Section 8. Trauma and the Individual 2 - Diagnostics

Trauma and the Individual 2 - Diagnostics

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“Ever since I can remember, beekeepers have been regarded by the media as harmless, doddery old men (mostly), who do strange things with wooden boxes full of bees, while dressed in sartorially suspect garb. However, this image is beginning to change, with more and more women and younger people being attracted to the idea of learning this ancient craft and a new urgency in the air about preserving our bees - both 'kept' and wild – for their important role as pollinators, as well as for their own sake.”

“Our great teacher, Elvin Semrad, actively discouraged us from reading psychiatry textbooks during our first year. Senrad did not want our perceptions of reality to become obscured by the pseudocertainties of psychiatric diagnosis. I remember asking him once:

“What would you call this patient – schizophrenic or schizoafetive?”

He paused and stoked his chin, apparently deep in thought.

I think I’d call him Michael McIntyre,” he replied.”

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

Notes:

1. This section, like all the others is prepared in such a way that the experts in their fields primarily tell the story. The sources are clearly displayed and the reader can seek them out for further interrogation of the subject matter.

2. For a more complete understanding of Trauma and the Individual this section should be read in conjunction with Section 7. Trauma and the Individual 1 – Scope.

Elsewhere in this proposal it is pointed out that the South Africa Mental Health Act 17 of 2002, appears to have no definition of a “diagnosis”, nor a standard to which South Africa prescribes. It appears that the American Psychiatric Association ‘DSM’ has simply been ‘assumed’ to be the standard to this point. This is a great pity. The worst of the scandals surrounding DSM 5 and some of its predecessors have been left to only brief hints by commentators below. The reader can easily explore the morbid details on Google or YouTube. Suffice to say that if South Africa were to buy into the DSM as its standard, it would be like agreeing to take over all the emission faulty Volkswagens in the USA; or to only agree to purchasing clothing from child labour produce factories in the East. The DSM is simply not ethical or moral enough to be held as South Africa’s standard. That said, the APA will hopefully emerge more righteous and rectify matters. As a research foundation for scientists the DSM can still play a critical role globally.

The available alternative is the WHO’s ICD. The ICD comes in two forms – one research based and one user based. In principle the ICD makes a terrific amount of sense for South Africa and our quest to bring Mental Health closer to Public Health. The ICD is already implemented in South Africa for Primary Health care. Expanding this officially to Mental Health will be appropriate on both a ‘language’ and a ‘cost’ basis. It does seem, from the arguments presented below, that the ICD has not quite had the ‘powers’ of Mental Health definition that are required. Certainly they are ignored in South African discourse, probably because they don’t have the same prestige for our academics, nor the established pathways to funding research projects. It looks as if the latest ICD version (11 –eleven) might rectify that. However, it will only be out in late 2017 or 2018 as some technical quality problems still have to be overcome.

Whilst the DSM is costly and only officially available in Manual form, the ICD is free and available online. Accessibility is important, but so is understanding and interpretation. The arrogance of some Psychiatrists is quite astounding when they scoff at the idea that diagnostic criteria should be made available to the Mental Health customer. Not only is that demeaning it’s an affront to basic Human Rights. If someone is going to cheat or try and defraud a health insurance provider, they will do it with or without public information. On the other hand, Primary Health care goes out of its way in many instances to inform the public about risks. Cancer is a prime example, but so are many others; even HIV/Aids has broken new ground now. Placing the information in the public domain is not the entire solution to issues of stigma, but without doing so the problems of stigma will never be overcome.

Etymology is very important. The diagnostics language is simply out of the comprehension reality of the average member of the public. The ICD is certainly easier to digest, but still falls way short of the norms of every day English let alone our other 10 official languages. Hopefully WHO will address this in years to come. It’s more than just the terminology. Humans experience symptoms not diagnostics. A quite simple example is provided under point 5 – PTSD diagnostics, below. Agreed, it’s a lot easier in Primary Health – Q? “What makes you think your leg is broken?” A? “My mother is carrying it for me!” Because its challenging should be the very reason why we pursue the answers!

TRISI is NOT proposed as a solutions institute for all Mental Health problems. However, Stress and Trauma are ever present in the healthy and the unhealthy. It is also the protagonist in the “Health Gang” of Substance Abuse, Poverty, Violence and HIV/Aids. (See introduction.) In Section 18 Trauma-Informed Care will be addressed. T-IC has simply moved on where the Diagnosticians have not. Nevertheless, this is a very important subject in the future of Mental Health care and TRISI’s place in that industry.
Mental Health Terminology

“The words we attach to our experience become our experience.”

Tony Robbins

It is with great hope that the content of this proposal will be read by people beyond the psych and primary health professions. In order to be part of the ‘conversation’ one is required to learn an elite new vocabulary. As many as possible of the strange sounding words in this section are given explanation through a single source: Wikipedia.

Some believe that this unique scientific etymology is meant to ensure that only a select few can participate in discussions as profound as Mental Health diagnostics. It does not really matter if this elite language is meant to be a barrier to entry or not. However, it is crucial that a customer language is developed. If the ornithologists can do it, why not the Mental Health Industry?

Of course, to be truly customer focused a common language is essential in English, Afrikaans, Isi-Xhosa, Isi-Zulu, Isi-Ndebele, Sesotho, Sesotho sa Leboa, Setswana, SiSwati, Tshivenda, Xitsonga; but unfortunately, English will have to do at this stage.

Aetiology
Biology
Classification
Cognition
Disorder
Diagnosis
Epidemiology
Epistemology
Etiology
Genetics
Mental disorder
Mental health
Neurology
Neurotransmitters
Nomenclature
Nosology
Pathology
Phenomenology
Psychiatry
Psychoanalysis
Psychology
Psychopathology
Psychopharmacology
Psychosocial
Stressor
Taxonomy

Aetiology
(See Etiology)

Biology is a natural science concerned with the study of life and living organisms, including their structure, function, growth, evolution, distribution, and taxonomy. Modern biology is a vast and eclectic field, composed of many branches and sub-disciplines. However, despite the broad scope of biology, there are certain general and unifying concepts within it that govern all study and research, consolidating it into single, coherent fields. In general, biology recognizes the cell as the basic unit of life, genes as the basic unit of heredity, and evolution as the engine that propels the synthesis and creation of new species. It is also understood today that all organisms survive by consuming and transforming energy and by regulating their internal environment to maintain a stable and vital condition.
Classification is a general process related to categorization, the process in which ideas and objects are recognized, differentiated, and understood. A classification system is an approach to accomplishing classification.

Cognition is the set of all mental abilities and processes related to knowledge, attention, memory and working memory, judgment and evaluation, reasoning and “computation” problem solving and comprehension and production of language, etc. Human cognition is conscious and unconscious, concrete or abstract, as well as intuitive (like knowledge of a language) and conceptual (like a model of a language). Cognitive processes use existing knowledge and generate new knowledge.

Disorder in medicine, a disorder is a functional abnormality or disturbance. Medical disorders can be categorized into mental disorders, physical disorders, genetic disorders, emotional and behavioral disorders, and functional disorders. The term disorder is often considered more value-neutral and less stigmatizing than the terms disease or illness, and therefore is a preferred terminology in some circumstances. In mental health, the term mental disorder is used as a way of acknowledging the complex interaction of biological, social, and psychological factors in psychiatric conditions. However, the term disorder is also used in many other areas of medicine, primarily to identify physical disorders that are not caused by infectious organisms, such as metabolic disorders. (See also Mental disorder)

Diagnosis is the identification of the nature and cause of a certain phenomenon. Diagnosis is used in many different disciplines with variations in the use of logics, analytics, and experience to determine "cause and effect". In systems engineering and computer science, it is typically used to determine the causes of symptoms, mitigations, and solutions

Epidemiology is the science that studies the patterns, causes, and effects of health and disease conditions in defined populations. It is the cornerstone of public health, and shapes policy decisions and evidence-based practice by identifying risk factors for disease and targets for preventive healthcare. Epidemiologists help with study design, collection, and statistical analysis of data, and interpretation and dissemination of results (including peer review and occasional systematic review). Epidemiology has helped develop methodology used in clinical research, public health studies, and, to a lesser extent, basic research in the biological sciences.

Epistemology (/ˈpɪstəməlɒdʒi/; from Greek ἐπιστήμη, epistēmē, meaning "knowledge, understanding", and λόγος, logos, meaning "word") is a term first used by the Scottish philosopher James Frederick Ferrier to describe the branch of philosophy concerned with the nature and scope of knowledge and is also referred to as "theory of knowledge". Put concisely, it is the study of knowledge and justified belief. It questions what knowledge is and how it can be acquired, and the extent to which knowledge pertinent to any given subject or entity can be acquired. Much of the debate in this field has focused on the philosophical analysis of the nature of knowledge and how it relates to connected notions such as truth, belief, and justification.

Etiology (/ˌetiˈɒlədʒiː/; alternatively aetiology or etiology) is the study of causation, or origination. The word is derived from the Greek αἰτιολογία, aitionlogia, "giving a reason for" (αἰτία, aitia, "cause"); and -λογία, -logia). The word is most commonly used in medical and philosophical theories, where it is used to refer to the study of why things occur, or even the reasons behind the way that things act, and is used in philosophy, physics, psychology, government, geography, spatial analysis, medicine, theology, and biology in reference to the causes of various phenomena. An etiological myth is a myth intended to explain a name or create a mythic history for a place or family.

Genetics is the study of genes, heredity, and genetic variation in living organisms. It is generally considered a field of biology, but it intersects frequently with many of the life sciences and is strongly linked with the study of information systems.

Mental disorder a mental disorder, also called a mental illness, psychological disorder or psychiatric disorder, is mental or behavioral pattern that causes either suffering or a poor ability to function in ordinary life. Many disorders are described. Conditions that are excluded include social norms. (Please refer to History of the DSM IV and DSM 5)
Mental health is a level of psychological well-being, or an absence of a mental disorder; it is the "psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment". From the perspective of positive psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience. According to World Health Organization (WHO) mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others." WHO further states that the well-being of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community. However, cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined.

Neurology (from Greek: νεύρον, neuron, and the suffix -λογία -logia "study of") is a branch of medicine dealing with disorders of the nervous system. Neurology deals with the diagnosis and treatment of all categories of conditions and disease involving the central and peripheral nervous system (and its subdivisions, the autonomic nervous system and the somatic nervous system); including their coverings, blood vessels, and all effector tissue, such as muscle. Neurological practice relies heavily on the field of neuroscience, which is the scientific study of the nervous system.

Neurotransmitters are endogenous chemicals that transmit signals across a synapse or junction from one neuron (nerve cell) to another "target" neuron, muscle cell or gland cell. Neurotransmitters are released from synaptic vesicles in synapses into the synaptic cleft, where they are received by receptors on other synapses. Many neurotransmitters are synthesized from simple and plentiful precursors such as amino acids, which are readily available from the diet and only require a small number of biosynthetic steps to convert them. Neurotransmitters play a major role in shaping everyday life and functions. Their exact numbers are unknown but more than 100 chemical messengers have been identified.

Nosology (from Ancient Greek νόσος (nosos), meaning "disease", and -λογία (-logia), meaning "study of-") is a branch of medicine that deals with classification of diseases.

Nomenclature is a system of names or terms, or the rules for forming these terms in a particular field of arts or sciences. The principles of naming vary from the relatively informal conventions of everyday speech to the internationally agreed principles, rules and recommendations that govern the formation and use of the specialist terms used in scientific and other disciplines. Naming "things" is a part of general human communication using words and language: it is an aspect of everyday taxonomy as people distinguish the objects of their experience, together with their similarities and differences, which observers identify, name and classify.

Pathology (from the Ancient Greek roots of πάθος (pathos), meaning "experience" or "suffering", and -λογία (-logia), "an account of") is a significant component of the causal study of disease and a major field in modern medicine and diagnosis. The term pathology itself may be used broadly to refer to the study of disease in general, incorporating a wide range of bioscience research fields and medical practices (including plant pathology and veterinary pathology), or more narrowly to describe work within the contemporary medical field of "general pathology," which includes a number of distinct but inter-related medical specialties which diagnose disease mostly through the analysis of tissue, cell, and body fluid samples.

Phenomenology is the study of subjective experience. It is an approach to psychological subject matter that has its roots in the philosophical work of Edmund Husserl.

Psychiatry is the medical specialty devoted to the study, diagnosis, treatment, and prevention of mental disorders. These include various affective, behavioural, cognitive and perceptual abnormalities.

Psychoanalysis is a set of psychological and psychotherapeutic theories and associated techniques, created by Austrian physician Sigmund Freud and stemming partly from the clinical work of Josef Breuer and others. Since then, psychoanalysis has been revised and developed in different directions. Some of Freud's colleagues and students, such as Alfred Adler and Carl Jung, went on to develop their own ideas independently. Freud insisted on retaining
the term *psychoanalysis* for his school of thought, and Adler and Jung accepted this. The Neo-Freudians included Erich Fromm, Karen Horney, Harry Stack Sullivan.

The basic tenets of psychoanalysis include:

1. a person’s development is determined by often forgotten events in early childhood besides inherited traits
2. human attitude, mannerism, experience, and thought is largely influenced by irrational drives that are rooted in the unconscious
3. it is necessary to bypass psychological resistance in the form of defense mechanisms when bringing drives into awareness
4. conflicts between the conscious and the unconscious, or with repressed material can materialize in the form of mental or emotional disturbances, for example: neurosis, neurotic traits, anxiety, depression etc.
5. liberating the elements of the unconscious is achieved through bringing this material into the conscious mind (via e.g. skilled guidance, i.e. therapeutic intervention). [3][4]

**Psychology** is the study of mind and behavior. It is an academic discipline and an applied science which seeks to understand individuals and groups by establishing general principles and researching specific cases. In this field, a professional practitioner or researcher is called a psychologist and can be classified as a social, behavioral, or cognitive scientist. Psychologists attempt to understand the role of mental functions in individual and social behavior, while also exploring the physiological and biological processes that underlie cognitive functions and behaviors.

**Psychopathology** is the scientific study of mental disorders, including efforts to understand their genetic, biological, psychological, and social causes; effective classification schemes (nosology); course across all stages of development; manifestations; and treatment.

**Psychopharmacology** (from Greek ψυχή, *psykhē*, “breath, life, soul”; φάρμακον, *pharmakon*, ”drug”; and -λογία, -*logia*) is the scientific study of the effects drugs have on mood, sensation, thinking, and behavior. It is distinguished from *neuropsychopharmacology*, which emphasizes the correlation between drug-induced changes in the functioning of cells in the nervous system and changes in consciousness and behavior.

**Psychosocial.** For a concept to be *psychosocial* means it relates to one’s psychological development in, and interaction with, a social environment. The individual needs not be fully aware of this relationship with his or her environment. It was first commonly used by psychologist Erik Erikson in his stages of social development. Contrasted with *social psychology*, which attempts to explain social patterns within the individual. It is usually used in the context of “psychosocial intervention,” which is commonly used alongside psycho-educational or psychotherapeutic interventions and points toward solutions for individual challenges in interacting with an element of the social environment.

**Stressor** a *stressor* is a chemical or biological agent, environmental condition, external stimulus or an event that causes stress to an organism.

An event that triggers the stress response may include:

- environmental *stressors* (hypo or hyper-thermic temperatures, elevated sound levels, over-illumination, overcrowding)
- daily stress events (e.g., traffic, lost keys, quality and quantity of physical activity)
- life changes (e.g., divorce, bereavement)
- workplace *stressors* (e.g., high job demand vs. low job control, repeated or sustained exertions, forceful exertions, extreme postures)
- chemical *stressors* (e.g., tobacco, alcohol, drugs )
- social stressor (e.g., societal and family demands)

Stressors have physical, chemical and mental responses inside of the body. Physical stressors produce mechanical stresses on skin, bones, ligaments, tendons, muscles and nerves that cause tissue deformation and in extreme cases tissue failure. Chemical stresses also produce biomechanical responses associated with metabolism and tissue repair. Physical stressors may produce pain and impair work performance. Chronic pain and impairment requiring
medical attention may result from extreme physical stressors or if there is not sufficient recovery time between successive exposures.

**Taxonomy (general)**, the practice and science of classification of things or concepts, including the principles that underlie such classification.

Taxonomy is the practice and science of classification. The word is also used as a count noun: a *taxonomy*, or *taxonomic scheme*, is a particular classification. The word finds its roots in the Greek τάξις, *taxis* (meaning 'order', 'arrangement') and νόμος, *nomos* ('law' or 'science'). Originally *taxonomy* referred only to the classifying of organisms or a particular classification of organisms. In a wider, more general sense, it may refer to a classification of things or concepts, as well as to the principles underlying such a classification. 

**Taxonomy (biology)**, a branch of science that encompasses the description, identification, nomenclature, and classification of organisms.

Taxonomy (from Ancient Greek: τάξις *taxis*, "arrangement," and -νομία -*nomia*, "method") is the science of defining groups of biological organisms on the basis of shared characteristics and giving names to those groups. Organisms are grouped together into taxa (singular: taxon) and given a taxonomic rank; groups of a given rank can be aggregated to form a super group of higher rank and thus create a taxonomic hierarchy. The Swedish botanist Carolus Linnaeus is regarded as the father of taxonomy, as he developed a system known as Linnaean classification for categorization of organisms and binomial nomenclature for naming organisms.

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**Diagnostics**

*Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma*, Viking 2014

‘Diagnostic reliability isn’t an abstract issue: if doctors can’t agree on what ails their patients, there is no way that they can provide proper treatment. When there’s no relationship between diagnosis and cure, a mislabelled patient is bound to be a mistreated patient. You would not want to have your appendix removed when you are suffering from a kidney stone, and you would not want to have somebody labelled as ‘oppositional’ when, in fact, his behaviour is rooted in an attempt to protect himself against real danger.’


[Summary]

**THE PURPOSES AND USES OF A DIAGNOSTIC CLASSIFICATION SYSTEM**

1. In a generic sense, a nosological system is simply a system of classifying disease or pathology...Although an a theoretical nosological system allows it to be more broadly applied to a variety of disorders as well as clinicians with a variety of theoretical backgrounds and training, these advantages come at a cost. In particular, an a theoretical nosological system may lack explanatory power as to the etiology of particular disorders, thus affecting patient treatment (Frances & Egger, 1999). Subsequent sections of this chapter continue to come back to this issue of an explanatory versus descriptive nosological system.

2. Another purpose of a diagnostic classification system () is the need to conduct clinical research on particular populations. Again, a reliable diagnostic system is a fundamental prerequisite needed to conduct such research.

3. Another use of (a) diagnostic classification system is that there are many other public institutions that rely on an accurate diagnosis.

