter involving domains such as functioning, personal and social values and resources, and quality of life (7).

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This also means bringing up to the front the humanistic purpose of clinical care (8). Its target and focus is the health of people who are not simply carriers of disease, but human beings with history and aspirations, whose dignity is to be respected and promoted. In connection to this, it should be recognized that diagnosis is not only a formulation, but an interactive process as concluded by dialog forums of patients, families and health professionals (9).

Related international health and institutional developments

It is encouraging to note an array of recent national and international developments and policies in mental health that are quite consistent with the above perspectives. A US Presidential Commission on Mental Health (10) has recommended to place consumers and families as well as integration of services at the center of an urgently needed transformation of the health systems. Also relevant here are recent policy statement on value-based practice from the National Institute of Mental Health of England, and the French *Etats Generaux de la Psychiatrie* in June 2003 demanding attention to 'complex clinical situations' through contextualized diagnosis and care. The WHO European Ministerial Conference on Mental Health (11) has spoken on the cruciality of mental health and the need to empower people and to obtain patient- and carer-centered integration of services.

In connection to the historical aspirations noted earlier and the above policy developments in the international health field, the WPA prepared and published in 2003 a set of *International Guidelines for Diagnostic Assessment* (IGDA) that pointed out that a patient is more than a carrier of disease and proposed a comprehensive diagnostic model with standardized and idiographic components that reflect person-centered integrative perspectives. More recently, WPA approved at its 2005 General Assembly an *Institutional Program on Psychiatry for the Person: from Clinical Care to Public Health* (IPPP). It represents an initiative affirming the whole person of the patient in context as the center and goal of clinical care and health promotion, at both individual and community levels. It involves an articulation of science and humanism to optimize attention to the ill and positive health aspects of the person. It includes four operational components: Conceptual Bases, Clinical Diagnosis, Clinical Care, and Public Health. The IPPP initiative finds stimulating consistency on many points with such significant conceptual developments in the

field as the European *Medicine de la Personne* (12), the Value-based Practice Approach promoted by the National Institute of Mental Health of England (8), and the Recovery Movement originating in the United States and now extending internationally (13, 14).

In April 2006, WPA updated its formal position concerning the development of ICD-11 and related diagnostic systems. This statement recognized that WPA over the past several years, particularly through its Classification Section and in collaboration with WHO and national and regional psychiatric associations, has contributed significantly to setting the foundations of future international classification and diagnostic systems. Key activities have included a large International Survey on the Use of ICD-10, DSM-IV and Related Diagnostic Systems, a number of WPA-WHO Symposia on International Classification and Diagnosis at WPA Congresses and Conferences, which have led to three published monographs and crucial advances in the field, and work commissioned by WHO on the bases for the development of the ICD-11 mental health component presented at WHO meetings from 2003 to 2005. It also noted that the process of ICD revision has recently entered a new phase with the WHO Classification Office directing the overall developmental process and the WHO Mental Health Department directing the development of the Mental Disorders Chapter. The position statement declared that WPA will offer its full collaboration to the World Health Organization for the preparation of ICD-11 and related diagnostic systems, and that it will cooperate with its Member Societies, including the American Psychiatric Association and other national and regional associations, concerning their own classification projects with the expectation that they be as consistent as possible with WHO's ICD-11 and Family of International Classifications. To ensure this, effective interactive mechanisms for coordination and harmonization should be implemented.

The position statement further indicated that WPA will continue exploring through its various components, particularly its Section on Classification and Diagnostic Assessment and pertinent Institutional Programs, and in collaboration with WHO and national and regional associations, the most promising approaches to fulfill etiopathogenic and clinical diagnostic validities and the accomplishment of the following principal developmental tasks:

- i) striving for the best possible core international classification of mental disorders, attending to

the elucidation of optimal definitions and thresholds for the ascertainment of mental disorders, utilizing complementary dimensional approaches, and taking into consideration the most appropriate cultural framework for classification and diagnosis, and

- ii) working for the development of the most useful comprehensive and integrative diagnostic models to enhance clinical care and health promotion.

