chapter two

Comparison Between ICD and DSM Diagnostic Systems for Mental Disorders

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CHAPTER OUTLINE

INTRODUCTION

The two major classifications of mental disorders that are used internationally are the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Health* (DSM). The ICD covers the entire range of human diseases, but the DSM covers only mental disorders. This chapter reviews the history of these classifications and contrasts the approaches taken by each

classification. In the past 60 years, each revision undertaken has enlarged both classifications. The value of both clinical prototypes and operational criteria for defining mental disorders is contrasted, and the innovations likely to be introduced when each classification is finalized are described.

THE ICD AND THE DSM DURING THE 20TH CENTURY

The first version of the precursor to the ICD had its origin at the International Statistical Conference in Brussels, in 1853, when William Farr, of the General Register Office in London, collaborated with Marc d'Espine, of Geneva, to prepare "a uniform nomenclature of diseases applicable to all the countries." Two years later, in Paris, a list of 138 categories was drawn up to cover the whole of human morbidity. The next edition was prepared by Jacques Bertillon, a medically qualified French statistician, who produced a revised edition for the International Statistical Institute in 1893, and represented a synthesis of English, German, and Swiss contributions. The International Classification of Diseases (ICD) was born in Paris, in 1900, under the auspices of the French government, and adopted Bertillon's classification.

The French government made itself responsible for subsequent revisions of the ICD, which occurred in 1909, 1920, 1929, and 1938, with collaboration from the League of Nations. Between 1909 to 1938, the number of disorders hovered near 200 diseases. In 1948, the French government convened a meeting for the last time with the newly formed World Health Organization (WHO), which took over responsibility for the ICD, beginning with the sixth edition, which included a fivefold increase in the number of disorders, to 954. It is important to understand that the ICD covers the whole of human disease and is supported by all member states of WHO.

The number of disorders remained at about 1000 diseases until ICD-9, in 1975, when WHO introduced a number of new developments, including the International Classification of Functioning, Disability and Health (ICF), a classification of procedures used in medicine, and specialist versions of the ICD, the first one being for oncology, known as the ICD-O. For the first time, the ICD now included a brief description of each category in the *mental illness chapter*. The category descriptions were in the form of clinical prototypes (as follow), with an accompanying glossary. This development stimulated work on definitions, criteria, and rules concerning the classification of mental disorders. There is also the major question of what means exist to make the classification used once it is produced. WHO has the signed promise of its member states that they will use the ICD for reporting health problems. Subsequent to ICD-8, WHO sought to involve the international

scientific and professional community in the making of the classification and in its promotion. Neither government pressure nor professional leadership was particularly effective in promoting its use.

The number of disorders abruptly rose again to almost 2000, in 1993, for ICD-10. Mental disorders had their own chapter beginning with ICD-6, and it was divided into 10 sections by the 10th edition:[1]

- F00–09 Organic mental disorders
- F10–19 Disorders due to drugs
- F20–29 Schizophrenia
- F30–39 Mood disorders
- F40–49 Neurotic disorders
- F50–59 Behavioral symptoms due to physical factors
- F60–69 Disorders of personality and behavior
- F70–79 Mental retardation
- F80–89 Disorders of physiological development
- F90–98 Disorders of childhood and adolescence

If all the subcodes are counted, the number of mental disorders in ICD-10 is 787. There is no limit to the number of categories that can be added, yet many of the existing ones are seldom used in practice. Müssigbrodt et al.[2] identified 32 specific diagnostic categories on a four-character level in the ICD-10 that are not used at all and 121 that are used less frequently than 0.1% in the number of inpatient and outpatient treatments.