4. A final use of (a) diagnostic classification system, and perhaps the most controversial, is to allow for third-party payment for psychological services.
VIVEK DATTA, MD, MPH; Psychiatry and the Problem of the Medical Model – Part 1; December 21, 2014; https://www.madinamerica.com/2014/12/psychiatry-problem-medical-model-part-1/

‘Diagnostic tests in the majority of cases were never meant to ‘make’ a diagnosis but to support a diagnosis, which is made from carefully listening to the history of the illness and through physical examination. As medical practice has become more litigious and we have become more reliant on tests to make diagnoses, doctors spend less time listening to their patients, and no longer trust their clinical skills. I went into psychiatry because of the focus on subjectivity, narrative, meaning and relationships. Because these are no longer valued in medicine, they are also less valued in psychiatry.’

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

‘If we look beyond the list of specific symptoms that entail formal psychiatric diagnosis, we find all mental suffering involves either trouble in creating workable and satisfying relationships or difficulties in regulating arousal (as is the case of habitually becoming enraged, shut down, over excited, or disorganised). Usually it is a combination of both. The standard medical focus on trying to discover the right drug to treat a particular “disorder” tends to distract us from grappling with how our problems interfere with our functioning as member of our tribe.’

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘Warwick Middleton is explicit regarding the extent to which both professional bodies and society at large ‘have buried the etiological significance of developmental trauma by devising rationales for ignoring it, re-diagnosing trauma caused conditions as some form of biological/genetic disorder or by assigning diagnoses that mitigate against an individual’s trauma being taken seriously’. His comments regarding what he calls ‘[t]he endemic nature of ‘re-badgeing’ of conditions caused by severe developmental trauma’ have their disturbing correlate in both minimisation of the prevalence of child abuse, and the absence of services to assist and treat the many who experience it. A further insidious effect of the ‘re-badgeing’ of symptoms and conditions associated with childhood trauma is upholding of the ‘culture of silence’ that continues to surround child abuse. This further compounds the already endemic myopia which seriously distorts both perceptions and current treatment of those whose underlying trauma is not recognised:

...for the most part, the issue of trauma is simply screened out organizationally and systemically...the reality of the traumatic origins of mental illness go unaddressed. And the patient, frequently diagnosed with chronic depression, borderline personality, or some other ‘axis II’ disorder, is labelled, everyone in the system colludes to support the reality and meaningfulness of the label in determining future behaviour and outcomes, and the patient’s more fundamental – and treatable – trauma conditions go untreated. Bloom & Farragher, Destroying Sanctuary, p.224.

SASOP/TGPD

Franco Colin; Department of Psychiatry, University of Pretoria; SASOP treatment guidelines for psychiatric disorders: Eminence or evidence based? - Response invited by the Editor: S Afr J Psych 2014;20(2):63-64. DOI:10.7196/SAJP.529

‘These guidelines had become critically important for two reasons: Firstly, algorithms for psychiatric treatment did not exist at that stage, and often State psychiatry would find itself in a very limited and often non-evidence-based vice grip regarding the availability of treatment methods. Secondly, private psychiatrists were progressively exposed to so-called ‘medication algorithms’ created by medical schemes and applied indiscriminately, often based on financial considerations rather than evidence-based medicine. It had therefore become essential to create some form of guideline to formulate the position of psychiatrists in South Africa regarding treatment of commonly occurring psychiatric disorders.’
The South African Society of Psychiatrists (SASOP) Treatment Guidelines for Psychiatric Disorders have been developed in order to address the local need for guidelines in our unique clinical setting. The need for treatment guidelines has frequently been expressed by South African psychiatrists and other medical practitioners, as well as by other role players such as medical scheme and other funding body advisors and the pharmaceutical industry. While several well-developed international treatment guidelines are readily accessible and are indeed extensively utilised in South Africa, they are not always applicable to our own circumstances. There are often important differences, not only regarding the availability of various psychotropic medications, but also in healthcare settings and availability of resources that need to be considered when selecting particular medications. For example, prescribing compounds that require regular monitoring such as lithium and clozapine may not always be feasible in certain rural settings in South Africa.

These Guidelines do not cover all of the psychiatric disorders at this stage, although most of the important ones are covered. We envisage an ongoing process of updating and expanding the Guidelines regularly, as new drugs are introduced and as healthcare settings evolve. The chapters comprise a collection of systematically developed chapters in standardised format that attempt to provide evidence-based recommendations for assessment and treatment of common psychiatric disorders. The aim is to provide guidelines that are of assistance to psychiatrists and other medical practitioners in clinical decision making. It is hoped that policy makers and administrators will also make use of them.

Critique of the TGPD

S Baumann; J Benson-Martin; Q Cossie; K Gilfillan; N Horn; S Kaliski; P Milligan; H Temmingh; T Timmermans; P Williams-Ashman; SASOP treatment guidelines for psychiatric disorders: Eminence or evidence based? S Afr J Psychiatr Treat 2014;20(2):63-64. DOI:10.7196/SATP.529

‘Although the authors seem to be critical of ‘evidence-based medicine’ (EBM) and mention that different interpretations of the evidence base in psychiatry are often selectively applied to support a particular point of view, they seem nevertheless to advocate that guidelines be backed up by evidence. However, the various guidelines fail to use a standardised and consistent methodology for appraising the evidence. There seems to be an absence of methodological input, with each guideline written by a single content expert only. In our opinion, the scope and purpose of each guideline lacks detail, particularly with regard to the patient population, particular treatment comparisons and specific patient-relevant outcomes. In addition, there is no clearly defined systematic search strategy for the literature and we are left to the mercy of ‘file drawer’ bias, with many statements made in the guidelines lacking appropriate referencing.’

‘There is little discussion of how certain psychological, psychosocial and pharmacological interventions, used in other international settings, could be generalised to the SA setting. Furthermore, the extent of stakeholder involvement, both from a patient and provider perspective, is not clearly conveyed, particularly with regard to different values and level importance ascribed to certain outcomes.

‘One potential dilemma is the dearth of necessary expertise to embark on guidelines of such a magnitude.’

Franco Colin; Department of Psychiatry, University of Pretoria; SASOP treatment guidelines for psychiatric disorders: Eminence or evidence based? - Response invited by the Editor: S Afr J Psychiatr Treat 2014;20(2):63-64. DOI:10.7196/SATP.529

‘When compiling these guidelines, the compilers and reviewers were requested to refer to existing international treatment guidelines such as the International Society for Bipolar Disorders guidelines, the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines and many other excellent guidelines existing in the literature. These formed the basis for an attempt at creating an initial document in this very difficult field.’

‘We agree with the authors that many excellent international guidelines exist. However, uncritical application to our local situation would be unwise.’

‘One should certainly take these criticisms seriously, but one should also acknowledge that this was a first attempt at creating something which, up until its publication, had not existed in contemporary South African psychiatry. Certainly the compilation of these guidelines, to a large extent, was grounded in a balance between ‘ability’ and ‘willingness’, rather than ‘eminence’. There is, furthermore, always the issue that when work gets done, only a few
stalwarts usually ‘rise to the occasion’. The guidelines were, as previously stated, intended to oppose the far worse and uncritically compiled treatment guidelines that had been created by many manage care organisations, leading to an infringement of patient rights and often denial of essential treatment.’

‘It is heartening to note that ten eminent academic psychiatrists from the University of Cape Town have clearly taken this issue seriously and propose an excellent methodology, including within their critical and constructive letter a suggestion to proceed forward. I would respectfully suggest that this letter and my response be referred to the Board of Directors of SASOP for consideration that these ten psychiatrists be tasked with the substantial and immediate review of the treatment guidelines.’

The DSM – Diagnostics and Statistical Manual

Wikipedia – ‘Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, abbreviated as DSM-5, is the 2013 update to the American Psychiatric Association’s (APA) classification and diagnostic tool. In the United States the DSM serves as a universal authority for psychiatric diagnosis. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications, so the appearance of a new version has significant practical importance.’

Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer

‘For over three decades, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has dominated psychiatry all over the world. American psychiatry was the fertile ground on which grew this new kind of classification. The latter, thanks to its hegemonic status, returned the favor by making American psychiatry the leading voice in the international field of psychiatric research. More than the mere symbol of the late but very fast development of American psychiatry since the second half of the twentieth century, the DSM played the role of a catalyst for American psychiatry: it accelerated its prominence and motivated its main choices and assumptions.’

‘Without a doubt, today no psychiatrist in the world is unaware of the meaning of the acronym “DSM,” even when many clinicians continue to resist the imperative to use this manual. Most certainly, all scientifically ambitious researchers in psychiatry must refer to the DSM, however unsatisfied they might be with the manual. Today, with the publication of the DSM-5 in 2013, and despite all the criticisms and complaints directed against this new edition even before it was published (and often formulated by American psychiatrists themselves), the hegemony of the American system remains intact.’

‘The DSM’s influence reached much beyond the psychiatric world itself. Its criteria are regularly mentioned in health magazines, newspapers, and advertisements (in the USA and New Zealand, “Direct-to-Consumer Advertising” is legal), and of course they are easily accessible online. With the Internet, it is in fact very easy for anyone to acquire a legal or illegal copy of the DSM-5, only a few months after its publication. It is not uncommon to see psychiatric patients recite the exact list of DSM criteria that are used to identify their disorder.’

‘Based on its editorial success alone, the DSM certainly deserves to be called a “Bible,” as it is often done. The APA spent nearly 25 million dollars on the DSM-5 (almost five times more than it did on its previous edition, the DSM-IV). One can only imagine the return on investment that is expected through the selling of the manual, of its translations, and through merchandising.

However, one could also argue that the proper metaphor for the DSM is not the Bible, but one of its stories: the Tower of Babel. Seen in this light, the DSM looks like an imperfect and unachievable monument, which was originally built to celebrate the new unity of clinical psychiatric discourse, and which ended up creating, as a result of its hubris, ever more profound practical divisions and theoretical difficulties. For while the DSM, in its fifth incarnation, has never been so well ingrained institutionally, it is fair to say that its cracks are also becoming increasingly visible.’
‘There is a(nother) paradox in the history of the DSM: its extraordinary success. While the DSM-III did not offer any theoretical innovation, but only a stupendous methodological audacity, its impact on contemporary psychiatric discourse and practice has been considerable. The first printing of the DSM-III, in 1980, was quickly sold out. It was soon translated into many languages: Chinese, Danish, Dutch, Finnish, French, German, Greek, Italian, Japanese, Norwegian, Portuguese, Spanish, Swedish, etc. (APA 1987, p. xvii). The successive editions, the DSM-III-R (1987), the DSM-IV (1994), and the DSM-IV-TR (2000), only reinforced the world domination of the DSM. The DSM quickly supplanted most national classifications, wiped them from memory, and contributed to an unprecedented homogenization and universalization in the practice of psychiatry.’

‘One of the great difficulties resulting from the DSM’s claim to universality comes from the fact that it requires leaving aside the different national traditions in health care systems. Yet the theoretical issue of the validity of the diagnostic categories is inextricably intertwined with the practical issue of the usefulness of the classification. The DSM Work Groups are almost exclusively constituted of American psychiatrists, and as a result it is naturally the American health care system that is invoked when practical constraints are taken into consideration to modify diagnostic criteria. A different health care system could determine different theoretical choices. For instance, in the context of French health insurance, many of the difficulties that American psychiatrists have to face become incomprehensible. In particular, the debate about the rigidity and authority of the DSM criteria is difficult to understand in France, where there is no requirement to receive an official diagnosis in order for a patient to be treated and reimbursed.’


‘Humans naturally attempt to sort and make sense of their environments, including how to classify psychopathology. Different methods are developed (taxonomies) in an attempt to most accurately represent reality. There are scientific pros and cons to each method, and politics play a role in deciding which methods are used. Throughout the histories of the DSMs, the researchers and clinicians have been struggling with similar issues, and these issues have not been resolved with the newly released DSM-5. We still do not know the etiology of mental disorders or when dimensions are better to use in classifying them as opposed to discrete categories. Theoretical positions oppose one another, which is good for science in that it allows theories to be falsified (Popper 1985) but bad if money and self-serving biases influence the system more than the data.’

‘The classification of psychopathology is integral to the science and practice of clinical psychology as well as all behavioral health disciplines. In the United States, the Diagnostic and Statistical Manual of Mental Disorders (DSM; Am. Psychiatr. Assoc. 1952) has been the official American classification scheme since its inception in 1952. The fifth edition of this system was recently released (DSM-5; Am. Psychiatr. Assoc. 2013a). Understanding the history of the DSM editions is important owing to their influence over diagnostic practice and research.’
History of the DSM

“The conceptual and methodological struggles of earlier editions of the DSM still apply, and thus the oft quoted piece of wisdom attributed to Edmund Burke pertains: “Those who do not know history are destined to repeat it.”


Early history


‘The origin of the concept of mental illness may date back to prehistoric man. That is, it is likely that prehistoric man had some understanding of the “mind”, and that surgery to the skull might relieve symptoms of illness due to head injury (Liu & Apuzzo, 2003). As human society has progressed, however, the concept of mental illness has both expanded as well as become more complex.

When the U.S. census was conducted in 1840, it included a single category of mental illness (“idiocy/insanity”) to describe portions of the American populace. This was the first time that data were systematically collected via the census for this purpose. In the 1880 census, seven categories of mental illness were included in the census materials, many of which were labeled with terms that now seem antiquated (e.g., monomania, dipsomania, melancholia).

Soon, a committee within the American Psychiatric Association began to collaborate with the census bureau in order to gather more extensive data. However, the emphasis remained primarily statistical rather than clinical (APA, 1952, 2000).


‘Prior to 1900, psychiatrists were few and far between and usually relegated to large state hospitals and asylums for the severely mentally ill. Psychoanalysis had not yet been created, and hardly any psychiatrists were engaged in outpatient psychotherapy (Grob 1991). Naturally, these psychiatrists were more interested in the pragmatic aspects of managing an asylum, and were less interested in academic pursuits. Thus, there was little interest in nosology (the branch of science dealing with the classification of disease) beyond how it would be practically useful in managing patients and performing administrative duties. In this context, as Grob (1991) notes, diagnosis was a primary concern for psychiatrists, but only insofar as it served a practical purpose.’

Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective: Philosophical Reflections on the Psychiatric Babel; Springer

‘Clinical psychiatry emerged in nineteenth century France, Germany, and Switzerland, and until World War II almost all the most influential psychiatrists, laboratories, and scientific journals were European. American psychiatry did not yet have an identity of its own. It was, at best, a borrowed psychiatry. Benjamin Rush, who in the USA is often considered the founding father of American psychiatry, was very heavily influenced by European psychiatrists, especially by Philippe Pinel and his “moral treatment.” Rush’s own influence outside the USA has always been minimal.’


‘A study from the 1930s that still has relevance to modern research was performed by a Catholic priest, Thomas V. Moore (1930, 1933). Moore gathered data on 367 psychotic patients from two mental institutions in the Washington, DC area. His descriptive data included 40 symptoms for which he provided prose definitions of what the symptoms meant, scores on cognitive ability tests, and behavior rating scales... Moore was ahead of his time when it came to thinking about psychopathology in terms of dimensions,... However, the factors identified in his research were not particularly stable.’
The development of a uniform nomenclature of disease in the United States is comparatively recent. In the late twenties, each large teaching center employed a system of its own origination, no one of which met more than the immediate needs of the local institution.

‘In late 1927, the New York Academy of Medicine spearheaded a movement out of this chaos towards a nationally accepted standard nomenclature of disease. In March, 1928, the first National Conference on Nomenclature of Disease met at the Academy; this conference was composed of representatives of interested governmental agencies and of the national societies representing the medical specialties. A trial edition of the proposed new nomenclature was published in 1932, and distributed to selected hospitals for a test run. Following the success of these tests, the first official edition of the Standard Classified Nomenclature of Disease was published in 1933, and was widely adopted in the next two years. Two subsequent revisions have been made, the last in 1942. The nomenclature in this manual constitutes the section on Diseases of the Psychobiologic Unit from the Fourth Edition of the Standard Nomenclature of Diseases and Operations, 1952.’

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‘The first American classifications of diseases, such as the Statistical Manual for the Use of Institutions for the Insane (1918) and the Standard Classified Nomenclature of Diseases (1933), lacked both rigor and originality. These classifications could have become useful tools for statistical inventories and the homogenization of diagnostic practices, but most clinicians dismissed them.

‘...brothers Menninger, Karl (1893–1990) and William (1899–1966). (were) the War Department Technical Bulletin, Medical 203, also called the Nomenclature of Psychiatric Disorders and Reactions. This military classification of mental disorders was published in 1946 and directly influenced the text of the first edition of the DSM (1952). But while William did not live to see the publication of the DSM-II (1968), his brother Karl came to deplore the direction taken by this second edition, accusing it of sacrificing simplicity at the altar of international standardization (Spitzer and Wilson 1975).’

DSM I - 5


‘In retrospect, the DSM-I had an inpatient psychiatry focus. This edition focused mainly on the organic and psychotic disorders. The inpatient focus can also be seen by examining the miscellaneous categories in this system such as “Transient, hospitalized only for psychological testing” and “Deceased at the time of examination.”’

‘After World War II, American psychiatry was embarrassed by the chaotic state of classification in the United States. Four systems were in use across different sectors of the mental health field (Houts 2000). The American Psychiatric Association (APA) decided to overcome this “Tower of Babel” situation by creating a classification that would be acceptable to all members of its organization and that could unify the diagnostic terms of its psychiatrists. The result was the DSM (later renamed the DSM-I because it was the first edition in a series of substantive revisions to this manual). The DSM-I contained 128 categories and was published as a smallish (132 pages) paperback book that cost $3.

Organizationally, the DSM-I had a hierarchical system in which the initial node in the hierarchy was differentiating organic brain syndromes from “functional” disorders. The functional disorders were further subdivided into psychotic versus neurotic versus character disorders. This organization roughly followed the decision-making process of clinicians.’
The first edition of the *DSM*, published by the American Psychiatric Association in 1952, was essentially a modified version of the International Classification of Diseases (ICD, published by the World Health Organization). The ICD was in its sixth edition at the time, and it was the first time in which that manual included a category for mental illnesses (APA, 2000).

**DSM II**

*Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer*

‘The rise of American clinical psychiatry only began in the 1960s. Around the world, a profound positivist transformation of psychiatry took place and was signaled by the invention of new statistical tools and experimental procedures, and by the development of research in psychopharmacology, genetics, epidemiology, and eventually neuroscience (Castel et al. 1979). In this new game, American psychiatrists quickly learned to play their cards right. In collaboration with British psychiatrists, they began, during the revisions of the sixth edition of the WHO’s *International Classification of Diseases* (ICD-6), to influence the debates about nosological issues. They launched epidemiological studies of an unprecedented size, such as the *Midtown Manhattan Study* at the beginning of the 1960s or the *Epidemiological Catchment Area* at the end of the 1970s, the results of which were analyzed and discussed all over the world. In American scientific journals, quantitative clinical research replaced long narrative reports of individual cases, while the spectacular progress of genetics and neurophysiology pushed even further the reduction of patients to their biological components.’