Developing the best possible classification of mental disorders

This is widely regarded as an important task. Obtaining an improved nosology of mental disorders would respond to the well-established expectations of clinicians, researchers, educators and public health planners for a tool long considered as crucial for their work. The assignment rules related to the definitions of the classified disorders would allow health professionals to identify them in the clinic and the community in a reasonably reliable manner for their pertinent professional purposes. In the Laín-Entralgo (2) terminology outlined earlier, this disorder identification process corresponds to *nosological diagnosis*.

Of relevance to this critical task, WHO following its constitutional responsibilities is launching the development of the 11th Revision of the International Classification of Diseases. This work is coordinated at the whole system level by the WHO Classification Office and at the mental disorders chapter level by the WHO Mental Health Department. At this more specific level, the work is expected to include discussions on how this chapter will fit within the whole system, the particular uses of the classification in the mental health field, the definition of mental disorders, the conceptualization of broad and narrow categories, the use of dimensionality, the presentation of the classification for research and for clinical care in specialized and primary care settings, the organization of workgroups for major disorder categories and cross-cutting themes, the harmonization of the ICD classification with those developed by national and regional associations, and the engagement of world-wide scientific and stake holder contributions. It is hoped that the development of the mental disorders chapter, through alpha and beta versions, be completed around 2012, with a possible approval of the whole ICD-11 in 2014. WPA, which has a substantial record of collaboration with WHO on the matter (15, 16), will participate actively throughout this developmental

process, at the various levels of work and through the engagement of national psychiatric societies and classification groups.

The American Psychiatric Association, which has contributed richly to the field through the preparation and publication of path-opening editions of its Diagnostic and Statistical Manual of Mental Disorders, particularly DSM-III and DSM-IV, is working intensively towards the preparation of a DSM-V (17). It is presently holding a series of research conferences on psychopathological and methodological aspects of the classification. It has included WHO and WPA representatives in their advisory committees for DSM-V.

There are also other national and regional psychiatric associations which have developed substantial adaptations of the International Classification of Mental Disorders to their particular circumstances and purposes. Specially notable are the Chinese Classification of Mental Disorders, 3rd Edition (CCMD-3) published by the Chinese Society of Psychiatry (18), the French Classification of Child and Adolescent Mental Disorders prepared by the French Federation of Psychiatry (19), the Third Cuban Glossary of Psychiatry (GC-3) (20), and the Latin American Guide of Psychiatric Diagnosis produced by the Latin American Psychiatric Association (21). All these associations, among others, are expected to contribute to the development of ICD-11 in coordination with the World Psychiatric Association.

Along with all this activity, a consensus is emerging towards ICD-11 as a single international reference for the classification of mental disorders, with national and regional versions representing adaptations, annotations or extensions of the ICD core classification.

Developing a Person-centered Integrative Diagnostic Model and Guide

The plan for the development of a Person-centered Integrative Diagnosis (PID) as a theoretical model as well as a practical guide is an initiative of the World Psychiatric Association through its Institutional Program on Psychiatry for the Person (IPPP). Collaboration for this development is being arranged with WPA's scientific sections and member societies and their national diagnosis and classification groups as well as with WHO. The growth of the World Psychiatric Association in recent years, in terms of the enlargement and strengthening of the WPA family of national psychiatric societies, its wide array of scientific sections, and active publications program is

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bolstering the position of WPA to undertake major global initiatives such as PID.

A key starting point for the development of PID would be the schema combining standardized multi-axial and personalized idiographic formulations at the core of the WPA International Guidelines for Diagnostic Assessment (IGDA) (22). Also informative to this process would be the recent Evaluation of the DSM Multi-axial System, which has documented the value of such a system and offered recommendations for its further development and implementation (23).

