

# New ICD-11 Diagnostic Guidelines for Mental Disorders: Challenging Implications for Psychology and Psychologists

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## Editorial

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## Editorial

It is time we realize that we are witnessing a transition of the diagnostic paradigm in mental health care due to the revision of the International Classification of Diseases for Morbidity and Mortality Statistics (ICD). It is well-known that ICD is a fundamental concept of WHO, focused on the processing of medical information and reporting for global health needs. Its global mission is to monitor threats to public health, improve health care, and develop standards of care. Accordingly, it should be applicable to all: users of different qualification, professionals of different mental health specializations, as well as of different regional or cultural backgrounds.

The general structure of the new ICD-11 version was approved by the WHO General Assembly in May 2019 and by January 2022 194 WHO member countries are expected to start using this classification in practice [1]. This will be preceded by campaign on training and implementation along with a priority task to translate both the classification itself and the guidelines for the chapter "Mental, behavioral and neurodevelopmental disorders", called "Clinical Descriptions and Diagnostic Guidelines" (CDDG). It is this guide that causes the greatest interest and discussion in the professional community, as it is a fundamental tool for qualifying a mental state and diagnosing a mental disorder.

In order to increase the reliability and utility of the CDDG, the global, multilingual, and multidisciplinary revision process has been organized under the auspices of WHO [2]. One of the main phases of the ICD-11 development consisted of evaluative field studies to investigate the way in which clinicians apply the proposed diagnostic

guidelines. First type of trials, internet based field studies have been conducted to examine accuracy and consistency of diagnostic judgements using ICD-11 in comparison with ICD-10 on standardized case material via Global Clinical Practice Network ([www.gcp.network](http://www.gcp.network)). This professional community brings together more than 15,000 mental health and primary care professionals from 158 countries with substantial proportion of psychologists (about 30 %) [3].

After that, "ecological" field studies have been organized on the basis of practical psychiatric institutions, i.e. in natural clinical conditions with real patients, in 5 languages, in 13 countries. The research results reflect the reasoned opinions of specialists from all over the world that makes the diagnostic guidelines more applicable in practice [4-6].

As an outcome of the revision process, the new enriched CDDG format has been proposed. In line with the essential (required) and additional features, differential diagnosis is more clearly marked: boundaries with the normality (threshold) and with other similar mental conditions are prescribed for each category. In addition, all disorders are considered separately from the standpoint of developmental presentations, gender and cultural specificity. Dynamic aspects are also taken into account in the form of indications of the particular course of the disease coding by the qualifiers [7].

Disorders blocks' structure has been transformed in accordance with renewed neurobiological and psychosocial data. Thus, for example, all anxiety and fear

related disorders are gathered together in a separate section and vary depending on the focus of apprehension, i.e. what incentives or situations cause fear or anxiety [7,8]. In ICD-10, many of these disorders were classified in the section "Neurotic, stress-related and somatoform disorders", which is not preserved in the new version and moved to different sections.

Significant changes have been made in the Obsessive-Compulsive and Related Disorders block, combining all disorders with unwanted thoughts and associated repetitive behavior as the main clinical symptoms [7,9]. Besides, the subtypes of disorder vary in the degree of insight about the accuracy of the beliefs that underlie the symptoms, marked and coded 2 levels (with fair to good insight or from poor to absent insight) that could be assessed and applied.

The ICD-10 section "Emotional disorders, behavioral disorders that usually begin in childhood and adolescence" has been eliminated, while mental disorders in children and adolescents are now partly presented Neurodevelopmental disorders block, which opens the entire chapter 6, and in the categories of all groupings in the section "Developmental presentations", so that we could have a panoramic picture of disorders during the life span [7].

ICD-11 innovations reflect both a categorical and dimensional approach to the diagnosis of mental disorders, combining phenomenological description and operational principle of the measurability of the disorder's severity.

Changes that have been made to the updated version of the ICD-11 clearly indicate the increasing role of clinical psychologists in the diagnostic process. And we are talking not only about the traditional psychological diagnostics of impaired mental functions, but also about the operational assessment of individual psychopathological manifestations. The renewed validated psychometric instruments, scales, designed for targeted detection of the severity of disturbances should be developed and recommended to clinicians.

In particular, it is necessary to assess the severity of symptoms groups (domains) in schizophrenic spectrum disorders, which partly replace the types of schizophrenia that are usual for clinical psychopathology. The specifics of any psychotic disorder will be determined taking into account the prevalence and severity of positive, negative, depressive, manic, psychomotor or cognitive symptoms

that is on absolutely new diagnostic approach in clinical practice [7,10].

The same dimensional principle is applied to assessment of the intensity of personality disorder. Division into mild, moderate and severe type becomes more important than an indication to pathology of character, that allows to consider the scale of the contribution of personality factors to the overall clinical pattern of disorder. It is really challenging that diagnosis of personality disorder is primary based on such psychological phenomena like the degree of disturbances in self-functioning and interpersonal relations, as well as in a pattern of emotional, cognitive and behavioural manifestations [7]. At the same time, there is the possibility of attributing personality disorders to the typology of 5 traits domains, which are mainly focused on behavioral patterns: negative affectivity, dissociation, anancastia, detachment, disinhibition [11,12]. Such an interpretation can contribute to a rapprochement of positions in the well-known divergence in conceptualization of personality pathology in psychiatry and psychology. The disorder is conceptualized as existing on a continuum of severity from trait to state and can be qualified according to its impact on functioning in personal, family, social, educational, occupational or other important areas which is quite new in the formal distinction between norm and pathology.

These are just some of the changes and innovations presented in ICD-11 Chapter on mental, behavioral and neurodevelopmental disorders, but it is clear that the psychological qualification of disorder is one of the essential parts in detection of psychopathology, while the role of psychologists grows up in dimensional diagnostic assessment of clinical manifestations.

In general, we see that the proposed version of the CDDG of the new ICD version looks quite logical and evident in its conception, more structured in form, approaching to a compromise between clinical correspondence, i.e. goodness of fit, and ease of use in practice, and what is most important, opening up new opportunities for utilizing comprehensive multidisciplinary approach affirming the well balanced cooperation of psychiatrists and psychologists.

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