‘A British psychiatrist named Stengel (1959) was asked to perform a thorough analysis of the psychiatric classifications that were used around the world. Stengel found that almost every country in the world had its own classification system, and some European countries had more than one. He was appalled at this multiplicity in diagnostic language. The DSM, from Stengel’s perspective, provided a model of how the international community should proceed in trying to create a consensual system that would be adopted by every country in the world.’

‘Stengel’s review became a call for action. The WHO funded a series of international committee meetings in which countries around the world worked to create a consensual system. The result was the ICD-8. The American version of the ICD-8 was the DSM-II. Although the DSM-II and the ICD-8 were almost identical, a few differences did exist. The ICD-8 had a category for “hysterical psychosis,” which Americans thought was an oxymoron because hysteria was clearly a neurotic disorder. Also Americans held onto a category that originated in military psychiatry called “passive-aggressive personality disorder.” Europeans thought that this diagnosis was pejorative and disingenuous. Finally, the DSM-II, like the DSM-I, did have short prose definitions of its categories. The ICD-8 was only a list of approved diagnostic terms. No attempt was made to define the terms in the ICD-8.

The DSM-II had 193 diagnostic categories, of which 120 were defined using short prose presentations. Like the DSM-I, the DSM-II was a paperback manual consisting of 119 pages (costing $3.50) and had a hierarchical organization. Unlike the DSM-I, many of the new categories added in the DSM-II were categories of relevance to outpatient mental health efforts.’

*Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer*

‘In the history of the DSM, one event marked the starting point of most philosophical reflections on mental disorder: the decision to remove homosexuality from the DSM-II in 1973. Although today sexuality is no longer the focus of most criticisms against the DSM, it remains a hotly debated issue…’


‘In 1973, Rosenhan published a provocative paper in *Science* about how a group of colleagues went to different inpatient facilities in the United States requesting admission. They were truthful about themselves during the intake interview except for two things: (a) they gave fictitious names so that their admissions would not appear on their future medical records, and (b) they reported hearing a voice saying “Empty” or “Thud.” All were admitted with a
diagnosis of schizophrenia. Their average length of stay in the inpatient facility was nineteen days (the total range was 7 to 52 days). When discharged, most of them were given a diagnosis of "schizophrenia, in remission." Rosenhan and his colleagues noted that most of the patients in the facilities spotted that they were fakes, but none of the pseudopatients were detected by the hospital staff. Rosenhan concluded that inpatient facilities of the time could not differentiate the sane from the insane.7

**DSM III**


‘The earlier DSMs used short, broadly worded prose definitions to describe categories. The DSM-III, built on the innovation of the Feighner et al. paper, contained diagnostic criteria to specify the meaning of the categories. In addition, for each category, there was a description of the typical demographic profile of patients experiencing this disorder, a lengthy prose explanation of what the category meant, a description of how to differentiate the target category from any other category with which it might be confused, and a brief discussion of what was known, if anything, about the course and onset of the disorder.

Another innovation to the DSM-III was that the system was multi-axial. Each patient was expected to be diagnosed along five separate axes: (a) the descriptive presentation of the patient (i.e., the mental disorder categories), (b) the underlying personality and/or intellectual disorder, (c) any associated medical disorder that was relevant to the patient’s psychiatric presentation, (d) the psychosocial stressors in the patient’s environment, and (e) the patient’s highest level of adaptive functioning in the past year. Finally, the DSM-III contained an extensive set of supplementary materials (e.g., a diagnostic flowchart) that could be useful to clinicians and to public health officials (e.g., tables showing how the DSM-III categories matched with ICD-8 categories).

There were 228 categories of mental disorders in the DSM-III (163 categories defined using diagnostic criteria) discussed in 494 pages, making the size of the DSM-III much larger than either the DSM-I or DSM-II. The price of the DSM-III increased ninefold ($31.75).’

‘[Robert] Spitzer and the organizing committee for the DSM-III took the bold step of proposing a tentative definition of the concept of mental disorder. They needed this definition because an explicit goal of the creators of the DSM-III was to avoid speculations about the causal mechanisms (especially theoretical concepts couched in psychoanalytic terms) that explained psychopathology. This definition was also in direct contrast to the antipsychiatry movement that attempted to define a mental disorder as society’s way of dealing with undesirable people—by labeling them with a mental disorder to keep them quiet and segregated. The definition in the DSM-III was:

*Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and the society.* (Am. Psychiatr. Assoc.1980, p. 6)

The DSM-III definition of mental disorder led to an interesting and growing discussion of psychiatric classification by philosophers, cognitive psychologists, social anthropologists, and historians.7

Steeves Demazeux, Patrick Singy; *The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel;* Springer

‘The third edition (DSM-III), published in 1980, constitutes according to historians a true nosological revolution. But this revolution did not consist in having fully embraced neurological or genetic factors, as we might have expected given the general evolution of psychiatry, and especially of American psychiatry. Rather, it consisted in remaining, or trying to remain, atheoretical. The DSM-III offered a classification that voluntarily ignored the etiological models of mental disorders, in order to focus instead on the task of providing unambiguous descriptions of these disorders by means of precise and exhaustive diagnostic criteria. It is often said that the DSM-III broke with psychoanalysis, which was dominant in large American cities. It is less often said that it also broke with the essentially biological direction of its predecessors (while the influence of psychoanalysis on the DSM-I and DSM-II is regularly stressed by historians,
we should not forget that the first two editions of the DSM gave an important role to biology, as illustrated by the key category of “Organic Brain syndrome”.

**DSM III-R**


The DSM–III was followed by the publication of the DSM–III–R in 1987. As its edition number indicates (with “R” standing for “revised”), the DSM–III–R did not represent an overhaul of the DSM–III. Instead, it was a relatively minor revision intended to clear up some inconsistent and ambiguous aspects of the DSM–III (APA, 2000). Thus, the DSM–III–R was quite similar in structure, format, and length to the DSM–III. In fact, all subsequent revisions of the DSM have remained consistent with the general structure, format, and length of the DSM–III.


‘Because of the research on diagnostic criteria that began appearing almost immediately after the DSM-III was published, the authors of the DSM-III decided to update those criteria. However, as often occurs when a committee is formed, the actions of the committee do not always match exactly the goals that were originally intended. The DSM-III-R (Am. Psychiatr. Assoc. 1987) did contain a number of changes to the diagnostic criteria. The DSM-III-R also contained new diagnostic categories that had not appeared in the DSM-III. Structurally, in terms of its multiaxial system, its use of diagnostic criteria, and its organization of the major families of mental disorders, the DSM-III-R was the same as the DSM-III. But, in terms of its specifics, the classification system changed substantially. The DSM-III-R was not just a revision; it was a new classification system.’

‘The DSM-III-R contained a total of 253 categories (there had been 228 in the DSM-III). Of these, 174 were defined using diagnostic criteria (163 categories in the DSM-III had criteria). The biggest change was in the sleep disorders.’

**DSM IV**


‘In 1994, the American Psychiatric Association published the fourth edition of the DSM (DSM–IV; APA, 1994a). In 2000, another edition was published, entitled DSM–IV–TR, with “TR” standing for “text revision.” The term “text revision” refers to the fact that only the text describing the diagnoses—not the diagnostic criteria—differs between the DSM–IV and the term DSM–IV–TR. That is, the DSM–IV–TR contains exactly the same diagnostic criteria as the DSM–IV, and they are officially defined in exactly the same way. The essential difference between the DSM–IV–TR and the DSM–IV is the addition of new text in the DSM–IV–TR to describe recent findings relevant to existing disorders.’

‘The creation of the DSM–IV was a massive effort, involving the collaborative work of over 1,000 people and a period of time greater than five years (APA, 1994b). It was overseen by a coordinating Task Force and 13 independent Work Groups, each of which focused on a particular category of psychopathology (e.g., Child and Adolescent Disorders, Anxiety Disorders, Mood Disorders, Personality Disorders). Throughout its development, its authors emphasized that empirical evidence was the cornerstone on which the DSM–IV was built, and was also the primary requirement for any changes from the previous edition of the DSM (APA, 1994b).’


‘The DSM-II had been published in 1968 to coincide roughly with the publication of the ICD-8. The DSM-III was published in 1980; the DSM-III-R came out in 1987; the DSM-IV appeared in 1994 (Am. Psychiatr. Assoc. 1994). Zimmerman (1988), among others, was quite critical of this rate of change. Researchers needed stability in the definition of categories in order to perform useful studies of psychopathology. Clinicians, likewise, were confused by and had difficulty adjusting to changes in the fundamental terminology that organized the diagnostic process. Additionally, the rate of scientific discoveries did not support the rapid changes.’
‘The DSM-IV grew to 383 categories. Of these, 201 diagnostic categories were defined using diagnostic criteria. The size of the DSM-IV also grew to 886 pages. The DSM-IV Source Books (three volumes) added 3,010 pages. Another area of considerable growth in the DSM-IV was the appendix for categories needing further study. The DSM-III-R had three. The DSM-IV had seventeen categories that needed further study... the DSM-IV-TR increased in length by 57 pages and the cost of purchase increased from $48.95 for the DSM-IV to $74.95 for the DSM-IV-TR.’

‘Sadler (2005) expanded on the idea that values were relevant to psychiatric classification in a book titled Values and Psychiatric Diagnosis, which is one of the most important books published on the topic of psychiatric classification since the DSM-III. Sadler highlighted five values and the roles they play in psychiatric nosology: (a) aesthetics—how people prefer things to be, in the sense that they “like” or “appreciate” them; (b) epistemology—choices about how we know what we know about classification (i.e., what research methods we prefer); (c) ethics—what morals the classification upholds; (d ) ontology—what is the fundamental nature of “things,” or in the case of psychiatry, what mental disorders are in a (meta)physical sense; and (e) pragmatics—how useful or user-friendly the classification might be. Until the publication of this book, most (although not all) of those assumptions were ignored or taken for granted. This book legitimized the imperative role philosophical discourse plays in the development of a classification of mental disorders.’

Eric R. Maisel Ph.D; The New Definition of a Mental Disorder Is it an improvement or another brazen attempt to name a non-existing thing? Rethinking Mental Health; Psychology Today; Jul 23, 2013

‘DSM-4: Mental Disorder definition: “A mental disorder is a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.”’


‘One should note that there are several important components to this definition, including the concept that the individual must be experiencing some sort of pain (presently or in the future) or impairment due to the symptoms of the disorder. The advantage of a broad definition such as this, is that it allows clinicians to include a host of disorders in cases where patients themselves may either not recognize their own symptomology as reflecting a disorder (e.g., during a psychotic episode) or even when patients may resign themselves to a longstanding period of suffering (e.g., dysthymia).’

DSM 5


‘The DSM-5 development process began in 1999, and the Internet allowed the world to watch how the manual was built. Drafts of the DSM-5 were posted on the APA’s website for people to make comments and suggestions (called the Prelude Project; Am. Psychiatr. Assoc. 2013b). The first draft was posted in February 2010, and in return, 8,000 comments were submitted. The second draft was released in 2011, and 2,000 additional comments were submitted. Although the Prelude Project allowed the DSM-5 to communicate with mental health professionals from around the world, it also opened the door for staunch opposition from anyone who took issue with the manual. In addition, Internet communication in the form of blogs and emails allowed criticism to coalesce in ways that the leaders of the DSM-5 had not anticipated.’

‘In physical size, the DSM-5 grew to 947 pages. There were a total of 541 diagnostic categories, an increase of nearly 160 categories compared with the DSM-IV. However, the number of categories defined using diagnostic criteria dropped to 151 compared with the 201 categories in the DSM-IV with diagnostic criteria. Unlike the DSM-IV, there were no “Source Books” published to document the processes used by the DSM-5 workgroups when creating this classification. The rationales and reviews posted on the DSM-5 development website were taken down and cannot be retrieved. The cost of the DSM-5 more than doubled to $199 per hardback copy.’

‘The DSM-5 did not meet its revolutionary goals. Just like eager but well-intentioned politicians who take office and then realize the dynamics of Washington, the DSM-5 did not make the changes it said it would. It is working not only
with science but also with people and politics. The themes will likely continue as psychiatry inches forward in attempting to understand psychopathology.’

Eric R. Maisel Ph.D; The New Definition of a Mental Disorder Is it an improvement or another brazen attempt to name a non-existing thing? Rethinking Mental Health; Psychology Today; Jul 23, 2013

“A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.”

‘The very idea that you can radically change the definition of something without anything in the real world changing and with no new increases in knowledge or understanding is remarkable, remarkable until you realize that the thing being defined does not exist. It is completely easy—effortless, really—to change the definition of something that does not exist to suit your current purposes. In fact, there is hardly any better proof of the non-existence of a non-existing thing than that you can define it one way today, another way tomorrow, and a third way on Sunday.

Certainly one could scrutinize the changes and make reasonable comments about the way that language has been employed to say absolutely nothing. A mental disorder is a psychological thing, or maybe it isn’t. A mental disorder is a biological thing, or maybe it isn’t. You can rail about your society unless you have a “dysfunction,” at which point your railing is a mental disorder. You can have a conflict with your politicians unless you have a “dysfunction,” at which point you are a mental deviant. One could go on with such observations but making such observations plays into the hands of the creators of non-existing things, who love it if you play their game. They can slip about with impunity, adding, qualifying, and shifting, while you waste your breath being reasonable and thoughtful.

The question is not, “What is the best definition of a mental disorder?” The question is not, “Is the DSM-5 definition of a mental disorder better than the DSM-IV definition of a mental disorder?” Those are absolutely not the right questions! The first and only question is, “Do mental disorders exist?” The phenomena certainly exist. The birds and bees exist; pain and suffering exist. But birds do not prove the existence of gods and pain does not prove the existence of mental disorders. Let us not play the game of debating the definitions of non-existent things. Let us move right on.’

Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer

‘For many, the publication of the DSM-5 was supposed to be a turning point in the history of the DSM. The subtle change in the numeral (from Roman to Arabic) was the promise of a profound historical change. But this promise remains unfulfilled. The DSM-5 undoubtedly continues the nosological tradition started with the DSM-III. Short of the paradigm shift that was prophesized, the Arabic numeral signals only a deliberate coming together of the DSM with the ICD (whose eleventh edition, the ICD-11, is due in 2017), and the desire to encourage progressive transformations (DSM-5.1, DSM-5.2, etc.). This is fixing a crumbling edifice with paper mâché.’

‘The combination of unprecedented methodological ambition, undisputable scientific and cultural success, and conspicuous theoretical weaknesses could not fail to attract the interest of many academic critics, in particular of philosophers, sociologists and anthropologists... In this substantial body of literature, we can roughly identify two types of critiques, which are closely related and often combined with each other, although they remain conceptually distinct: an epistemological critique that focuses on the theoretical principles and assumptions of the classification, on its impasses and alternative strategies, and on its implied conception of the normal and the pathological, and a sociological critique of the (harmful) effects of the DSM on psychiatric practice and on the patients’ understanding and experience of their suffering.’
Critique of the DSM

“If the owl of Minerva, according to Hegel, spreads its wings only with the falling of the dusk, then today is the time to evaluate philosophically and methodologically, the strengths and weaknesses of the DSM.”

Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer


‘The controversy over DSM-5 is not a guild dispute or turf war. Psychiatrists, psychologists, and mental health professionals across the disciplines reject medical type diagnoses like DSM-5 as ways of describing the varied human experiences that we call mental disorders and support ways of formulating these that capture their complexity and diversity. There are many other voices engaged in the debate over the future of psychiatric diagnosis who share our concerns. The Hearing Voices Network has expressed serious reservations about DSM-5, and rightly drawn attention to the importance of the perspectives of experts by experience in the debate about the controversy. Mental Health Europe, a non-governmental organisation that represents a diverse range of perspectives, including experts by experience, carers and professionals from a range of disciplines has also expressed deep concern about DSM-5 and the future direction of psychiatric diagnosis. Many psychiatrists, too, share these concerns, and we will continue to support the need for, and contribute to an informed public debate about the limitations and failings of psychiatric diagnosis symbolised by DSM-5. The DSM is incapable of capturing the full range of experiences of distress in the way that narrative formulation can.’


‘The DSM editions, in addition to growing in size, have grown in the extent of the controversies surrounding them. The issues with the DSM-III and DSM-III-R were the schism between the biological, pro-science wing of the APA with the psychoanalytic, pro-clinical wing. For the DSMIV, the strongest critics of that system were the feminists, who viewed many of the DSM changes as potentially destructive to women. With the DSM-5, controversy erupted over the potentially secretive process that was being used to make decisions as well as the corrupting influence of income and its potential revenues. More than once, important decisions that affected the final outcome of a DSM categorization system were made at the level of the Board of Trustees of the APA. The claim that the DSMs represent the best science possible is not credible when the final arbitrator of decision making is not a scientific body but the leaders of an organization with profit motives. For instance, one speculation about why the DSM-5 PD section ended up looking like it did was that adopting already existing dimensional models for this area of psychopathology was not in the financial interest of the APA because copyrights for those existing measurement instruments were held by others.’


‘It's been portrayed as a clash of mental health titans. In April, just weeks before the American Psychiatric Association released the long-awaited fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the National Institute of Mental Health said that the federal agency will move away from funding research based on DSM categories.’

‘This is the saddest moment in my 45 year career of studying, practicing, and teaching psychiatry. The Board of Trustees of the American Psychiatric Association has given its final approval to a deeply flawed DSM 5 containing many changes that seem clearly unsafe and scientifically unsound. My best advice to clinicians, to the press, and to the general public - be skeptical and don’t follow DSM 5 blindly down a road likely to lead to massive over-diagnosis and harmful over-medication. Just ignore the ten changes that make no sense.’

Brief background. DSM 5 got off to a bad start and was never able to establish sure footing. Its leaders initially articulated a premature and unrealizable goal- to produce a paradigm shift in psychiatry. Excessive ambition combined with disorganized execution led inevitably to many ill-conceived and risky proposals.
These were vigorously opposed. More than fifty mental health professional associations petitioned for an outside review of DSM 5 to provide an independent judgment of its supporting evidence and to evaluate the balance between its risks and benefits. Professional journals, the press, and the public also weighed in- expressing widespread astonishment about decisions that sometimes seemed not only to lack scientific support but also to defy common sense.’