The American Psychiatric Association's (APA's) *Diagnostic and Statistical Manual of Mental Health* (DSM)[3] covers only mental disorders and is produced by a single professional group in the United States. The APA relies on the professional community to use and promote the use of the DSM. The first version (DSM-I) was produced in 1952 and consisted of 102 different mental disorders, broadly equivalent to the ICD's mental disorders. The DSM-II, in 1968, described 182 mental disorders, and, until 1968, users of the two classifications tended to use clinical prototypes, where the task of the clinician was to recruit the patient to the nearest clinical category. To assist in this task, both the ICD and the DSM used phrases such as *will often*, *usually*, and *sometimes accompanied by* in their descriptions of different mental disorders so that the classification had indefinite borders. The essential characteristic of each disorder was symptom similarity (Table 2.1).

In the early systems of both the ICD and the DSM, the classifications were produced by consensus among selected experts and neither could lay claim to scientific validity. An important difference is that WHO has to reflect

Table 2.1 Pros and Cons of Clinical Prototypes

Strengths of Clinical Prototypes	*Weaknesses of Clinical Prototypes*
✔ Best for clinical usefulness	✘ Low reliability makes it unsuitable for research
✔ Recruits patient to nearest category	✘ May not fit nearest category well
✔ May suggest best management	✘ Top down, no validity

the varied opinions of doctors around the world, whereas the DSM has to represent the opinions of only the experts appointed by the APA. However, both classifications are essentially *nomenclatures* based primarily on symptom similarity. No upper limit exists as to the number of disorders that can theoretically be added to either. The only groups of disorders that might lay claim to being based on etiology are organic disorders and toxic disorders.

The poor reliability of concepts defined clinically made both systems unsuitable for research, which prompted the Department of Psychiatry at Washington University to produce the first operational criteria, aimed at making mental disorders more precise and thus improving reliability. Feighner et al.[4] described 14 disorders, and Spitzer et al.[5] expanded and improved these categories to produce a set of 45 disorders, using the Research Diagnostic Criteria. This system first stipulates what a given category *excludes*, then stipulates any symptom(s) that *must* be present, and then lists possible symptoms and stipulates *how many* of these symptoms have to be present to make a diagnosis. One principle of the operational system is that the same symptom could not appear in more than one disorder—thus anxiety, a very common symptom in major depression, could not be allowed as a possible identifying symptom for any other chapter because anxiety was assigned to the anxiety and stress-related disorders chapter. Regarding this principle, Lee Robins remarked, "I thought then, as I still do, that the rule was not a good one."[6] In general medicine, for a symptom like fever or anemia to appear in only a single description of a physical disease would clearly be absurd, yet that is the case with operational descriptions of disorders (Table 2.2).

These operational descriptions were no more valid than were the clinical prototypes and were also produced by consensus among experienced clinicians. They were easy to apply and were greatly welcomed by medical insurance companies and by courts of law in determining whether an individual has or does not have a disorder in question.

In 1980, the entire DSM-III was converted to operational diagnosis, with an increase in the number of categories from 182 to 265. Seven years

Table 2.2 Pros and Cons of Operational Criteria

Strengths of Operational Criteria	*Weaknesses of Operational Criteria*
✔ Reliable	✘ Procrustean bed
✔ Easily applied	✘ Reification of disorders
✔ Research interview easy to design	✘ Artificial dichotomies
✔ International acceptance	✘ Top down, no validity
✔ Adds to research base	✘ Creates needless comorbidity

later, a revised edition, the DSM-IIIR, had 27 new categories, and more were introduced in DSM-IV, in 1994, bringing the total number of categories to 297. The ICD kept pace with these changes in the DSM, and WHO produced two parallel versions of the ICD-10, one with operational criteria and the other with clinical prototypes. In contrast to the 10 chapters of the ICD, the DSM-IV has 16 chapters:

- Child and adolescent
- Organic disorders
- Substance use
- Schizophrenia
- Psychoses NEC*
- Delusional disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Sexual disorders
- Sleep disorders
- Factitious disorders
- Impulse disorders
- Adjustment disorders
- Personality disorders
- V codes