At the heart of Person-centered Integrative Diagnosis (PID) is a concept of diagnosis different from the more conventional notion of just identifying and differentiating disorders. In PID, diagnosis is tentatively defined as the description of the positive and negative aspects of health, interactively, within the person's life context. PID would include the best possible classification of mental and general health disorders (expectedly the ICD-11 classification of diseases and its national and regional adaptations) as well as the description of other health-related problems, and positive aspects of health (adaptive functioning, protective factors, quality of life, etc.), attending to the totality of the person (including his/her dignity, values, and aspirations). The approach would employ categorical, dimensional, and narrative descriptive approaches as needed, to be formulated and applied interactively by clinicians, patients, and families. It appears that PID comes close to Lain-Entralgo's (2) concept of real diagnosis.

The proposed phases for the development of Person-centered Integrative Diagnosis, including its theoretical model and its practical guide or manual, in terms of main activities and outcomes, follow.

- i) *Design of the Person-centered Integrative Diagnostic (PID) Model.* This would encompass a review of the pertinent background (including the monographs listed above) aimed at evaluating critically the status of the diagnostic field, its fundamental limitations to provide an adequate basis for clinical care and public health actions, and the most suitable and promising domains and structures for the diagnosis of a person's health. Possible domains include illnesses, disabilities/functioning, risk and protective factors (resilience, resources, supports) and quality of life. Possible structures may include multilevel schemas encompassing standardized (categories and dimensions) and idiographic/narrative information. This work would include literature research conducted and discussed by members

of the IPPP Clinical Diagnosis Component through the internet and face to face meetings, with input from WPA components and pertinent health stakeholders. The timeline for this phase would be calendar year 2007.

- ii) *Development of the Person-centered Integrative Diagnostic (PID) Guide.* The sub-phases of the PID Guide development would include the following:
 - a) *Preparation of the PID Guide draft.* This would include the schemas, instruments and procedures to evaluate real persons according to each of the domains of the PID. This work would include literature research and intense interactive discussions conducted by members of the IPPP Clinical Diagnosis Component through the internet and face to face meetings, with input from WPA components and pertinent health stakeholders. This draft is hoped to be ready by the end of 2008.
 - b) *Evaluation of the PID Guide draft.* This evaluation would be conducted by the IPPP Clinical Diagnosis Workgroup in collaboration with the WPA Global Consortium of Classification and Diagnosis Sections through clinical and epidemiological studies using reliability, validity, and feasibility criteria. This work is hoped to be completed by the end of 2009.
 - c) *Preparation and publication of the final version of the PID Guide.* This work will be based on the results of the evaluative phase outlined above, expert discussions and health stakeholders input. This is hoped to be accomplished by the end of 2010.
- iii) *Person-centered Integrative Diagnosis Guide translations, implementation, and training.* This work would include, first, the translation of the PID Guide to prominent world languages; second, the promotion and facilitation of the implementation of the PID Guide across the world; and third, the development of training curricula and programs at graduate, post-graduate and continuing professional education levels both for specialty and primary care arenas. The work would be conducted by the IPPP Clinical Diagnosis Workgroup in collaboration with partner organizations in the year 2011 and thereafter.

Concluding remarks

The upcoming work on the development of the best possible classification of mental disorders

(through WHO's ICD-11 and related versions from the APA and other national and regional psychiatric associations) as well as that of a Person-centered Integrative Diagnosis brings a sense of excitement and historical responsibility to the many institutions and individuals involved. It will be certainly a world-wide effort. In contemplating this scenario from the pages of *Acta Psychiatrica Scandinavica* it is necessary to reflect on the enormous contributions from Nordic European colleagues to the foundations of these developments. We are celebrating this year the 300th birthday of Carolus Linnaeus, who as professor of biology and medicine at Uppsala University set key principles for systematization in the life sciences. We must also recognize the contributions of Stengel (24) to the international classification of mental disorders and of Essen-Moeller and Wohlfahrt (25) to the original conceptualization of multiaxial diagnosis. Last, but not least, we would like to thank Otto Steinfeldt-Foss (26), who has argued cogently that psychiatry and medicine being based on science and humanism must be personalized in diagnosis and care.

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