*J Med Ethics; Debating DSM-5: diagnosis and the sociology of critique - doi:10.1136/medethics-2013-101762*

‘The development of DSM-5 has resulted in wide-ranging critical commentary, underscoring the importance of diagnosis to the governance of social life. A sociological analysis of critique can help map out its multiple dimensions, as well enable us to understand and interrogate the assumptions it is built around and the uses to which it is put. In so doing, an analysis of a critique of one specific case—that is, the DSM—can reveal how debate is contoured by a broader ‘ecology’ of criticism associated with the field (ie, mental health) more generally (eg, concerns around pharmaceuticalisation and medicalisation). This in itself has normative implications since it directs attention to concerns and issues that are not being so loudly voiced, and voices which are not allowed to be heard. For biomedical ethics, it also enjoins a sensitivity to nuance and the contexts within which knowledge claims are advanced, especially when these are heavily inflected with moral discourse (eg, regarding the validity of changes to the category of depression). Attending to the plurality of perspectives different actors and institutions express in relation to diagnostic entities, tools and practices reminds us that uniformity of opinion within professional (but also patient and other) communities cannot be taken for granted. This must necessarily be kept in mind when formulating ethical questions and directives that involve diagnosis and DSM-5.’

*Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014*

‘In a statement released in June 2011, the British Psychology Society complained to the APA that the sources of psychological suffering in the DSM-5 were identified “as located within individuals” and overlooked the “undeniable social causation of many much problems….Why are relationships or social conditions left out? If you pay attention only to faulty biology and defective genes as the cause of mental health problems and ignore abandonment, abuse, and deprivation, you are likely to run into as many dead ends as previous generations did blaming it all on terrible mothers.

Humans are social animals and mental health problems involve not being able to get along with other people, not fitting in, not belonging, and in general not being able to get on the same wave length.

Everything is about us – our brains, our minds, and our bodies – is geared toward collaboration in social systems. This is our most powerful; survival strategy, the key to our species, and is precisely this that breaks down in most forms of mental suffering. …the neural connections in brain and body are vitally important for the understanding human suffering, but it is important not to ignore the foundations of our humanity: relationships and interactions that shape our minds and brains when we are young and that give substance and meaning to our entire lives.’

*The DSM & ‘The Medical Model’*


‘Psychiatric classification has swollen into a kaleidoscope of putative disorders. It is not likely that any one rule of taxonomy will define the many entities that may be included in DSM-V. But a medical diagnostic model will define those conditions for which we already have a biological interest in their identification and, more importantly, methods of resolution.’


‘The idea that psychiatry is a branch of medicine is not universal, but even if we stick to professed believers in the medical model with the same broad view of the subject, we find disagreements about how its core commitments should be understood. It may be helpful to distinguish *minimal* and *strong* interpretations. A minimal interpretation makes no commitments about the underlying physical structure that causes mental illness. The strong interpretation of the medical model, in contrast, dissents on just this issue. It says that the proper medical understanding of disease
is in terms of morbid anatomy. It is committed to specific causal hypotheses in terms of abnormalities in underlying neurobiological systems. Minimalists treat diagnostic labels as useful heuristics rather than natural kind terms, whereas a strong interpretation commits psychiatry to a view of mental illness as a medical disease in the strongest sense, that of a pathogenic process unfolding in bodily systems.’

‘The DSM treats mental disorders as syndromes along the lines of the minimal medical model. Individuals who share a DSM diagnosis have a subset of symptoms in common, often drawn from a larger list so that although some people may have all their symptoms in common, there may be no overlap at all in other cases. These collections of symptoms are also supposed to unfold over time in more or less the same way, once we make due allowances for some individual variation.’

‘DSM diagnoses are usually taken to reflect a conventional concept of disease, despite the talk of underlying malfunction, because of their emphasis on syndromes and their lack of any causal hypotheses. In the manner of the minimal medical model, they let us make use of descriptive and statistical reasoning and offer the hope of accurate prediction and effective control. In the opinion of some philosophers, that is all science ever aspires to.’

‘Other philosophers, though, will tell you that the job of science is to discover the causal structure of the world. Furthermore, there are plenty of students of psychopathology who argue that the neglect of causal structure in psychopathology is getting in the way of science (Poland, Von Eckardt and Spaulding 1994, Murphy 2006, Gerrans 2014). They worry that we are lumping together different groups of people based on behavioral evidence alone, when in fact their observable similarities mask important underlying differences, including differences between normal people who are troubled but basically healthy, and their pathological counterparts. From this philosophical-cum-clinical perspective it looks like dereliction of duty when any scientific discipline, but especially psychiatry, decides to isolate itself from inquiry into causes.’

‘DSM leaves itself open to the charge that a classification which groups together observable phenomena can sort entities into heterogeneous classes, with underlying diversity masked by surface similarities. We already know from other areas of medicine that what looks like the same phenomenon—a cough, say, or a sore throat, or chest pain—can reflect different biological processes and hence may really signify different conditions. A taxonomy that relies content with surface features risks lumping different conditions together and keeping related ones apart.’

VIVEK DATTA, MD, MPH; Psychiatry and the Problem of the Medical Model – Part 1; December 21, 2014; https://www.madinamerica.com/2014/12/psychiatry-problem-medical-model-part-1/

‘The mental health industry has a lot to answer for. The psychologization of everyday life has eroded the range of human experience seen as normal, disempowered people to manage their own life challenges, professionalized helping relationships and undermined the already decaying support structures through which people found meaning and connection, stigmatized people through psychiatric labeling, led to iatrogenic misery from harmful treatments and traumatized already vulnerable individuals through excessively coercive practices. It is not because psychiatry is distinct from the rest of medicine that it has done so much damage. Rather it is precisely because it is a part of medicine and aspires to the medical model, a model that outside all but the most acute problems has been an abject failure, that it has done so. If our approach to problems of emotion, thought, behavior, human relations, and living is to be radically altered, we must take a closer look at what is wrong with medicine as a whole.’

‘Psychiatry is a branch of medicine. As such, psychiatrists apply the medical model to problems of emotion, thought, behavior, human relations, and living. This narrow gaze of the biomedical on problems that seem to transcend disease and disorder, brain and biology, has brought the field under severe criticism both from external commentators and from within its own ranks. Thomas Szasz, the libertarian psychiatrist, went as far as to argue that mental illness was in fact a “myth.” In contrast, the narrative of the history of medicine is one of technical triumphalism, with the historian Roy Porter titling his treatise on the topic The Greatest Benefit to Mankind.

Many critics of psychiatry engage in “splitting.” They see psychiatry as an “all bad” object, mired by pseudoscience, pathologizing all of mental life, peddling quack treatments, often under coercion or control. So-called “real medicine” is idealized as the product of scientific advancement, with diagnoses and treatment precise, its diseases and treatments not influenced by sociopolitical, or economic fancy, and its practitioners portrayed as healers rather than agents of social control. Psychiatry aspires to be like the rest of medicine. Given that the problems that beleaguer psychiatry in particular, are true of medicine in general, it is a mistake to criticize psychiatry alone, and not locate it within a medical-industrial complex in need of dire reform.’
‘Psychiatry has rightly been criticized for the ever-expanding definition of mental illness, with the boundaries between mental health and mental illness (arbitrary as they are) becoming increasingly blurred. However this is true of medicine as well, where asthma is now diagnosed in children with minor wheezing and breathlessness, and diabetes expanded with a lower threshold of glucose level needed for the diagnosis. There is now even ‘pre-diabetes,’ a harbinger state of full-blown disease recognized as a condition.’

‘The medical establishment has become a threat to health.’ So begins Ivan Illich, social scientist and priest, in his book Medical Nemesis: The Expropriation of Health. He noted that with the professionalization of medicine, doctors had come to transform problems that were previously seen as social, moral or spiritual in nature into medical ones. In the process, physicians had created a new disease killing many: iatrogenesis. As such, medicine was doing more harm than good with the ill-conceived notion of treating problems that physicians had no business treating.

Psychiatry has particularly come under attack for transforming grief, shyness, hyperactivity, worry, and social suffering into mental disorders requiring professional intervention and quite rightly so. Given that extreme states of despair lie on a nebulous continuum with emotional states we all experience on a daily basis, it is no surprise that the mental health industry in particular has been particularly successful in increasing the range of human misery falling under its province. But it is a mistake to think that psychiatry alone is guilty of making us sick.

The menopause, once part of the normal reproductive trajectory of a woman’s life has been transformed into a sickness needing medical intervention. These interventions have now been shown to increase the risk of blood clots, strokes, and breast cancer. The urge to moves one’s legs about is now an increasingly diagnosed as restless leg syndrome, and treated with drugs that can cause confusion, psychosis, dependency, or compulsive gambling. Pfizer has been successful in redefining the quality of an erection, leading many men to seek Viagra as a lifestyle pill, with the risk of blindness, deafness, and priapism. The American Medical Association last year voted to classify obesity as a disease, despite the evidence showing doing so is harmful by de-emphasizing the role of behavior and lifestyle in weight control. It is not by coincidence the emergence of obesity as a ‘disease’ occurred just as two new drugs for obesity appeared on the market. The pharmaceutical industry’s co-option of medicine neither begins nor ends with psychiatry.’

‘Psychiatry by its very nature deals with subjectivity. Patients present with experiences; experiences that I can never know, nor ever see. The field has come under criticism for lacking objectivity, and not having blood tests or imaging or other confirmatory markers for the existence of illness or disorder. In a misguided attempt to look more scientific and objective, psychiatry has turned to the ridiculous task of looking for blood tests or biomarkers for depression and other such mental states. Quite apart from just how absurd it would be to ‘diagnose’ someone with depression or psychosis from a blood test or brain scan, the reliance on so-called objective indicators of disease is a hermeneutical nightmare. The technologization of medicine has led to spiraling healthcare costs, the devaluing of relationships and narratives, and the deskilling of doctors.’


‘Since the first edition of the DSM in 1952, there have been numerous critics of this classification system, and the ICD–10 is subject to the same types of criticisms. Most recently, criticism has been focused on the DSM–IV because of its increasing adherence to the “medical model” of mental illness (Widiger & Clark, 2000). Although there is some variation as to how experts define this medical model, some possibilities are outlined below as well and an explanation is provided as to how the medical model affects our understanding of mental illness.’

‘The medical model of mental illness can be understood as having similarities with the medical community’s understanding of physical illness (Cloninger, 1999). The assumptions of the medical model as they apply to mental illness are threefold.

First, it is assumed that the concept of a disease exists, and that persons can be placed into two categories, those who are diseased and those who are healthy and without disease. This categorical way of conceptualizing mental illness, as opposed to placing persons along a continuum of disease and health (also known as a dimensional model), are discussed in more detail in further sections.
The second assumption of the medical model is that the disease, or mental illness, resides within the individual (as opposed to the individual’s circumstances, context, relationships, etc.).

The third assumption is that any treatment to alleviate this disease must occur at the level of the individual as well.

‘When one understands these assumptions that are implicit in the medical model, coupled with the descriptive and atheoretical nature of the DSM-IV as previously described, a type of tautological circular reasoning can arise. Specifically, one might ask, “Why is this child often truant, cruel to people, and cruel to animals,” which would be answered “Because he has Conduct Disorder.” The next question is, “Why does this child have Conduct Disorder,” to which might come the answer, “Because he is often truant, he is cruel to people, and is cruel to animals.” This error in reasoning is often referred to as “reifying” disorders, and many have urged clinicians and researchers to formulate mental disorders as simplified descriptions of behavior clusters rather than actual entities (Knapp & Jensen, 2006).

Another related disadvantage of the medical model of mental illness is that the model in and of itself lends credibility to a biological etiology of mental illness, when in fact such an exclusive etiology may not necessarily exist. For example, when working within a nosological system that assumes that disease lies within the individual, resulting research will most likely examine the disease at the individual level, neglecting other facets of the human experience that contribute to the mental disorder. This process of scientific inquiry, if allowed to proceed in this fashion, could then build a research literature that describes mental disorders as biological in origin (neglecting other avenues of research).

‘The question as to the etiology of mental disorders leads to another important concept related to the medical model, which is the relative importance of environmental variables in understanding mental illness. Bronfenbrenner (1979) first discussed what he described as the ecological model of psychological functioning. This model changed the internal process of the “disease” of mental illness to one wherein an individual’s internal characteristics do not fit within his environmental context. Bronfenbrenner (1979) theorized that each child is surrounded by a complex ecology or environment with which he or she interacts. This environment consists of relationships and systems proximal to the child, such as other family members. Additionally, however, the child is both directly and indirectly affected by other systems in the environment, including the school environment, religious and other community organizations, and other broader cultural variables.

Therefore, the ecological model would view the aggressive behaviors of an individual child within their social context. Whether these aggressive behaviors might be indicative of a mental disorder depends on whether they are adaptive and fit within the child’s context. If this particular child lives in a home where violence is both modeled and expected, and within a high crime neighborhood that exposes the child to daily threats, then aggressive behavior may in fact be adaptive and may not necessarily be indicative of a mental disorder. On the other hand, if that same child lives in a safe environment where aggression is punished, then repeated displays of aggression would be maladaptive. This aggression could lead to impairment of the child’s functioning, and could be viewed as a symptom of a mental disorder.’


‘Many psychiatrists are deeply concerned about the limitations and failings of diagnosis in psychiatry. These concerns were expressed in a recent special article co-authored by twenty-nine Members and Fellows of the Royal College of Psychiatrist, published in the British Journal of Psychiatry in December 2012.

The paper points out that since its origins in the early part of the nineteenth century, psychiatry has faced a fundamental question that remains unanswered: can a medicine of the mind work with the same epistemology as a medicine of the tissues. In recent decades, there has been a concerted effort to ignore this question and psychiatry has approached the ‘mind’ as if it was simply another organ of the body. It has assumed that problems with our feelings, thoughts, behaviours and relationships can be grasped with the same sort of diagnostic and scientific tools that are used to investigate problems with our livers, hearts and lungs. This model has not served psychiatry well. Whether we like it or not, mental problems resist both explanation in terms of simple causal models and categorization in terms of singular diagnostic categories.’
'We are also concerned about the way that some commentators, particularly from within academic psychiatry, question the importance of environmental factors in understanding psychosis. Many psychiatrists disagree with this position, and find such accusations unhelpful. Psychiatry has always prided itself on being an eclectic profession, one that recognises the importance of holistic approaches to understanding and responding to people who use mental health services. Biological, neuro-developmental and genetic factors have little role to play in explaining psychosis because they are incapable of accounting for the complexity of consciousness and embodied experience. In contrast, personal narratives of adversity have a central role in understanding how people cope with, and recover from, psychosis. To deny the importance of these factors is to deny the importance of finding meaning in suffering, a prerequisite for recovery.'

*American Family Therapy Academy Policy Statement; Dsm-5: Toward A Relational And Contextual Approach To Diagnosis*

'The American Family Therapy Academy (AFTA) is concerned with the intersection of the biological, psychological, relational and socio-cultural dimensions of individual and family health and well-being. It is from this frame of reference that AFTA has serious reservations about the process and content of the ongoing revision of the Diagnostic and Statistical Manual (DSM-5).

AFTA has joined over fifty organizations and thousands of practitioners and researchers worldwide, in writing to the DSM Task Force and the American Psychiatric Association to express these concerns. The response from the American Psychiatric Association has been minimal, at best. None of the organizations or individuals have been invited to participate in the decision making process.

We find that the current revision of the DSM continues a long history of ignoring research and excluding vital contributions of non-psychiatric mental health disciplines resulting in invalid diagnostic categories and treatment protocols. The DSM is dominant in determining mental health diagnosis and treatment and is more harmful than helpful in delineating best practices. AFTA calls upon the American Psychiatric Association to engage in a more inclusive and research-supported process.

AFTA has three primary concerns:

1. We recognize that people think as they have been trained and thus the American Psychiatric Association, being the sole creator and developer of the DSM-5, almost exclusively considers medical causation and medical treatment. The DSM employs a biomedical model suggesting that people and their problems can be explained in terms of an underlying deviation from normal function such as a pathogen, injury, genetic or developmental abnormality; in other words, a description of symptoms and causation. This narrow focus omits the entirety of human experience as little or no consideration is given to the role that family and socio-cultural contexts have on wellbeing. This frame of reference ignores years of research and provides no mechanism for those using the DSM to incorporate the familial, psychological and social factors affecting child development and adult functioning. It delegitimizes the focus on relationship, life stage, community, and access to power and resources. It is no accident that there has been a decline in funding for services to help families with normal problems in living as the DSM has become increasingly dominant in mental health diagnosis.

Input has been limited from other mental health professionals who subscribe to a biopsychosocial model, which is based in part, on the vast research on the social determinants of health. This research shows that social factors play a major role in the development of serious health problems. The findings of the ‘Adverse Childhood Experiences’ study conducted by the CDC suggest that certain traumatic and/or stressful childhood experiences are major risk factors for the leading causes of illness and death in adults.

The extensive body of high quality evidence-based research examining the social, psychological, familial, and environmental factors in understanding mental health issues must be considered on a par with the biomedical, biochemical and physiological research that has been predominant in developing the DSM-5. *Such a comprehensive and realistic approach is essential to the understanding and alleviation of human suffering.*

2. This strong emphasis on a biomedical model results in medication becoming the treatment of choice to the detriment of other psychological and systemic approaches. Research has shown that therapy can be equally as effective or more effective than pharmacology. It does not cause the side effects often associated with medication.
Some psychiatrists who contributed to the DSM offered the disclaimer that "they do not mean this to be a bible." However, the DSM's control of treatment derives from insurance companies that only pay for treatment following "DSM medical guidelines," ultimately defining treatment and diagnosis in every public and private setting. This has led to the marginalization and subordination of other effective approaches such as family therapy.

Thus, the DSM has become a supporter and partner of the pharmaceutical industry which stands to profit from the emphasis on medication as treatment. The financial connections between psychiatry and pharmaceutical companies, which often fund research studies, raise questions about the bias toward medication.

3. We strongly criticize the current system of deciding diagnostic categories primarily by "medical consensus." The reports are that the studies done by the DSM task force had very weak results, and these studies have not yet been released. Therefore the current DSM reflects the opinions of its writers and without scientific studies to support these opinions. The "medical consensus" in formulating the DSM has not included much actual research on human problems (psychosis, ADD, anxiety, depression, trauma, etc.) or on child development, leading to a number of destructive changes.

a. The normal process of grief has been pathologized and reduced to a diagnostic category.

b. Children's behavioral problems have been further pathologized without consideration of the relevance to child development of such contextual factors as stress, family and social systems.

c. The addition of medical diagnoses for sexually violent predator acts opens the door for those who commit these crimes to avoid prosecution and/or incarceration;

Clinicians and the DSM

Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer

‘One of the most important historical consequences of the DSM has been that the manual replaced or displaced the clinicians’ clinical judgment. With its gnawing authority, the DSM has profoundly transformed everyday clinical practice, both by desacralizing the diagnostic assessment and by sanctioning the use of symptom checklists and diagnostic questionnaires. Perhaps irreversibly, the DSM has replaced an opaque, traditional, and almost regal clinical art, with a transparent, public, and debatable technique. Perfectly standardized criteria have replaced clinical experience and insight.’