*Not elsewhere classified

The new operational criteria had a number of important disadvantages, which became more apparent over time: the criteria encouraged clinicians to *reify* mental disorders and to make diagnoses by checking off criteria in

a mechanical way. Illnesses were seen as being present or absent. Because no distinction was made between varying degrees of severity of a disorder, a person with symptoms that fell just short of the criteria was regarded as "normal." It was also possible to create new entities by stipulating different criteria for duration or by including different etiologies. Thus an illness that soon remitted could be called an adjustment disorder, while another illness with similar symptoms might reach criteria for major depression. Three disorders with broadly similar symptoms, for example, might qualify as postpartum depression, bereavement, or major depression.

Any changes to either the ICD or the DSM classifications are made relatively quickly, but writers of textbooks for undergraduate and postgraduate studies do not immediately revise their texts in accordance with the changes of either classification, while the diagnostic habits of psychiatrists in practice change even more slowly.

THE PROBLEM OF COMORBIDITY

Feinstein introduced the term *comorbidity* in medicine to denote those cases in which a *"distinct* additional clinical entity"[7] (italics added) occurred during the clinical course of a patient's having a particular illness. Thus, although a person with both schizophrenia and peptic ulceration might reasonably be said to have two comorbid disorders, a person with major depression and an anxiety disorder cannot—the illnesses are not distinct. However, psychiatrists using operational criteria solemnly enumerate the different disorders that have occurred simultaneously. Credulity is further strained by the fact that comorbidity is also common in random samples of the general population, as evidenced in Kessler and his colleagues' replication of the National Comorbidity Survey.[8] Over the course of a year, 14.4% of the US population had suffered a mental disorder, but an additional 5.8% had satisfied criteria for two disorders and a further 6.0% had satisfied criteria for three or more disorders in the same year. Similar figures have been reported in Holland, Australia, and the United Kingdom. First has commented that in psychiatric classification, comorbidity does not necessarily imply the presence of multiple diseases but instead can reflect our current inability to supply a single diagnosis that accounts for all symptoms. He describes "*spurious co-morbidity*"[9] (italics added), which might stem from the fact that the definitions of many broadly defined disorders contain more narrowly defined disorders within them—for example, dementia and amnestic syndrome. A much more important cause of comorbidity is when different categorical diagnoses are not distinct from one another because they contain many common symptoms—an example being major depression and generalized anxiety.

Psychological disorders are intrinsically complex disorders in which people with different temperaments are likely to develop different combinations of symptoms when under stress. Before operational criteria, the two systems, ICD and DSM, dealt with this problem by arranging the different disorders in a *hierarchy*, with organic disorders produced by structural brain disorders at the top and transient distress syndromes at the bottom. It was conceded that disorders lower in the hierarchy often occurred when a higher disorder was present. Maj writes:

> [A] consolidated tradition in psychiatry was to establish a hierarchy of diagnostic categories so that, for example, if a psychotic disorder were present, the possibly concomitant neurotic disorders would not be diagnosed because they would be regarded as part of the clinical picture of the psychotic condition.[10]

He goes on to say:

> [M]ental disorders are the expression of preformed response patterns shared by all humans, which may be activated simultaneously or successively in the same individual by noxae of various nature—a view endorsed by Kraepelin himself in one of his later works, in which he dismissed the model of discrete disease entities even for dementia praecox and manic–depressive insanity.[11]

However, the arrival of operational diagnoses and the abandonment of hierarchical rules meant that, when individuals were found to satisfy more than one diagnostic category, the concept of comorbidity appeared in mental disorders. The chapter structure of both classifications makes comorbidity difficult to avoid because, if criteria are satisfied in more than one chapter, it is difficult to avoid making more than one diagnosis. The greater number of chapters in the DSM system compared to the ICD produces a correspondingly greater problem. Table 2.3 provides an overall general comparison of the two systems.

Points of similarity between the ICD and the DSM are that each has published versions for primary care, many categories of each are unused in practice, and neither system can lay claim to validity.