‘From at least as far back as Overall’s study of clinicians, individual researchers have conducted studies of how clinicians make diagnoses. But rarely have grants been funded to extensively study clinicians’ conceptualizations of psychopathology and diagnostic decisions. Nor has the APA made it a priority to study clinicians’ use of the DSM. The WHO, in contrast, has supported a focused series of research to study clinicians’ use of diagnostic categories. These studies have used sophisticated methodologies developed by cognitive psychologists to study how clinicians view the relationships among mental disorder categories.

The rationale is that—barring empirical evidence on etiology or phenomenology about the relationships among disorder categories—classificatory decisions about the structure of the manual could be informed by how clinicians organize that information cognitively (Reed 2010). The APA would advance the field’s understanding of psychopathology if it developed, funded, and supported a research agenda to study the clinical utility of the DSM categories and to make clinical utility an important consideration when the workgroups design categories. This development would require a paradigm shift for contemporary psychiatry, from largely focusing on neuroscience and the biological validity of diagnostic concepts to recognizing clinicians as worthwhile and informative targets of study.’


**Cultural Aspects of the DSM**

G. Scott Sparrow, Ed.D, The DSM-IV; University of Texas-Pan American; Published in the Encyclopedia of Multicultural Psychology

‘From the standpoint of culture and gender sensitivity, the DSM has been criticized for minimizing the impact of contextual factors on the development of psychological disorders. For instance, the DSM IV defines a personality disorder \ as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment." By implying that personality disorders originate within the individual, and remain relatively stable over time, the DSM discounts the way that social norms can influence the way that individuals behave. Consequently, the DSM effectively pathologizes exaggerated compliance with prescribed gender roles. Similarly, black men who show resistance to authority may "qualify" for a diagnosis of Antisocial Personality Disorder if the clinician conducting the diagnostic interview fails to take into account the environmental stressors contributing to such defiance, or the effect of identifying with prevailing racial stereotypes. In contrast, the DSM does not similarly pathologize compliance with white male stereotypic behavior, such as putting work above relationships, and disregarding others’ needs when making decisions.

The influence of culture and gender bias in the formulation of DSM disorders is especially apparent in so-called mental disorders that have been revised or stricken from earlier editions, or effectively challenged prior to inclusion. For example, the DSM III treated homosexuality as a personality disorder, but the DSM-IIIIR downgraded it to an egodystonic disorder. By the time the DSM-IV was published, homosexuality had been dropped as a mental disorder due to social and political pressure to treat homosexuality as a normal gender choice.

Two other controversial diagnoses would have been enshrined in the DSM III if women hadn’t objected. Under Spitzer’s editorship, which lasted through the publication of the DSM-IIIIR, the diagnosis of "masochistic personality disorder" was briefly considered before women expressed concern that it would only serve to pathologize patients -- especially women -- who were abused. Another diagnosis that was briefly considered would have made PMS a mental disorder, but again the outrage from women dissuaded Spitzer and his colleagues from including it.’

Constance Cummings; DSM-5 on Culture: A Significant Advance; https://thefprorg.wordpress.com/2013/06/27/dsm-5-on-culture-a-significant-advance/

‘The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) was finally presented on May 18th at the American Psychiatric Association’s annual meeting in San Francisco. Much ink has been spilled in the media about the ten-year process leading up to last month’s unveiling. But there has been virtually no mention of the fact the DSM-5 is a vast improvement in its treatment of culture. It reflects a much more inclusive description of the range of psychopathology across the globe, not just the particular constructs or exemplars most commonly encountered in the US, Western Europe, and Canada. I think the cultural component of DSM-5 has the makings of a model on which subsequent versions of the manual should be based.

According to cultural psychiatrist Roberto Lewis-Fernández (Columbia University), “including information on cultural concepts of distress in DSM-5 will enhance the validity and clinical usefulness of diagnostic practice” across the board.

Under the direction of Kimberly Yonkers and Lewis-Fernández, chair and co-chair respectively of the Gender and Cross-Cultural Issues Study Group, DSM-5 is a vast improvement... As Lewis-Fernández explained, the notion of “culture-bound syndromes” has been replaced by three concepts: (1) cultural syndromes: “clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts . . . that are recognized locally as coherent patterns of experience” (p. 758); (2) cultural idioms of distress: “ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns” (p. 758); and (3) cultural explanations of distress or perceived causes: “labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress” (p. 758).’
There are reasons to assume that the cultural innovations in DSM-5, even though placed for the most part in Section III of the manual, reflect a degree of acceptance and commitment. This does not mean that the product is problem free. Specific mentions of individual strengths and weaknesses and of risk and protective factors are missing, in spite of the strong cultural load of such features. Moreover, a variety of obstacles or difficulties in their implementation emerge.

‘Strengthening the structure and broadening the scope of a document like DSM and, more specifically, making cultural inroads in a medical diagnostic instrument whose main purpose is to provide convincing solidity to a decisive clinical step, requires tenacity and patience, among other ingredients.’

‘Agreeing on the importance of culture and cultural factors in psychiatric diagnosis is not guarantee of its full acceptance or consistent consideration in clinical practice. The multifaceted impact of these factors on availability, accessibility and acceptability of mental health and general medical services still leaves out issues of affordability and accountability. Neglecting them may lead to non-contextual, therefore irrelevant, clinical information, diagnostic biases and errors, therapeutic disengagement, insufficient coping strategies or uncertain outcomes. Medical educators also must adopt a basic cultural approach if they want to form professionals comprehensively equipped to deal with psychiatric patients in the contemporary world. To take for granted cultural sources is a form of condescension; broadening the inroads made so far can only be successfully accomplished through an adequate instrumentalization of the diagnostic process, the first step in the clinical evaluation of every patient.’

‘In the diagnostic field, facts such as globalization and diversity, buttressed by massive internal and external migrations across the world, and technological advances reachable by the masses in all countries and continents, have made the need for a comprehensive cultural understanding of patients’ lives, their symptoms, family history, beliefs and existential suffering, an almost mandatory requirement. Furthermore, realities such as poverty, inequities, racism, political restlessness, collective stress and disasters shape up clinical pictures, help-seeking modalities and the subsequent provider-patient relationship frames with an unmistakable cultural stamp.’

Successive editions of the DSM have been published in North America, and questions have always arisen about the applicability of its categories outside the West. DSM-5 follows its predecessor in coping with cross-cultural variety in two ways. First, some conditions, such as depression and anxiety, are treated as universal – found in every culture, despite local differences in character. We may term this the unificationist project. The DSM-IV-TR averred that major DSM categories occur all around the world but with symptoms and courses that are influenced by local cultural factors. Second, DSM-IV-TR employed the concept of culture-bound syndromes, which were defined as “recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category” (p. 898). Culture-bound syndromes occur in a limited number of specific societies or cultural areas. They are local, often traditional, diagnostic categories that make sense of patterns of thought and behaviour that are treated as deviant or troubling in that context.

In theory, culture-bound syndromes are those folk illnesses in which alterations of behaviour and experience figure prominently, relative to local norms. Standard DSM diagnoses are not thought of in this way, even if they are culturally limited. Multiple Personality Disorder/ Dissociative Identity Disorder, for example, was widely diagnosed in the USA in the 1980s, but seldom found elsewhere. That did not lead psychiatrists to treat it as a culture-bound syndrome, even though it seems to fit the definition. The assumption in mainstream psychiatry is that Western conditions are not culture-bound; they represent abnormalities in a universal human endowment. This is the case even for conditions (such as some kinds of body dysmorphia) for which prevalence data only exists in a few western nations.

DSM-5 has moved away from concept of a culture-bound syndrome and adopted that of “cultural concepts of distress” (p.758). These are ways in which “cultural groups experience, understand and communicate suffering, behavioural problems or troublesome thoughts and emotions”. DSM-5 distinguishes three main types of cultural concepts: syndromes, idioms (ways of expressing distress), and local explanations. The last is particularly interesting: a standard picture of mental illness in both non-Western and premodern societies represents it as explained by supernatural forces like ghost possession. But Edgerton (1966) reported that the East African tribes he studied were
divided over the explanation of psychosis. Some tribes did understand it in terms of ghost possession, but others thought of it as having an organic cause ("brain worms"). DSM-5 makes room for such findings as part of the integration of local explanations into a theory of mental illness.’


‘There is considerable debate about the cross-cultural applicability of the PTSD category as currently specified. Concerns include the possible status of PTSD as a Western culture-bound disorder and the validity of individual items and criteria thresholds. This review examines various types of cross-cultural validity of the PTSD criteria as defined in DSM-IV-TR, and presents options and preliminary recommendations to be considered for DSM-5.’

Ahmed Okasha, Tarek Okasha; A plea to change the misnomer ECT - Letter to The Editor; World Psychiatry 13:3 - October 2014

‘A group of eminent Arab psychiatrists have just finalized the preparation of “guidelines for the treatment of depression in the Arab World” and have also replaced the term ECT by BST in order to reduce the stigma and change the wrong perception of families and patients.

In Egypt, we changed the name into brain synchronization therapy (BST). This has made a shift to the positive in the family awareness and patient’s acceptance of the treatment. Explaining to the patient and family the procedure without referring to convulsions has been of great help.’

Research Domain Criteria (RDOC)

Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer

‘Only a few weeks before the DSM-5 was published in May 2013, an alternative project that had started in 2009, the Research Domain Criteria financed by the NIMH, was publicized in the media. The director of the NIMH, Thomas Insel, publicly denounced the lack of validity of the DSM-5 (Insel 2013). The ripple effect of this declaration was immediate: the adversaries of the DSM picked up on Insel’s critique and repeated it in popular and scientific journals worldwide.’


‘The US National Institute for Mental Health (NIMH) said the DSM-5 had so many problems we effectively need to tear it up and start again. The way forward, it said, is a new research programme to discover the brain problems that underlie mental illnesses.

“Let’s not study the ‘disorder’ but the underlying biological systems that are going wrong”

That research is now taking off. The first milestone came earlier this year, when the NIMH published a list of 23 core brain functions and their associated neural circuitry, neurotransmitters and genes — and the behaviours and emotions that go with them (see “The mind’s 23 building blocks”). Within weeks, the first drug trials conceived and funded through this new programme will begin. While just a first draft, the list arguably represents the future of neuroscience-based mental healthcare.’


‘Striking criticisms of the conceptualizations and measurements of psychopathology have been published in response to the DSM-5. Most shocking was the rejection of the DSM-5 by the NIMH. The director of the NIMH stated that the DSM-5 was a clinical tool rather than one that would assist researchers (Insel 2013), which is a further indictment that the DSM is not meeting its research goal.’

American Psychology Association NIMH funding to shift away from DSM categories July/August 2013, Vol 44, No. 7; http://www.apa.org/monitor/2013/07-08/nimh.aspx

‘The DSM — the so-called bible of mental health professionals — has long been the primary tool for diagnosing and classifying mental illnesses. But in a blog post, NIMH Director Thomas Insel, MD, said that it was time to "re-orient"
away from the DSM's symptom-based categories. Instead, the institute is developing a new framework called Research Domain Criteria (RDoC) that replaces the DSM diagnoses with broader research categories that incorporate behavioral and neuroscience evidence.

*Steves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer*

‘When in 2009 the National Institute for Mental Health (NIMH) elaborated a new experimental classification project entitled “Research Domain Criteria” (RDoC), many commentators in the psychiatric field were surprised. The DSM-5 revision was still far to be finalized, and the emergence of this new and generously funded project raised much speculation: was it aimed at constituting a rival classification to the DSM-5? Was the existence of such a project tantamount to an official acknowledgment that the DSM’s model was in a deadlock? Was it possible to conceive that the RDoC project could in the near future supplant the DSM-5, for both research and clinical purposes?’


‘A judgment that the DSM-5 categories have insufficient validity has led the National Institute of Mental Health to introduce the Research Domain Criteria (RDoC) in grant proposals (Insel et al. 2010). The originators of the RDoC acknowledge that the system entrenched by previous versions of the DSM has increased diagnostic reliability. But they worry that it is too detached from the nature of mental illness, which they conceive of as disorders of brain circuits: though the domains of inquiry themselves are to be identified in psychological terms. For example, rather than existing categories such as depression, the RDoC envisages a domain of negative valence which will include symptoms of anxiety or depression that might come to be seen as expressions of an underlying disorder of specific brain circuits (Sanislow et al 2010). These disorders could be studied at many levels and need not be identified with simple lesions. But future models of mental illness are expected, on this vision, to draw on psychological, neurological, and genetic mechanisms, as well as information about the wider cultural context. It is expected that current research and future diagnosis will have to be based on these models in order to be properly warranted by the underlying facts about the causal structure of mental illness, rather than on clinical signs and symptoms. Clearly, in this case, validating a diagnosis is thought of as understanding its underlying causal structure: a diagnosis is valid if it rests on a biological process that can be identified by experiment and observation using the methods of the biological and cognitive sciences.

Ross and his colleagues argued along similar lines in their discussion of gambling, which may be seen as an example of the sort of work the RDoC foresees. They think there are two benefits to the conceptual change that they advocate. First, it would provide a clearer and principled demarcation of the addicted gambler from the “problem gambler” which is currently somewhat arbitrary (201). They also show the way to a better understanding of the nature of the addictive disorders more generally via the use of their preferred approach, which combines neuroscience and behavioural economics. They draw on prior research (ch. 6.2) to suggest that addictive gambling resembles dependence on stimulants (like cocaine) more than it does alcoholism, and hence enlarges our understanding of addiction more fully than purely behavioural criteria would do. The worry is that a behavioural approach misses the similarities and differences between forms of addiction by treating all as more or less the same, based on shared behavioural and phenomenological effects.

*DSM - South Africa*

*This article in the African Journal of Psychiatry by Burns J.K. & O Alonso-Betancourt pulled no punches.*


‘The best protection against wild over-diagnosis is to ignore DSM-5. It is not official. It is not well done. It is not safe. Don’t buy it. Don’t use it. Don’t teach it’. These are the words of Allen Frances, Emeritus Professor of Psychiatry at Duke University, who was chairperson of the taskforce that developed DSM-IV.’

‘Reliability and validity: As Insel says “the weakness is its lack of validity. Unlike our definitions of ischaemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. Moreover, the testing and scientific review process in the development of the manual was deeply flawed. Its field trials were designed for two stages of implementation. The first was intended to
address reliability, the second quality control. The first field trials revealed reliability problems. Despite this, the second stage of the field trials was cancelled due to pressure from the APA to expeditiously recoup the $25 million spent on the revision process.’

‘In addition to these shortcomings, no primary care or general practice professionals were involved in the field trials, despite the fact that they provide the majority of mental health treatment and prescribe the majority of psychiatric medications. The run-on effects of these major challenges to validity of course imply alarming threats to patient safety.’

‘The new diagnosis of “disruptive mood dysregulation disorder” threatens to label and treat children with temper tantrums, pathologising irritability in children. Finally, concerned clinicians and researchers have drawn attention to the “callous and unmotivated” specifier added to conduct disorder, warning that this may entrench the extant stigma these children experience.’

‘Why the continued use of the DSM in South Africa? The historical route to DSM diagnostic hegemony in South Africa is not entirely clear. Was this a consensus decision? What was the rationale? These are relevant questions, since this “tradition” places us in the global minority. Seventy percent of a sizeable global sample of psychiatrists recently reported using the International Classification of Diseases (ICD) for diagnosis in clinical practice. When one considers that South Africa is a WHO member state, and that within South Africa public health practitioners and institutions are required by law to report clinical “cases” using the ICD-10 coding system, these questions take on particular relevance. Just how significantly was South Africa represented in the DSM-5 field trials? How then do we know that this system is valid within our African, “developing country” context? And one final question: Why do we blindly continue to choose to be among the global few who use a diagnostic system that has a torrid history of attracting massive public criticism and distrust? It’s a bit like being an AIDS denialist, isn’t it?’

**International Classification of Diseases (ICD)**


‘For precision in reporting causes of illness or death, a nomenclature of diseases is essential. A nomenclature is a list of acceptable or approved disease terminology and differs from a classification, which refers to disease terms organized in a systematic way. Many disease nomenclatures are listings of diseases in alphabetical order. Such a simple alphabetic arrangement of disease terms is not regarded as a disease classification. However, when the disease terms are grouped according to topographic site and etiology, they become disease classifications. The semantic distinction between the terms “nomenclature” and “classification” has not always been maintained in use. For example, the first Bertillon classification in 1899, predecessor to the International Classification of Diseases (ICD), was called a nomenclature even though it was designed to be a statistical classification.

**WHO; International Classification of Diseases (ICD); [http://www.who.int/classifications/icd/en/](http://www.who.int/classifications/icd/en/)**

The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems, proving a picture of the general health situation of countries and populations.

ICD is used by physicians, nurses, other providers, researchers, health information managers and coders, health information technology workers, policy-makers, insurers and patient organizations to classify diseases and other health problems recorded on many types of health and vital records, including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States. Finally, ICD is used for reimbursement and resource allocation decision-making by countries.
All Member States use the ICD which has been translated into 43 languages. Most countries (117) use the system to report mortality data, a primary indicator of health status.

*Wikipedia; Classification of Mental Disorders; https://en.wikipedia.org/wiki/Classification_of_mental_disorders*

'The International Classification of Diseases (ICD) is an international standard diagnostic classification for a wide variety of health conditions. The ICD-10 states that mental disorder is "not an exact term", although is generally used "...to imply the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions." (WHO, 1992). Chapter V focuses on "mental and behavioural disorders" and consists of 10 main groups:

- F0: Organic, including symptomatic, mental disorders
- F1: Mental and behavioural disorders due to use of psychoactive substances
- F2: Schizophrenia, schizotypal and delusional disorders
- F3: Mood [affective] disorders
- F4: Neurotic, stress-related and somatoform disorders
- F5: Behavioural syndromes associated with physiological disturbances and physical factors
- F6: Disorders of personality and behaviour in adult persons
- F7: Mental retardation
- F8: Disorders of psychological development
- F9: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Within each group there are more specific subcategories. The ICD includes personality disorders on the same domain as other mental disorders, unlike the DSM.

The WHO is revising their classifications in this section as part of the development of the ICD-11 (scheduled for 2014) and an "International Advisory Group" has been established to guide this.'


'The ICD is currently the most widely used statistical classification system for diseases in the world. International health statistics using this system are available at the Global Health Observatory (GHO).

In addition, some countries—including Australia, Canada, and the United States—have developed their own adaptations of ICD, with more procedure codes for classification of operative or diagnostic procedures.’

*Steeves Demazeux, Patrick Singy; The DSM-5 in Perspective Philosophical Reflections on the Psychiatric Babel; Springer*

'Since countries that are members of the WHO are bound by treaty to use the ICD (or a system close to the ICD), they are forced to gradually abandon their national classifications. This is what happened for instance with the Chinese classification, the Chinese Classification and Diagnostic Criteria of Mental Disorders (CCMD) published by the Chinese Society of Psychiatry.’
**History of the ICD**

**Early history of global classification standards**


'The history of ICD is rich in international collaboration and cooperation. This, and the fact that it is a classification based on sound, time-tested principles, accounts for its long and continuous international acceptance. More use is now being made of ICD than ever before. To meet the demands for greater detail in disease classification, ICD has greatly expanded in successive revisions; this expansion can be expected to continue as the non-statistical uses of ICD grow.'