CURRENT REVISIONS OF BOTH CLASSIFICATIONS

At the time of this writing, both classifications are under revision. In addition to the differences already referred to, the different ways in which each classification has developed have meant that there are numerous trivial differences

Table 2.3 Points of Difference Between the ICD and the DSM

ICD-10 *Chapter F Mental Disorders*	***DSM-IV*** *(still uses ICD-9 codes!)*
Experts represent the countries of the world	Experts mainly from the United States
Organized in 10 chapters	Organized in 16 chapters
Freely available, although some versions commercially distributed	Users must pay the APA for current versions
Versions use both operational and clinical prototypes	All categories defined using operational criteria
Different degrees of severity recognized for some categories (e.g., depression)	All disorders either present or absent

between the two. First examined the diagnostic requirements in both systems and concluded that "of the 176 criteria sets in both systems, only one, 'transient tic disorder,' is identical. Twenty-one per cent had conceptually based differences and 78% had non-conceptually based differences."[12] It is clearly desirable to eliminate trivial differences between the two classifications and to then go on to closely examine conceptual differences.

Both systems are rightly concerned about the proliferation of comorbidity, and those responsible for the revision of the DSM also want to include dimensional models to supplement the all-or-nothing approach of the categorical concepts. The ICD-10 already recognizes degrees of severity in some of its categories. For example, depressive episode can be separately coded as mild, moderate, or severe.

The WHO Revision Process

WHO held a series of preliminary meetings with representatives from international professional organizations representing psychiatrists, nurses, clinical psychologists, and social workers and a selection of experts in the classification of mental disorders. One topic discussed at these meetings was the overall metastructure of the chapter on mental disorders because most of the chapter titles were justified mainly by symptom similarity and it was thought that recent research findings might allow a simpler chapter structure. These discussions resulted in a proposal by Andrews et al.,[13] aimed at possibly eliminating some comorbidity between disorders that share common symptoms. Another topic was that the main ICD is likely to be adopting electronic forms of diagnosis.

After this set of meetings concluded, WHO set up a new advisory group to oversee the preparation of a new classification, this time with representation from each of WHO's nine regions, with developed, as well as developing, countries represented and a more equal gender representation. Seven subgroups, each one also balanced in the same way as the advisory group, report to the advisory group and are each responsible for designing modifications to the previous version of the ICD. These subgroups are primary care mental disorders, schizophrenia and related disorders, substance abuse disorders, behavioral dependencies, intellectual disability, a field studies coordination group, and behavioral disorders of childhood and adolescence. In addition, the World Psychiatric Association has undertaken to conduct surveys regarding problems with the present classification in each country and feed these results back to WHO.

The DSM Revision Process

The DSM revision process has followed a pathway different in some important respects from the ICD's and from its own previous procedures. About one-third of the experts consulted were researchers from outside the United States, thus providing an international perspective. The emphasis was on research data whenever modification to an existing diagnosis or creation of a new one was discussed. The various experts were divided into 18 groups, specializing either on a particular group of disorders or on five cross-cutting issues, for example, gender or effects of culture. The groups communicated in face-to-face meetings and through repeated conference calls. The face-to-face meetings typically had two or more groups meeting to provide some agreement on issues that affected both. The chairperson of each group communicated his or her group's findings with an overall steering group.

Five issues were initially identified: the problem of subthreshold disorders, the possible addition of dimensional models to the present categorical definitions, the undesirability of having unlimited numbers of new diagnoses, the exploration of ways to limit spurious comorbidity between categories, and whether it might be possible to limit the use of "not elsewhere classified" (NEC) diagnoses, which clinicians thought to be overused.

The Problem of Subthreshold Disorders

There are two problems here: Patients may often consult for disorders that do not meet operational criteria, yet professional time is spent establishing this. Second, psychiatrists are often accused of "medicalizing" relatively trivial human problems, and the growth of subthreshold categories can only strengthen this criticism.