'The beginnings of death registration can be found in mid-15th century Italy, where medical education and social administration were more advanced than elsewhere in Europe. The Councilors for the cities of northern Italy, remembering the great pandemics of plague in the century before that killed more than one-third of the whole population of Europe, set up boards of health to consider how best to deal with the recurring epidemics that ravaged their populations.'

In the 16th century, boards of health were set up in France, Switzerland, and the Netherlands, but they were only temporary measures during a crisis, not continuous organizations as in Italy.

In England, three activities that foreshadowed death registration began in the 1530s: 1) In 1532, one of the earliest, if not the earliest, systematic collection of data on causes of death, the Bills of Mortality, began.'

In 1534, Queen Elizabeth introduced quarantine and plague orders in England. 3) Shortly thereafter, parish registers were also established in England. These registers recorded baptisms rather than births and burials instead of deaths, and the registers contained no information on causes of death.

'Starting in the mid-18th century, national civil registration systems came into being and made possible the continuous recording of births and deaths and the annual compilation of birth and death statistics. However, it was not yet possible to produce comparable statistics on causes of death as disease classification had not reached that stage of development.'


'Sir George Knibbs, the eminent Australian statistician, credited François Bossier de Lacroix (1706-1777), better known as Sauvages, with the first attempt to classify diseases systematically (10). Sauvages' comprehensive treatise was published under the title *Nosologia methodica*. A contemporary of Sauvages was the great methodologist Linnaeus (1707-1778), one of whose treatises was entitled *Genera morborum*. At the beginning of the 19th century, the classification of disease in most general use was one by William Cullen (1710-1790), of Edinburgh, which was published in 1785 under the title *Synopsis nosologiae methodicae*.

For all practical purposes, however, the statistical study of disease began a century earlier with the work of John Graunt on the London Bills of Mortality. The kind of classification envisaged by this pioneer is exemplified by his attempt to estimate the proportion of liveborn children who died before reaching the age of six years, no records of age at death being available. He took all deaths classed as thrush, convulsions, rickets, teeth and worms, abortives, chrysomes, infants, livergrown, and overlaid and added to them half the deaths classed as smallpox, swinepox, measles, and worms without convulsions.'


'In 1837, the Registration Act was passed in England with provisions for inquiry into causes of death in the population. In 1839, William Farr was appointed compiler of abstracts in the Registrar-General’s office, and he, probably more than anyone else, developed and analyzed mortality statistics to delineate the sanitary and health problems of the day.'

'Fortunately for the progress of preventive medicine, the General Register Office of England and Wales, at its inception in 1837, found in William Farr (1807-1883) - its first medical statistician - a man who not only made the best possible use of the imperfect classifications of disease available at the time, but laboured to secure better classifications and international uniformity in their use.'
History of the development of the ICD; http://www.who.int/classifications/icd/en/HistoryOfCD.pdf

‘The utility of a uniform classification of causes of death was so strongly recognized at the first International Statistical Congress, held in Brussels in 1853, that the Congress requested William Farr and Marc d’Espine, of Geneva, to prepare an internationally applicable, uniform classification of causes of death. At the next Congress, in Paris in 1855, Farr and d’Espine submitted two separate lists which were based on very different principles. Farr’s classification was arranged under five groups: epidemic diseases, constitutional (general) diseases, local diseases arranged according to anatomical site, developmental diseases, and diseases that are the direct result of violence. D’Espine classified diseases according to their nature (gouty, herpetic, haematic, etc.). The Congress adopted a compromise list of 139 rubrics. In 1864, this classification was revised in Paris on the basis of Farr’s model and was subsequently further revised in 1874, 1880, and 1886. Although this classification was never universally accepted, the general arrangement proposed by Farr, including the principle of classifying diseases by anatomical site, survived as the basis of the International List of Causes of Death.’


‘In 1860, during the international statistical congress held in London, Florence Nightingale made a proposal that was to result in the development of the first model of systemic collection of hospital data. In 1893, a French physician, Jacques Bertillon, introduced the Bertillon Classification of Causes of Death at a congress of the International Statistical Institute in Chicago. A number of countries and cities adopted Bertillon’s system, which was based on the principle of distinguishing between general diseases and those localized to a particular organ or anatomical site, as used by the City of Paris for classifying deaths. Subsequent revisions represented a synthesis of English, German, and Swiss classifications, expanding from the original 44 titles to 161 titles. In 1898, the American Public Health Association (APHA) recommended that the registrars of Canada, Mexico, and the United States also adopt it. The APHA also recommended revising the system every ten years to ensure the system remained current with medical practice advances. As a result, the first international conference to revise the International Classification of Causes of Death took place in 1900, with revisions occurring every ten years thereafter. At that time, the classification system was contained in one book, which included an Alphabetic Index as well as a Tabular List. The book was small compared with current coding texts.’

History of the development of the ICD; http://www.who.int/classifications/icd/en/HistoryOfCD.pdf

‘The International Statistical Institute, the successor to the International Statistical Congress, at its meeting in Vienna in 1891, charged a committee, chaired by Jacques Bertillon (1851-1922), Chief of Statistical Services of the City of Paris, with the preparation of a classification of causes of death.’

‘The French Government () convoked in Paris, in August 1900, the first International Conference for the Revision of the Bertillon or International List of Causes of Death. Delegates from 26 countries attended this Conference. A detailed classification of causes of death consisting of 179 groups and an abridged classification of 35 groups were adopted on 21 August 1900. The desirability of decennial revisions was recognized, and the French Government was requested to call the next meeting in 1910. In fact the next conference was held in 1909, and the Government of France called succeeding conferences in 1920, 1929, and 1938.’

‘At the 1923 session of the International Statistical Institute, Michel Huber, Bertillon’s successor in France, recognized this lack of leadership and introduced a resolution for the International Statistical Institute to renew its stand of 1893 in regard to the International Classification of Causes of Death and to cooperate with other international organizations in preparation for subsequent revisions. The Health Organization of the League of Nations had also taken an active interest in vital statistics and appointed a Commission of Statistical Experts to study the classification of diseases and causes of death, as well as other problems in the field of medical statistics.’

‘The Fifth International Conference for the Revision of the International List of Causes of Death, like the preceding conferences, was convened by the Government of France and was held in Paris in October 1938. The Conference approved three lists: a detailed list of 200 titles, an intermediate list of 87 titles and an abridged list of 44 titles. Apart from bringing the lists up to date in accordance with the progress of science, particularly in the chapter on infectious and parasitic diseases, and changes in the chapters on puerperal conditions and on accidents, the Conference made as few changes as possible in the contents, number, and even in the numbering of the items.’
‘In 1944, provisional classifications of diseases and injuries were published in both the United Kingdom and the United States of America for use in the tabulation of morbidity statistics.’

‘The International Conference for the Sixth Revision of the International Lists of Diseases and Causes of Death was convened in Paris from 26 to 30 April 1948 by the Government of France under the terms of the agreement signed at the close of the Fifth Revision Conference in 1938. Its secretariat was entrusted jointly to the competent French authorities and to the World Health Organization, which had carried out the preparatory work under the terms of the arrangement concluded by the governments represented at the International Health Conference in 1946.’

**ICD 6-11**

*Wikipedia; International Statistical Classification of Diseases and Related Health Problems;*


‘The revisions that followed contained minor changes, until the sixth revision of the classification system. With the sixth revision, the classification system expanded to two volumes. The sixth revision included morbidity and mortality conditions, and its title was modified to reflect the changes: International Statistical Classification of Diseases, Injuries and Causes of Death (ICD). Prior to the sixth revision, responsibility for ICD revisions fell to the Mixed Commission, a group composed of representatives from the International Statistical Institute and the Health Organization of the League of Nations. In 1948, the WHO assumed responsibility for preparing and publishing the revisions to the ICD every ten years. WHO sponsored the seventh and eighth revisions in 1957 and 1968, respectively. It later became clear that the established ten year interval between revisions was too short.’

**ICD-6**

*Wikipedia; International Statistical Classification of Diseases and Related Health Problems;*


‘The ICD-6, published in 1949, was the first to be shaped to become suitable for morbidity reporting. Accordingly, the name changed from International List of Causes of Death to International Statistical Classification of Diseases. The combined code section for injuries and their associated accidents was split into two, a chapter for injuries, and a chapter for their external causes. With use for morbidity there was a need for coding mental conditions, and for the first time a section on mental disorders was added.’


‘The Sixth Decennial Revision Conference marked the beginning of a new era in international vital and health statistics. Apart from approving a comprehensive list for both mortality and morbidity and agreeing on international rules for selecting the underlying cause of death, it recommended the adoption of a comprehensive programme of international cooperation in the field of vital and health statistics.’


‘The World Health Organization (WHO) added a psychiatric section to its classification of medical disorders with the sixth version of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-6). However, this psychiatric classification proved to be a political failure because it was ignored by almost every country in the United Nations at that time.’

**ICD-7**


‘The International Conference for the Seventh Revision of the International Classification of Diseases was held in Paris under the auspices of WHO in February 1955 (22). In accordance with a recommendation of the WHO Expert Committee on Health Statistics, this revision was limited to essential changes and amendments of errors and inconsistencies.’
In the early 1960s, the Mental Health Programme of the World Health Organization (WHO) became actively engaged in a programme aiming to improve the diagnosis and classification of mental disorders. At that time, WHO convened a series of meetings to review knowledge, actively involving representatives of different disciplines, various schools of thought in psychiatry, and all parts of the world in the programme. It stimulated and conducted research on criteria for classification and for reliability of diagnosis, and produced and promulgated procedures for joint rating of videotaped interviews and other useful research methods. Numerous proposals to improve the classification of mental disorders resulted from the extensive consultation process, and these were used in drafting the Eighth Revision of the International Classification of Diseases (ICD-8).

ICD-8


The Eighth Revision Conference convened by WHO met in Geneva, from 6 to 12 July 1965 (24). This revision was more radical than the Seventh but left unchanged the basic structure of the Classification and the general philosophy of classifying diseases, whenever possible, according to their etiology rather than a particular manifestation.


During the years that the Seventh and Eighth Revisions of the ICD were in force, the use of the ICD for indexing hospital medical records increased rapidly and some countries prepared national adaptations which provided the additional detail needed for this application of the ICD. In the USA, a group of consultants was asked to study the 8th revision of ICD (ICD-8a) for its applicability to various users in the United States. This group recommended that further detail be provided for coding hospital and morbidity data. The American Hospital Association's "Advisory Committee to the Central Office on ICDA" developed the needed adaptation proposals, resulting in the publication of the International Classification of Diseases, Adapted (ICDA). In 1968, the United States Public Health Service published the International Classification of Diseases, Adapted, 8th Revision for use in the United States (ICDA-8a). Beginning in 1968, ICDA-8a served as the basis for coding diagnostic data for both official morbidity [and mortality] statistics in the United States.

World Health Organization; The ICD-10 Classification of Mental and Behavioural Disorders; Clinical descriptions and diagnostic guidelines.

The 1970s saw further growth of interest in improving psychiatric classification worldwide. Expansion of international contacts, the undertaking of several international collaborative studies, and the availability of new treatments all contributed to this trend.

ICD-9


The International Conference for the Ninth Revision of the International Classification of Diseases, convened by WHO, met in Geneva from 30 September to 6 October 1975. In the discussions leading up to the conference, it had originally been intended that there should be little change other than updating of the classification. This was mainly because of the expense of adapting data processing systems each time the classification was revised.

There had been an enormous growth of interest in the ICD and ways had to be found of responding to this, partly by modifying the classification itself and partly by introducing special coding provisions. A number of representations were made by specialist bodies which had become interested in using the ICD for their own statistics. Some subject areas in the classification were regarded as inappropriately arranged and there was considerable pressure for more detail and for adaptation of the classification to make it more relevant for the evaluation of medical care, by classifying conditions to the chapters concerned with the part of the body affected rather than to those dealing with the underlying generalized disease.

At the other end of the scale, there were representations from countries and areas where a detailed and sophisticated classification was irrelevant, but which nevertheless needed a classification based on the ICD in order
to assess their progress in health care and in the control of disease. A field test with a bi-axial classification approach—one axis for anatomy, another for etiology—showed the impracticability of such approach for routine use.


‘The final proposals presented to and accepted by the Conference retained the basic structure of the ICD, although with much additional detail at the level of the four-digit subcategories, and some optional five-digit subdivisions. For the benefit of users not requiring such detail, care was taken to ensure that the categories at the three-digit level were appropriate.’


‘For the benefit of users wishing to produce statistics and indexes oriented towards medical care, the Ninth Revision included an optional alternative method of classifying diagnostic statements, including information about both an underlying general disease and a manifestation in a particular organ or site. This system became known as the dagger and asterisk system and is retained in the Tenth Revision. A number of other technical innovations were included in the Ninth Revision, aimed at increasing its flexibility for use in a variety of situations. It was eventually replaced by ICD-10, the version currently in use by the WHO and most countries. Given the widespread expansion in the tenth revision, it is not possible to convert ICD-9 data sets directly into ICD-10 data sets, although some tools are available to help guide users.[15] Publication of ICD-9 without IP restrictions in a world with evolving electronic data systems led to a range of products based on ICD-9, such as MeDRA or the Read directory.’

**ICPM**


‘When ICD-9 was published by the World Health Organization (WHO), the International Classification of Procedures in Medicine (ICPM) was also developed (1975) and published (1978). The ICPM surgical procedures fascicle was originally created by the United States, based on its adaptations of ICD (called ICDA), which had contained a procedure classification since 1962. ICPM is published separately from the ICD disease classification as a series of supplementary documents called fascicles (bundles or groups of items). Each fascicle contains a classification of modes of laboratory, radiology, surgery, therapy, and other diagnostic procedures. Many countries have adapted and translated the ICPM in parts or as a whole and are using it with amendments since then.’

**ICD-9-CM**


‘*International Classification of Diseases, Clinical Modification* (ICD-9-CM) is an adaption created by the U.S. National Center for Health Statistics (NCHS) and used in assigning diagnostic and procedure codes associated with inpatient, outpatient, and physician office utilization in the United States. The ICD-9-CM is based on the ICD-9 but provides for additional morbidity detail. It is updated annually on October 1.

It consists of two or three volumes:

- Volumes 1 and 2 contain diagnosis codes. (Volume 1 is a tabular listing, and volume 2 is an index.) Extended for ICD-9-CM
- Volume 3 contains procedure codes. ICD-9-CM only

The NCHS and the Centers for Medicare and Medicaid Services are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM.
World Health Organization; The ICD-10 Classification of Mental and Behavioural Disorders; Clinical descriptions and diagnostic guidelines.

‘In 1978, WHO entered into a long-term collaborative project with the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) in the USA, aiming to facilitate further improvements in the classification and diagnosis of mental disorders, and alcohol- and drug-related problems.’

‘A mutually beneficial relationship evolved between these [ADAMHA – and others] projects and the work on definitions of mental and behavioural disorders in the Tenth Revision of the International Classification of Diseases and Related Health Problems -3- (ICD-10)’

‘Chapter V, Mental and behavioural disorders, of ICD-10 is to be available in several different versions for different purposes. This version, Clinical descriptions and diagnostic guidelines, is intended for general clinical, educational and service use. Diagnostic criteria for research has been produced for research purposes and is designed to be used in conjunction with this book. The much shorter glossary provided by Chapter V(F) for ICD-10 itself is suitable for use by coders or clerical workers, and also serves as a reference point for compatibility with other classifications; it is not recommended for use by mental health professionals. Shorter and simpler versions of the classifications for use by primary health care workers are now in preparation, as is a multiaxial scheme. Clinical descriptions and diagnostic guidelines has been the starting point for the development of the different versions, and the utmost care has been taken to avoid problems of incompatibility between them.’

‘Disorder The term "disorder" is used throughout the classification, so as to avoid even greater problems inherent in the use of terms such as "disease" and "illness". "Disorder" is not an exact term, but it is used here to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here.’

ICD-10

History of the development of the ICD; http://www.who.int/classifications/icd/en/HistoryOfICD.pdf

‘Even before the Conference for the Ninth Revision, WHO had been preparing for the Tenth Revision. It had been realized that the great expansion in the use of the ICD necessitated a thorough rethinking of its structure and an effort to devise a stable and flexible classification, which should not require fundamental revision for many years to come.’


‘Work on ICD-10 began in 1983, and the new revision was endorsed by the Forty-third World Health Assembly in May 1990. The latest version came into use in WHO Member States starting in 1994. The classification system allows more than 155,000 different codes and permits tracking of many new diagnoses and procedures, a significant expansion on the 17,000 codes available in ICD-9. Adoption was relatively swift in most of the world. Several materials are made available online by WHO to facilitate its use, including a manual, training guidelines, a browser, and files for download. Some countries have adapted the international standard, such as the "ICD-10-AM" published in Australia in 1998 (also used in New Zealand), and the "ICD-10-CA" introduced in Canada in 2000.’

ICD-10: The History, the Impact, and the Keys to Success; 1-800-626-2633 | www.aapc.com | info@aapc.com

‘The International Classification of Diseases, Tenth Revision, (ICD-10) was endorsed by the 43rd World Health Assembly in May 1990 and came into use in World Health Organization (WHO) States in 1994. ICD-10, Clinical Modification (ICD-10-CM) was developed by the U.S. National Center for Health Statistics (NCHS) along with an advisory panel to ensure accuracy and utility in 1993. In the United States, we will use the clinically modified version, as we did with ICD-9. On January 5, 2009, the U.S. Department of Health & Human Services (HHS) announced that ICD-9-CM would be replaced by the ICD-10 system (ICD-10-CM and ICD-10-PCS) on October 1, 2014.

CMS reports the following benefits of converting to the

- ICD-10 coding system in the United States;
- Improving payment systems and reimbursement accuracy
- Measuring the quality, safety and efficacy of care
Conducting research, epidemiological studies, and clinical trials
Setting health policy
Monitoring resource utilization
Preventing and detecting healthcare fraud and abuse

‘Canada’s conversion to ICD-10-CA (Canada’s version of ICD-10-CM) and Canadian Classification of Health Interventions, or CCI (Canada’s version of PCS) is that they experienced a large learning curve and loss in productivity. Maaret Brandon, a project analyst and coordinator for the Vancouver General Hospital in British Columbia stated, “Becoming familiar with all the ICD-10-CA/CCI coding concepts was like learning to read Greek.”

‘Some studies have estimated that inadequate training could result in reduced productivity levels for as long as six months due to increased re-work for denied claims, adjustments and pended claims, and coders directing an increasing amount of queries to physicians when documentation is not adequate to support the higher level of specificity required with ICD-10.’

ICD-10-CM

Wikipedia; International Statistical Classification of Diseases and Related Health Problems;

‘Adoption of ICD-10-CM has been slow in the United States. Since 1979, the USA had required ICD-9-CM codes for Medicare and Medicaid claims, and most of the rest of the American medical industry followed suit. On 1 January 1999 the ICD-10 (without clinical extensions) was adopted for reporting mortality, but ICD-9-CM was still used for morbidity. Meanwhile, NCHS received permission from the WHO to create a clinical modification of the ICD-10, and has production of all these systems:

• ICD-10-CM, for diagnosis codes, is intended to replace volumes 1 and 2. Annual updates are provided.
• ICD-10-PCS, for procedure codes, is intended to replace volume 3. Annual updates are provided.

On August 21, 2008, the US Department of Health and Human Services (HHS) proposed new code sets to be used for reporting diagnoses and procedures on health care transactions. Under the proposal, the ICD-9-CM code sets would be replaced with the ICD-10-CM code sets, effective October 1, 2013. On April 17, 2012 the Department of Health and Human Services (HHS) published a proposed rule that would delay, from October 1, 2013 to October 1, 2014, the compliance date for the ICD-10-CM and PCS. Once again, Congress delayed implementation date to October 1, 2015, after it was inserted into "Doc Fix" Bill without debate over objections of many.

Revisions to ICD-10-CM Include:

• Relevant information for ambulatory and managed care encounter.
• Expanded injury codes.
• New combination codes for diagnosis/symptoms to reduce the number of codes needed to describe a problem fully.
• Addition of sixth and seventh digit classification.
• Classification specific to laterality.
• Classification refinement for increased data granularity.’

ICD-10-CA

Wikipedia; International Statistical Classification of Diseases and Related Health Problems;

‘ICD-10-CA is a clinical modification of ICD-10 developed by the Canadian Institute for Health Information for morbidity classification in Canada. ICD-10-CA applies beyond acute hospital care, and includes conditions and situations that are not diseases but represent risk factors to health, such as occupational and environmental factors, lifestyle and psycho-social circumstances.'
'Opponents to the adoption of ICD-10 have been quick to assert that the nation’s healthcare system should bypass it and make the leap to ICD-11 when it is introduced.

Typical of this rationale is a quote from a form letter that the Florida Medical Association (FMA) has been urging its members to send to their elected representatives. In the cut-and-paste version on the association’s website, FMA president Alan B. Pillersdorf, MD, offers this argument for members to use in letter-writing campaigns.

“ICD-10 is old technology developed during the 1980s. ICD-11, designed for use with EHRs (electronic health records) and the Internet, is right around the corner. It makes absolutely no sense to force my practice to go through the time and expense of adopting an outdated system when there is a viable alternative that will soon be available.”

ICD-11

The World Health Organization is currently revising the International Classification of Diseases (ICD) towards the ICD-11. The development is taking place on an internet-based workspace, called iCAT (Collaborative Authoring Tool) Platform, somewhat similar to a wiki – yet it requires more structure and peer review process. The WHO collaborates through this platform with all interested parties.

The final draft of the ICD-11 system is expected to be submitted to WHO’s World Health Assembly (WHA) for official endorsement by 2017. The beta draft was made available online in May 2012 for initial consultation and commenting.

In ICD-11 each disease entity will have definitions that give key descriptions and guidance on what the meaning of the entity/category is in human readable terms - to guide users. This is advancement over ICD-10, which had only title headings. The Definitions have a standard structure according to a template with standard definition templates and further features exemplified in a “Content Model”. The Content Model is a structured framework that captures the knowledge that underpins the definition of an ICD entity. The Content Model therefore allows computerization (with links to ontologies and SNOMED CT). Each ICD entity can be seen from different dimensions or “parameters”. For example, there are currently 13 defined main parameters in the Content Model (see below) to describe a category in ICD.

1. ICD Entity Title - *Fully Specified Name*
2. Classification Properties - *disease, disorder, injury, etc.*
3. Textual Definitions - *short standard description*
4. Terms - *synonyms, other inclusion and exclusions*
5. Body System/Structure Description - *anatomy and physiology*
6. Temporal Properties - *acute, chronic or other*
7. Severity of Subtypes Properties - *mild, moderate, severe, or other scales*
8. Manifestation Properties - *signs, symptoms*
10. Functioning Properties - *impact on daily life: activities and participation*
11. Specific Condition Properties - *relates to pregnancy etc.*
12. Treatment Properties - *specific treatment considerations: e.g. resistance*
13. Diagnostic Criteria - *operational definitions for assessment*

ICD exists in 41 Languages in electronic versions and its expression in multiple languages will be systematically pursued in ICD11.'
Still struggling with ICD-10? ICD-11 gets a new release date?

‘The agency had been considering for several months delaying ICD-11 implementation. Although no official announcement has been made, the WHO fact sheet states that “the 11th revision process is underway and the final ICD-11 will be released in 2017.” Feb 12, 2014

Rosemary Roberts; Marjorie Greenberg; Helene Richardsson; Report of ICD-11 Revision Review Consultancy Interim Assessment of 11th ICD Revision; January – March 2015; 14 April 2015

‘One of the main priorities for the Review Team was to determine if the ICD-11 release date of 2017 is feasible. It was also important to examine the concerns expressed by stakeholders relating to the classification being ‘fit for purpose’ and sufficiently stable in comparison with ICD-10 to allow least impact on time series data especially for mortality reporting purposes.’

‘Revising the International Classification of Diseases is a balancing act between conservatism and innovation. While it is necessary to update the classification content to reflect clinical knowledge and practice, it is also important that there be comparability between data collected in successive revisions and an understanding of how changes in the classification affect data trends. Particularly for this 11th Revision, the environment in which it is being prepared is completely different from that of the 10th revision in the 1980s. For mortality, multiple cause of death coding software has been updated and expanded and promotes consistent application of underlying cause of death rules. For morbidity, as well as allowing data collection for reporting disease trends and hospital utilisation, the codes are being increasingly used for case mix and reimbursement purposes. Technology and data handling tools are dramatically different, as are the expectations of users to extract data from electronic health records.’

‘While the infrastructure required to enable the ICD-11 Revision project is in place, there have been some delays due to the pioneering nature of the overall endeavour and the limited resources to achieve the visionary aims of many of its component goals. However, considerable progress has been made, and ICD-11 now appears achievable with tight project management and critical personnel resources for completing the Joint Linearization and reviewing the current product. Although the assessment concluded that the whole of ICD-11 is not yet ready for broad-scale field trials, the process should not be allowed to drag on interminably. It needs clear goals for 2017-2018 which are reachable and met. It also needs a staged process for achieving other key goals, including properly created and vetted primary care linearization’s and building on the relationship with SNOMED-CT as well as other planned developments of ICD-11 and its maintenance.

The main issues now are project and resource management, communication with stakeholders and rebuilding of trust from the stakeholder community. All these have suffered due to pressure of time, an unclear governance model and inadequate communication as well as the enormous number of people, countries and aspects involved and the sheer complexity of the project. The decision making process needs to be clarified as well as plans for future funding of this project and lines of financial accountability.’

‘One of the major risks to WHO in producing ICD-11 is loss of credibility and trust. Loss if the revision is delayed again, loss if it is published in an unfinished form. Either would weaken this classification lynchpin of WHO and should be avoided at all costs – hence our recommendations to produce a basic linearization for 2017 as expected and to deliver on investments. The knowledge that has gone into ICD-11 is not static. It should not be allowed to go stale. Resources should be used wisely to allow a staged implementation of this vital tool and to bring stakeholders along with the process and help them to implement this extraordinary revision as a solid and updatable foundation for health information systems.’

Critique of the ICD


‘The ICD comes in several versions. One is intended for clinicians and uses prototypes in its description of disorders [ICD-10-CM (clinical manual)], whereas the other is intended for researchers and uses operationalized diagnostic criteria [ICD-10-RDC (research diagnostic criteria)]. Thus, the ICD developers recognized that the optimal structure
and nature of a classification system might be different for different purposes. The DSM, however, attempts to serve all masters simultaneously and may thereby diminish its own ability to do justice to any.’

“F43.1 Post-traumatic stress disorder

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).”

PTSD- Post-traumatic Stress Disorder


‘An extreme event may be sufficient to produce PTSD in all who experience it so that personal vulnerability is not a factor. But a less extreme event may only produce PTSD in those who are already vulnerable. Not surprisingly, in a culture in which mental illness is stigmatized, the issue of whether PTSD is caused by an event or by personal vulnerability is one which is charged with emotion. As the public understanding seems closer to the original definition of PTSD, the current definition is fraught with problems.’

National Center for PTSD; PTSD History and Overview; US Department of Veterans Affairs.

‘PTSD is unique among psychiatric diagnoses because of the great importance placed upon the etiological agent, the traumatic stressor. In fact, one cannot make a PTSD diagnosis unless the patient has actually met the "stressor criterion," which means that he or she has been exposed to an event that is considered traumatic.

Clinical experience with the PTSD diagnosis has shown, however, that there are individual differences regarding the capacity to cope with catastrophic stress. Therefore, while most people exposed to traumatic events do not develop PTSD, others go on to develop the full-blown syndrome. Such observations have prompted the recognition that trauma, like pain, is not an external phenomenon that can be completely objectified.

Like pain, the traumatic experience is filtered through cognitive and emotional processes before it can be appraised as an extreme threat. Because of individual differences in this appraisal process, different people appear to have different trauma thresholds, some more protected from and some more vulnerable to developing clinical symptoms after exposure to extremely stressful situations.

Although there is currently a renewed interest in subjective aspects of traumatic exposure, it must be emphasized that events such as rape, torture, genocide, and severe war zone stress are experienced as traumatic events by nearly everyone.’
PTSD Diagnostics

Nebraska Department of Veterans’ Affairs Post Traumatic Stress Disorder; www.ptsd.ne.gov/what-is-ptsd.html

‘PTSD, or Posttraumatic Stress Disorder, is a psychiatric disorder that can occur following the experience or witnessing of a life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or physical or sexual assault in adult or childhood.’

Nancy C. Andreasen, Posttraumatic Stress Disorder: A History and a Critique; Annals of the New York Academy of Sciences

‘Because World War II brought together psychiatrists from all over the world and from all over the United States, it became clear that they could differ in training, conceptual framework, and in approaches to diagnosis and treatment. A consensus developed that some standardization was needed, and this challenge led to the creation of the first diagnostic manual, developed by the Veterans’ Administration. This provided an incentive to the American Psychiatric Association (APA) to develop its own manual: the first Diagnostic and Statistical Manual of the APA, or DSM-I, which appeared in 1952. This manual included a category called gross stress reaction. It was defined as a stress syndrome that is a response to an exceptional physical or mental stress, such as a natural catastrophe or battle; it occurs in people who are otherwise normal; and it must subside in days to weeks; if it persists, another diagnosis should be made.

The first revision of this manual, DSM-II, was published in 1968. Without any explanation, the diagnosis of gross stress reaction was omitted. The most plausible explanation for the omission is that the concept was closely linked to warfare and combat, and DSM-II was written in a peaceful era. Consequently, between 1968 and 1980 no official diagnosis for stress disorders was available.

This change in the official APA nosology and classification occurred just as the Vietnam War was beginning its escalation. The publication of DSM-II and the Tet Offensive occurred in the same year. The war refocused attention on postcombat stress disorders. As the war became more unpopular, returning veterans were often greeted with contempt. No accepted diagnosis was available for those who had psychiatric symptoms, and treatment facilities were minimal. Activists began to note the inequity created by sending men to war without recognizing the psychiatric consequences and the need to provide adequate treatment for them. When the DSMIII Task Force was assembled in the mid-1980s, the status of gross stress reaction was one of the issues that it faced.’

‘In recognition that a stress syndrome is a final common pathway with many entry points reflecting the variety of stressors that can produce it, there was no specific “post-Vietnam syndrome.” Instead the new diagnosis [in DSM 111] was given the very general name of “posttraumatic stress disorder.” For the stressed, there was no requirement of preexisting normality; this decision was based on the recognition that individuals vary in vulnerability and resilience. The symptoms were divided into three general categories: reexperiencing (including dissociative states), numbing of responsiveness, and cognitive or autonomic symptoms. The onset could be either acute or delayed.’

National Center for PTSD; PTSD History and Overview; US Department of Veterans Affairs.

‘In 1980, the American Psychiatric Association (APA) added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III) nosologic classification scheme. Although controversial when first introduced, the PTSD diagnosis has filled an important gap in psychiatric theory and practice. From an historical perspective, the significant change ushered in by the PTSD concept was the stipulation that the etiological agent was outside the individual (i.e., a traumatic event) rather than an inherent individual weakness (i.e., a traumatic neurosis). The key to understanding the scientific basis and clinical expression of PTSD is the concept of “trauma.”

In its initial DSM-III formulation, a traumatic event was conceptualized as a catastrophic stressor that was outside the range of usual human experience. The framers of the original PTSD diagnosis had in mind events such as war, torture, rape, the Nazi Holocaust, the atomic bombings of Hiroshima and Nagasaki, natural disasters (such as earthquakes, hurricanes, and volcano eruptions), and human-made disasters (such as factory explosions, airplane crashes, and automobile accidents). They considered traumatic events to be clearly different from the very painful stressors that constitute the normal vicissitudes of life such as divorce, failure, rejection, serious illness, financial reverses, and the like. (By this logic, adverse psychological responses to such “ordinary stressors” would, in DSM-III terms, be characterized as Adjustment Disorders rather than PTSD.) This dichotomization between traumatic and
other stressors was based on the assumption that, although most individuals have the ability to cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor.’

‘DSM-IV Diagnostic criteria for PTSD included a history of exposure to a traumatic event and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerned duration of symptoms; and, a sixth criterion stipulated that PTSD symptoms must cause significant distress or functional impairment.

The latest revision, the DSM-5 (2013), has made a number of notable evidence-based revisions to PTSD diagnostic criteria, with both important conceptual and clinical implications. First, because it has become apparent that PTSD is not just a fear-based anxiety disorder (as explicated in both DSM-III and DSM-IV), PTSD in DSM-5 has expanded to include anhedonic/dysphoric presentations, which are most prominent. Such presentations are marked by negative cognitions and mood states as well as disruptive (e.g. angry, impulsive, reckless and self-destructive) behavioral symptoms. Furthermore, as a result of research-based changes to the diagnosis, PTSD is no longer categorized as an Anxiety Disorder. PTSD is now classified in a new category, Trauma- and Stressor-Related Disorders, in which the onset of every disorder has been preceded by exposure to a traumatic or otherwise adverse environmental event. Other changes in diagnostic criteria will be described below.’


‘Clinicians use the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a guide in understanding clusters of symptoms so that they know how to treat different clients. The DSM has gone through a number of revisions through the years, and recently the 5th edition was released. Posttraumatic Stress Disorder (PTSD) was one of the diagnoses that received some revisions.

PTSD used to be considered a type of anxiety disorder and in this edition was moved into a new category: “Trauma and Stress-related Disorders”. This could help de-stigmatize PTSD since it is no longer an anxiety related mental illness, but a disorder connected to an external event.

The criteria for PTSD include specifying qualifying experiences of traumatic events, four sets of symptom clusters, and two subtypes. There are also requirements around duration of symptoms, how it impacts one’s functioning, and ruling out substance use and medical illnesses. Also, there is now a pre-school diagnosis for PTSD, so the following description is for people ages 7 and older.’

Criterion A: Traumatic event

‘Trauma survivors must have been exposed to actual or threatened:

- death
- serious injury
- sexual violence

The exposure can be:

- direct
- witnessed
- indirect, by hearing of a relative or close friend who has experienced the event—indirectly experienced death must be accidental or violent
- repeated or extreme indirect exposure to qualifying events, usually by professionals—non-professional exposure by media does not count’

‘Many professionals who work in trauma differentiate between “big T-traumas,” the ones listed above, and “little-t traumas.” Little-t traumas can include complicated grief, divorce, non-professional media exposure to trauma, or childhood emotional abuse, and clinicians recognize that these can result in post-traumatic stress, even if they don’t qualify for the PTSD diagnosis.’

‘There is no longer a requirement that someone had to have an intense emotional response at the time of the event. This requirement excluded many veterans and sexual assault survivors in the past.’
‘Criterion B: Intrusion or Re-experiencing
These symptoms envelope ways that someone re-experiences the event. This could look like:

- Intrusive thoughts or memories
- Nightmares related to the traumatic event
- Flashbacks, feeling like the event is happening again
- Psychological and physical reactivity to reminders of the traumatic event, such as an anniversary

‘Criterion C: Avoidant symptoms
Avoidant symptoms describe ways that someone may try to avoid any memory of the event, and must include one of the following:

- Avoiding thoughts or feelings connected to the traumatic event
- Avoiding people or situations connected to the traumatic event

‘Criterion D: Negative alterations in mood or cognitions
This criterion is new, but captures many symptoms that have long been observed by PTSD sufferers and clinicians. Basically, there is a decline in someone’s mood or though patterns, which can include:

- Memory problems that are exclusive to the event
- Negative thoughts or beliefs about one’s self or the world
- Distorted sense of blame for one’s self or others, related to the event
- Being stuck in severe emotions related to the trauma (e.g. horror, shame, sadness)
- Severely reduced interest in pre-trauma activities
- Feeling detached, isolated or disconnected from other people

‘Criterion E: Increased arousal symptoms
Increased arousal symptoms are used to describe the ways that the brain remains “on edge,” wary and watchful of further threats. Symptoms include the following:

- Difficulty concentrating
- Irritability, increased temper or anger
- Difficulty falling or staying asleep
- Hypervigilance
- Being easily startled

‘Criteria F, G and H
These criteria all describe the severity of the symptoms listed above. Basically, they have to have lasted at least a month, seriously affect one’s ability to function and can’t be due to substance use, medical illness or anything except the event itself.

‘Subtype: Dissociation
Dissociation has now been set apart from the symptom clusters, and now its presence can be specified. While there are several types of dissociation, only two are included in the DSM:

- Depersonalization, or feeling disconnected from oneself
- Derealisation, a sense that one’s surroundings aren’t real”


‘This editorial is strongly critical of the DSM-5’s removal of PTSD from the Anxiety Disorder category. Arguments are:
1) fear is a critical construct for the development of PTSD, 2) treating trauma-related fear and avoidance is central to PTSD, 3) a lack of evidence exists for a stressor meta-construct separate from the Anxiety Disorders, and 4) this shift ignores cumulative evidence and moves the field backward.’