Dimensional Models

Initially, the use of dimensional models appears to solve the subthreshold problem, but, on closer examination, such models pose two problems: they are easier to introduce in some areas than in others, and it will always be necessary to stipulate a point on each dimension where a clinically important disorder begins for which a treatment is available. Below this point, the problem of subthreshold disorders remains. It is relatively easy to introduce dimensions into personality disorders but much more complex into the psychoses. Yet a real need exists to be able to stipulate the severity of several common and important disorders, for example, depression, eating disorders, and cognitive disorders. It is likely that first steps will be taken to introduce such measures alongside the various categories. It is relatively easy, for example, to construct scales measuring degrees of severity of suicidal intentions and to require clinicians to make such a determination whenever they are making a diagnosis. This and other such dimensions may well find favor in the DSM-V field trials.

Limiting the Use of "Not Elsewhere Classified" (NEC) Categories

The problem with NEC diagnoses may largely be related to fee-for-service health systems in which insurance companies are prepared to pay reimbursement for NEC diagnoses but not for a disorder that the clinician rates as subthreshold. Such diagnoses may also be used because the clinician did not have enough time to make a definitive diagnosis or has not had the training to be able to do so. Having categories for either of these diagnoses would not make reimbursement more likely. Even a dimensional system does not solve the problem because insurance companies want to know whether a recognized category was present or not. Centrally funded systems, which do not use a fee-for-service system, can encounter similar problems with NEC diagnoses, but at least these systems can accept subthreshold degrees of a disorder. Only a system using clinical prototypes avoids the problem entirely, but DSM is unlikely to adopt that type of system. Thus, this problem remains unresolved.

Limiting the Expansion of the Classification

The steering group set clear standards that need to be met for a new diagnosis: Ideally, a new category has to be distinct from existing categories and has to remain stable over time. It should display familial aggregation, and any personality correlates and possible biomarkers should be stipulated. The potential harm in the creation of a new category should not exceed the benefit, and a treatment should be available. Finally, a new category should not

be a variation of normal functioning. These conditions are difficult to satisfy in their entirety, and not all the new possible categories satisfy all of them. Indeed, not all the existing categories do. Thus Maj argues that if homeostatic reactions to adverse life situations are not to be regarded as mental disorders, then many existing "common mental disorders"[14] may have to be excluded. It seems likely that some progress will be made in solving this problem—although some new disorders will inevitably be created.

The Problem of Comorbidity

What was described as "spurious comorbidity" can certainly be addressed by a better design of exclusion criteria for diagnoses that are effectively contained within another, larger one. However, as long as disorders that have many symptoms in common are to be found in different chapters of the DSM, comorbidity will be an intractable problem. Diagnostic categories may share many symptoms and differ in only a critical few.

However, simplifying the chapter structure of a revised classification is likely to be a difficult task, particularly as each of the specialized groups tends to defend its turf within its chapter. The greater the number of groups, the greater the problem becomes. Although much progress has been made in psychiatric research since 1994, researchers have not yet progressed to a point where our knowledge of the neural substrate of each group of disorders is either clear or universally agreed on. Thus, any simplification of the chapter structure—if the structure is no longer to rely on symptom similarity alone—may not be achievable in this revision. However, I hope two things might be achieved: correspondence between the number of chapters in each classification and first steps in producing chapters in which similarities in etiology exist where this is possible.

CLASSIFICATIONS OF MENTAL DISORDERS SUITABLE FOR GENERAL MEDICAL PRACTICE

A shorter version of each classification suitable for primary care was produced. The shorter version of the DSM used operational criteria assisted by complex algorithms,[15] while the ICD version[16] used clinical prototypes for each of its 28 categories and provided detailed guidance on the management of each disorder.

The **DSM-IV-PC** was produced by a collaborative effort between psychiatrists and general practitioners and deals with nine disorders common in primary care, together with detailed diagnostic algorithms to deal with each. The

disorders are depressed mood, anxiety, unexplained physical symptoms, cognitive disturbance, problematic substance use, sleep disturbance, sexual dysfunction, weight change or abnormal eating, and psychotic symptoms. Pingitore and Sansone's paper is illustrated with a 10-step algorithm for diagnosing anxiety, in which each step leads to side arms, enabling the clinician to consider 18 different anxiety diagnoses. The authors concede that the system "remains a large and complex volume that requires some level of familiarity before it can be used."[17] The system has been accompanied by a research instrument to screen for mental disorders, the PRIME-MD.[18] This research instrument has been much used in primary care research. Bakker et al. found low test–retest reliability for some of the categories and commented as follows:

> [T]he PRIME-MD is one of the few instruments in primary care that actually diagnoses specific mental disorders according to the DSM criteria. However, there was a failure to adequately classify sub-threshold disorders. Mental disorders, as seen in primary care, encompass important specific symptoms and clinical syndromes that vary in duration and severity over time, but they also encompass an admixture of somatic and psychological symptoms that do not match current diagnostic systems. This most likely resulted in methodological uncertainty about the level of agreement. Diagnostic criteria in psychiatry need to be operationalised for use in primary care and require further evaluation.[19]

It would be fair to say that few practicing general practitioners conduct their interviews using complex algorithms, however satisfying it may be to devise these in theory.

Weissman et al.[20] produced their Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) as a way of making DSM-IV diagnoses in primary care through a fully computerized system, aimed at seven diagnoses common in primary care and that requires no special staff training. However, when general practitioners were asked what they thought was wrong with patients who had been diagnosed by the system, they confirmed only MDD, GAD, suicidal ideation, and panic in about 60–68% of cases, while the other four diagnoses were confirmed in only 12–42% of cases. The authors assert that their results are similar to Spitzer et al.'s[18] using the PRIME-MD.

The **ICD10-PHC** is also limited to disorders common in primary care, and consultation between psychiatrists and general practitioners produced a list of 28 disorders common in primary care (Table 2.4). For each disorder, the classification provided not only information about how the patients

presented but also clinical descriptions and differential diagnoses for each disorder and then went on to provide information for the patient and his or her family, psychological treatments that had been shown to be effective, effective medications, and indications for referral.[21] WHO carried out field trials involving 478 general practitioners in 19 countries and found a satisfactory interrater reliability between two general practitioners ($\kappa = 0.68$; $n = 1691$) and a satisfactory concurrent validity between ICD10-PHC and an independent research interview ($\kappa = 0.83$).

Fifty trainee general practitioners participated in the field trials in the United Kingdom, and an increase in the participants' interest in mental

Table 2.4 The 26 Disorders in ICD10-PHC

F00	Dementia
F05	Delirium
F11	Drug use disorder
F10	Alcohol use disorder
F17.1	Tobacco use disorder
F20	Chronic psychosis
F23	Acute psychosis
F31	Bipolar disorder
F32	Depression
F40	Phobic disorders
F41	Panic disorder
F41.1	Generalized anxiety
F42.2	Mixed anxiety and depression
F43	Adjustment disorder
F44	Dissociative disorder
F45	Unexplained somatic symptoms
F48	Neurasthenia
F50	Eating disorders
F51	Sleep problems
F52	Sexual disorders (male)
F52	Sexual disorders (female)
F70	Mental retardation
F90	Hyperkinetic disorder
F91	Conduct disorders
F98	Enuresis
Z63	Bereavement

Source: Courtesy of Dr. T. Bedirhan Üstün.

disorders and in their confidence in making diagnoses was found. Use of the depression card increased the range of symptoms considered when making a diagnosis of depression, increased the threshold for prescription of antidepressants, and added to the managements suggested for depressive illnesses.[22] A later study with established general practitioners as participants showed that the guidelines had no impact on the overall detection of mental disorders, the accuracy of diagnosis, or the prescription of antidepressants, but there was a significant increase in the number of patients diagnosed with depression or unexplained somatic symptoms. The general practitioners also made increased use of psychological interventions.[23] A well-conducted randomized controlled trial (RCT) with established general practitioners failed to show that the guidelines had any impact on either detection or on patient outcomes.[24] However the ICD10-PHC has had a major impact in developing countries and is used in the training of nurses and multipurpose health workers, as well as medical officers.[25]

The **ICD11-PHC** is currently under development and is advised by a group consisting of approximately equal numbers from developed and developing countries, of primary care physicians and psychiatrists who actually teach mental health skills to trainees in primary care, and of men and women. Many of the disorders are recommended to be retained—often with suitable amendments—but several interesting new disorders have been suggested, as well as several disorders proposed for removal. Two new disorders during childhood are autism spectrum and specific learning disability because it is thought important that general practitioners should be able to recognize these disorders. New adult disorders are posttraumatic stress and health anxiety (was hypochondriasis), and the general practitioners also want a single category of personality disorders.

A new disorder, called bodily stress syndrome (BSS), will now include milder somatic symptom disorders, as well as the DSM-V's proposed complex somatic symptom disorder, and will replace medically unexplained somatic symptoms.

Perhaps the most radical proposal is to abandon the distinction between anxiety disorders and depressive disorders and to classify them all under the single umbrella of dysphoric disorders. Within this important group, two innovations are proposed: First, some simple operational criteria will be tested to distinguish among anxious depression, depression, and anxiety. Second, in the presence of any of these three disorders achieving the severity required of a "case," any somatic symptoms not part of a known physical disorder will be assumed to be related to the dysphoric disorder. This leaves BSS defined as being diagnosed only in the absence of a dysphoric disorder (Table 2.5).

Table 2.5 The 28 Disorders Proposed for ICD11-PHC

Developmental disorders:

1. Intellectual development disorder
2. Autism spectrum disorder
3. Specific learning disability
4. ADHD
5. Problems of bladder and bowel control

Impulse control disorders:

6. Conduct disorder

Psychotic disorders:

7. Acute psychotic disorder
8. Persistent psychotic disorder
9. Bipolar disorder

Dysphoric disorders:

10. Anxious depression
11. Depressive disorder
12. Anxiety disorder
13. Health anxiety
14. PTSD

Body distress disorders:

15. Bodily stress syndrome
16. Acute stress reaction
17. Dissociative disorder
18. Self-harm

Bodily function disorders:

19. Sexual function disorder, male
20. Sexual function disorder, female
21. Sleep problems
22. Eating disorders

Substance use disorders:

23. Alcohol use disorders
24. Drug use disorders
25. Tobacco use disorders

Personality disorders:

26. Personality disorder

Acquired neurocognitive disorders:

27. Dementia
28. Delirium

These proposals are radical indeed, and by no means will all of the proposed disorders survive the field tests. Each proposed category will be commented on by experts who are not part of the group, and final amendments will be made even before the classification is released for field tests. The field tests are likely to be quite extensive and to involve studies in both developed and developing countries. A second set of revisions will be made after the field tests.

CONCLUSION

Classifications that are based on clinical prototypes are of more use to the practicing clinician, but the classifications based on operational criteria have undoubted superiority in medical research. However, reliability has been purchased at the expense of validity. It is clear that different classifications are needed for different purposes: the needs of specialist mental health professionals are clearly quite different from those of health care professionals working in primary care. While the former use the concept of comorbidity in an attempt to include the various overlapping symptom complexes they are asked to see, the latter are more likely to use comorbidity to refer to the occurrence of mental disorder in those with chronic physical diseases. Both sets of professionals are coming to acknowledge the importance of dimensional models, which allow an assessment of the severity of a disorder, in terms of the number and severity of the symptoms and the disability associated with those symptoms.

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