‘Using a binomial equation to elucidate possible symptom combinations, the authors demonstrate DSM-5’s “high level of symptom profile heterogeneity.” Whereas there were 79,794 ways to meet PTSD diagnostic criteria in DSM-IV, there are now 636,120 combinations in DSM-5. They further argue that this heterogeneity indicates “the
limitations of DSM-based diagnostic entities for classification in research” and elucidates “inherent flaws that are either specific artifacts from the history of the DSM or intrinsic to the underlying logic of the DSM’s method of classification.”

European Society for Traumatic Stress Studies; ICD10 PTSD; https://www.estss.org/learn-about-trauma/icd10/

‘International Classification of Diseases (ICD) - 10
Chapter V
Mental and behavioural disorders (F00-F99)
Neurotic, stress-related and somatoform disorders (F40-F48)

ICD 10 Version:2008 F43.1 Post-traumatic Stress Disorder

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories (“flashbacks”), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).

F43.1 Post-traumatic stress disorder

Diagnostic Criteria
A. Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.
B. Persistent remembering or "reliving" the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.
C. Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).
D. Either (1) or (2):
   (1) Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor
   (2) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:
      a) difficulty in falling or staying asleep;
      b) irritability or outbursts of anger;
      c) difficulty in concentrating;
      d) hyper-vigilance;
      e) exaggerated startle response
E. Criteria B, C (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately.)

Proposed ICD 11 Version Post-traumatic Stress Disorder

Matthew J. Friedman MD, Ph.D.; Literature on DSM-5 and ICD-11; National Center for PTDD; PTSD Research Quarterly; VOLUME 25/ NO. 2 • ISSN: 1050-1835 • 2014

‘... the World Health Organization has been developing the eleventh edition of its International Classification of Diseases (ICD-11). Although publication of ICD-11 won’t occur until 2015, it looks like the PTSD criteria will be very different than in DSM-5. There are a number of reasons for this:

1) ICD-11 has endorsed a narrow approach that will focus exclusively on PTSD as a stress-induced fear-based
anxiety disorder,
2) ICD-11 has taken a much less conservative approach so that DSM-5’s requirement for a large burden of scientific proof to change any DSM-IV criterion has not been a guiding principle. As a result, the ICD-11 revision looks much more drastic than DSM-5, and
3) ICD-11 will include Complex PTSD as a separate diagnosis, whereas DSM-5 will not.’

‘Because the ICD-11 process is at least two years behind DSM-5, with a projected publication date in 2015, there are only a few available articles to give us a glimpse of what is to come. Three articles lay out the rationale for the narrow approach to PTSD and restriction to six symptoms (Brewin, 2013; Maerker et al., 2013; Maerker & Perkonigg, 2013). This approach can be traced back to an important article by Brewin and colleagues (2009) that clearly influenced the ICD-11 work group. Another key position paper is that providing the rationale and supporting data from latent profile analysis for inclusion of Complex PTSD in ICD-11 (Cloitre et al., 2013).’

ICD 11 Beta Draft Foundation Id: http://id.who.int/icd/entity/585833559

‘Post-traumatic stress disorder

Disorders specifically associated with stress

Definition
Post-traumatic stress disorder (PTSD) is a disorder that may develop following exposure to an extremely threatening or horrific event or series of events characterized by reexperiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares, typically accompanied by strong and overwhelming emotions such as fear or horror, and strong physical sensations, avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events, and persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms must last for at least several weeks and cause significant impairment in functioning.

Synonyms
- Traumatic neurosis *

Narrower Terms
- battered person syndrome
- combat neurosis
- rape trauma syndrome

Exclusions
- Acute stress reaction ⇒
- Complex post-traumatic stress disorder ⇒

Body Site
- Entire brain (body structure)
- Brain structure (body structure)

Causal Mechanisms
- Traumatic injury (disorder)
- Traumatic abnormality (morphologic abnormality)’

Matthew J. Friedman MD, Ph.D.; Literature on DSM-5 and ICD-11; National Center for PTDD; PTSD Research Quarterly; VOLUME 25/ NO. 2 • ISSN: 1050 -1835 • 2014

‘Two important papers comparing DSM-5 with ICD-11 have appeared although others are in various stages of preparation. O’Donnell et al. (2014) compared PTSD prevalence according to DSM-IV, DSM-5, ICD-10 and ICD-11 criteria respectively among 510 randomly selected injury patients assessed 72 months post-trauma. ICD-11 prevalence, co-morbidity with depression and disability rates were lower than with the other three systems. Although there was great overlap between individuals who met both DSM-5 and ICD-11 criteria, a substantial number met criteria for one but not for the other. Similar findings were reported by Stein et al. (2014) from 23,936 respondents from 13 countries included in the World Mental Health Survey. Only one-third of broadly defined cases met criteria in all four classification schemes (e.g., DSM-IV/5 and ICD-10/11) and another third met PTSD criteria in only one of the four systems. The authors concluded that “all four definitions (of PTSD) are providing information on unique clinically significant cases that are omitted from the other systems” so that “any one diagnostic system will
overlook many individuals who suffer from clinically significant symptoms including distress and impairment” (page 502).


‘Current prevalence of PTSD under DSM-5 scoring was not significantly different from DSM-IV (6.7% v. 5.9%, z = 0.53, p = 0.59). However, the ICD-11 prevalence was significantly lower than ICD-10 (3.3% v. 9.0%, z = -3.8, p<0.001). The PTSD current prevalence was significantly higher for DSM-5 than ICD-11 (6.7% v. 3.3%, z = 2.5, p = 0.01). Using ICD-11 tended to show lower rates of comorbidity with depression and a slightly lower association with disability. Conclusions: The diagnostic systems performed in different ways in terms of current prevalence rates and levels of comorbidity with depression, but on other broad key indicators they were relatively similar. There was overlap between those with PTSD diagnosed by ICD-11 and DSM-5 but a substantial portion met one but not the other set of criteria. This represents a challenge for research because the phenotype that is studied may be markedly different according to the diagnostic system used.’


‘The development of the DSM-5 and ICD-11 has led to reconsideration of diagnostic criteria for PTSD. The World Mental Health (WMH) surveys allow investigation of the implications of the changing criteria compared to DSM-IV and ICD-10.’

‘A total of 5.6% of respondents met criteria for “broadly defined” PTSD (i.e., full criteria in at least one diagnostic system), with prevalence ranging from 3.0% with DSM-5 to 4.4% with ICD-10. Only one-third of broadly defined cases met criteria in all four systems and another one-third in only one system (narrowly defined cases). Between-system differences in indicators of clinical severity suggest that ICD-10 criteria are least strict and DSM-IV criteria most strict. The more striking result, though, is that significantly elevated indicators of clinical significance were found even for narrowly defined cases for each of the four diagnostic systems. Conclusions: These results argue for a broad definition of PTSD defined by any one of the different systems to capture all clinically significant cases of PTSD in future studies.’

Challenging the Diagnostic Models of PTSD

To bring this back to human reality his is a rather more customer centric way of appreciating and diagnosing PTSD:
**WHAT ARE SYMPTOMS OF PTSD?**

- Numbness
- Guilt
- Anger
- Bad Memory
- Hopelessness
- Self-Destruction
- Nightmares
- No Focus
- Shame
- Insomnia
- Hallucinations
- Flashbacks
- Violence
- Substance Abuse
- Irritability

**PHYSICAL SIGNS:**

- Headaches
- Agitation
- Dizziness
- Increased Chest Pain
- Fainting

**INTERESTING FACTS**

- One of the first descriptions of PTSD was made in 490 BC when Herodotus described an Athenian soldier going blind after witnessing the death of a fellow soldier.

- The events of September 11, 2001 caused one or more symptoms of PTSD as proved by the 44% adults surveyed who affirmed they experienced them.

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**12 Steps of PTSD**

Randy J. Hartman, Ph.D.

<table>
<thead>
<tr>
<th>Acute Anxiety</th>
<th>Panic/anxiety episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Self-esteem in a downward spiral</td>
</tr>
<tr>
<td>Resentment</td>
<td>Distrusting others</td>
</tr>
<tr>
<td>Anger</td>
<td>Fight or flight developing</td>
</tr>
<tr>
<td>Fear</td>
<td>PTSD is now forming</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Mixed episodes occur</td>
</tr>
<tr>
<td>Self-Worth Dissipating</td>
<td>Feeling worthless</td>
</tr>
<tr>
<td>Shame</td>
<td>Filled with shame; who else knows?</td>
</tr>
<tr>
<td>Guilt</td>
<td>Feeling guilty; how responsible am I?</td>
</tr>
<tr>
<td>Confusion</td>
<td>Trying to remember; can I trust my memory?</td>
</tr>
<tr>
<td>Pain</td>
<td>Emotional, spiritual &amp; physical pain</td>
</tr>
<tr>
<td>Activating Event(s)</td>
<td>Any event that causes distress</td>
</tr>
</tbody>
</table>

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Source: @PTSD-Jedi

**Neurotical Disorders. Mental Disorders in Congenital and Acquired Defects of the Oral Cavity And Maxillofacial Area; Psychopathies and Pathocharacteriological Development of Personality;**

Traumatic and/or stressful experiences are defined by some scholars as the events and incidents that are physically, emotionally and mentally difficult to process and are considered as harmful. For most individuals and communities,
these experiences disrupt lives and have overwhelming levels of negative impact and dangers. Often, it is almost impossible for the survivors to adjust and adapt without external help. Repeated exposure to violence or any stressful circumstances or chains of such events and experiences may increasingly deplete human and cultural resources. Individuals and/or communities experience a downward spiral of response and consequences that are difficult to reverse following a trauma. This comes from the meaning of the word itself, which shows that it has an intention to harm and ‘squeeze’ its victim, with the result affecting the person in his or her totality. It also has strong social and spiritual connotations which cannot easily be pushed aside. Therefore trauma has to be redefined in the African socio-centric cultural perspective using the African worldview.

This redefinition must include the effects of natural disasters, social, economic, political, gender and age abuses, as well as violations and injustices on issues that affect all our lives. The events and their impact on the individuals and community must be taken into consideration. A threat to family and community overrides a threat to self. As such, we thought initially that trauma in the African perspective should be defined as a ‘mental and health problem’, or simply a mental health crisis, which may have been caused by a natural disaster, political violence, abuse, loss and/or spiritual issues. However, the term ‘mental health’ has negative connotations in Africa, which originate from stigmatisation. The problem affects the person physically, socially, mentally and spiritually (i.e. the whole person) and as a result the community is also affected problematically. We therefore propose that this kind of trauma in Africa be called psychosocial crises.’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

The definition of psychological trauma is not limited to diagnostic criteria, however. In fact, some clinicians have moved away from considering trauma-related symptoms as indicators of a mental disorder and instead view them as part of the normal human survival instinct or as “adaptive mental processes involved in the assimilation and integration of new information with intense survival emphasis which exposure to the trauma has provided” (Turnbull, 1998, p. 88). These normal adaptive processes only become pathological if they are inhibited in some way (Turnbull, 1998), or if they are left unacknowledged and therefore untreated (Scott, 1990).

Carly Parnitzke Smith and Jennifer J. Freyd University of Oregon; Institutional Betrayal; September 2014; American Psychologist

‘Historically, definitions of traumatic experiences have tended to be narrow and in keeping with publicly accepted ideas of what might lead to disruptive levels of distress (Courtois & Ford, 2009). Typically, these identified experiences—combat, natural disasters, and violent crimes, for example—have been associated with intense fear and horror. In early editions of the American Psychiatric Association’s (2000) Diagnostic and Statistical Manual of Mental Disorders (DSM), this meant that valid traumatic experiences were largely limited to military combat, life-threatening disasters or accidents, or violent rape. Over time, the field of trauma psychology has grown to accommodate a shift in the understanding of traumatic events from one in which they are regarded as “unusual experiences” as defined by earlier editions of the DSM to one in which they are seen to include all-too-common experiences of many members of society (e.g., incest, child sexual abuse, domestic violence; American Psychiatric Association, 2013). This shift often required advocacy by outspoken critics of typical psychological practices in order to expand the field’s understanding and convince it to look at uncomfortable truths.

Efforts aimed at alleviating distress associated with traumatic experiences are typically focused on individuals rather than systems and are usually reactive rather than preventative (Hertzog & Yeilding, 2009). However, new research has begun to focus on events that are clearly traumatic and yet historically have not fit neatly within the individually focused model that has dominated the field of traumatic stress. What effect does experiencing chronic fear, stress, or mistreatment have on psychological well-being? What does it mean to find danger in a place where one instead expected to find safety? These questions mark a notable departure from descriptions of traumatic experiences as flashpoints of danger in an otherwise safe world.’


The diagnosis of PTSD has been criticized on numerous grounds, but principally for three reasons (a) the alleged pathologizing of normal events, (b) the inadequacy of Criterion A, and (c) symptom overlap with other disorders. The authors review these problems along with arguments why the diagnosis is nevertheless worth retaining in an amended form. A proposal for DSM-V is put forward that involves abolishing Criterion A, narrowing the B criteria to
focus on the core phenomena of flashbacks and nightmares, and narrowing the C and D criteria to reduce overlap with other disorders. The potential advantages and disadvantages of this formulation are discussed.


‘This review examines the question of whether there should be a cluster of disorders, including the adjustment disorders (ADs), acute stress disorder (ASD), PTSD, and the dissociative disorders (DDs), in a section devoted to abnormal responses to stress and trauma in the DSM-5. Environmental risk factors, including the individual’s developmental experience, would thus become a major diagnostic consideration. The relationship of these disorders to one another is examined and also their relationship to other anxiety disorders to determine whether they are better grouped with anxiety disorders or a new specific grouping of trauma and stressor-related disorders.’

‘The recommendation to shift ASD and PTSD out of the anxiety disorders section reflects increased recognition of trauma as a precipitant, emphasizing common etiology over common phenomenology. Similar considerations are addressed with regard to AD and DD.’

Peter Tyrer; Time to choose – DSM-5, ICD-11 or both?; Archives of Psychiatry and Psychotherapy, 2014; 3 : 5–8

‘Post-traumatic stress disorder (PTSD) is one of the more controversial diagnoses in psychiatry because, unlike almost all others, it combines aetiology with diagnosis. It has been noted previously that many patients develop all the symptoms of PTSD but in the context of normal stress rather than exceptional trauma. It is diagnosed remarkably frequently whereas the related concept of adjustment disorders is very infrequently diagnosed but would be expected to be much more frequent.

In ICD-11 the definition of post-traumatic stress disorder is much tighter than in DSM-5, so the diagnosis cannot be based entirely on non-specific symptoms. It also includes a new complex PTSD category that comprises three clusters of intra- and interpersonal symptoms that overlap with personality change, and which also includes the core symptoms of PTSD. It also redefines the disorders associated with grief as a new diagnosis –prolonged grief disorder – a condition in which patients suffer an intensely painful, disabling, and abnormally persistent response to bereavement.

There is also a major revision of adjustment disorder involving much tighter specification of symptoms; and a conceptualization of “acute stress reaction” as a normal phenomenon that still may require clinical intervention. These changes will set ICD-11 stress disorders on a different path from DSM-5.’

ICD 11 Beta Draft Foundation Id : http://id.who.int/icd/entity/2070699808

‘Disorders specifically associated with stress

- Post-traumatic stress disorder
- Complex post-traumatic stress disorder
- Prolonged grief disorder
- Adjustment disorder
- Reactive attachment disorder
- Disinhibited social engagement disorder’


‘(Using) data from the 2009 PTSD diagnostic subsample (n=3013) of women from the Nurses’ Health Study II to investigate the relative importance of traumatic events (as defined both in DSM-III and DSM-IV) as compared to non-traumatic events (e.g., miscarriage, financial problems, legal difficulties, etc.). The major comparison was between women who met all other PTSD diagnostic criteria whether or not they met Criterion A in either DSM-III or DSM-IV. The authors found that “sequelae of PTSD did not vary systematically with the type of stressful event that initiated PTSD symptoms” (whether it was traumatic or non-traumatic). The authors conclude, given their finding that events not considered traumatic produced PTSD as consequential as PTSD precipitated by a Criterion A event in either DSM-III or DSM-IV, that “PTSD may be an aberrantly severe but nonspecific stress response syndrome.”’
Complex Trauma

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘... post-traumatic stress disorder (PTSD) is now widely acknowledged and recognised. Yet (), it does not exhaust the varieties of trauma which exist. Complex trauma, which may coexist with PTSD, is not adequately described by this classificatory label (although is widely conflated and confused with it)’

‘Crucially, omission from the DSM of explicit delineation of complex trauma also obscures understanding of appropriate treatment options for those experiencing it. Omission of clear elaboration of complex trauma from the DSM in fact increases the likelihood of diagnosis of a ‘bewildering array’ of conditions and disorders for which different treatment paths are indicated, which miss and compound the complex, pervasive and underlying trauma, and which are stigmatising and pathologising.’

Trauma & Dissociation; Complex Post-traumatic Stress Disorder; http://traumadissociation.com/complexptsd

‘Complex Post-traumatic Stress Disorder, also known as "complex trauma", is the result of multiple traumatic events occurring over a period of time, for example caused by multiple incidents of child abuse. Complex Post-traumatic Stress Disorder is a not a diagnosis in the DSM-5 psychiatric manual, released in 2013,[5] but is proposed to be included in the ICD-11 diagnostic manual, due for release in 2017.’


‘In addition, it is expected that (our) guidelines will be relevant to treatment decisions based on diagnostic assessments derived from either the International Classification of Disorders (ICD; World Health Organization) or the Diagnostic Statistical Manual (DSM; American Psychiatric Association). The ICD-11 proposal includes a new diagnostic category, Complex PTSD, which would replace EAPCE and which has a symptom profile that substantially overlaps with the ISTSS profile (see World Health Organization. (n.d.) ICD-11 Alpha). In regards to the DSM-5 process, the proposal for trauma disorders currently includes a dissociative subtype of PTSD with preferred treatments likely to be similar to those recommended for Complex PTSD (see Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012).’

Trauma & Dissociation; Complex Post-traumatic Stress Disorder; http://traumadissociation.com/complexptsd

‘Complex PTSD was considered to be included within "associated features of PTSD" for the DSM-IV under the name Disorders of Extreme Stress Not Otherwise Specified (DESNOS), but this was not included in either the DSM-IV or DSM-V.[8]:23 See also: Enduring Personality Change After Catastrophic Event ICD 11 draft - Complex Post-traumatic Stress disorder The ICD-11, which is currently a draft document, includes the diagnosis of Complex Post-traumatic Stress Disorder in the Disorders specifically associated with stress section, immediately after Post-traumatic Stress Disorder. [3] Code 7B21’

‘“Complex PTSD is a disorder that arises after exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible. The disorder is characterized by the core symptoms of PTSD as well as the development of persistent and pervasive impairments in affective, self and relational functioning, including difficulties in emotion regulation, beliefs about oneself as diminished, defeated or worthless, and difficulties in sustaining relationships.”’
‘Complex post-traumatic stress disorder

Disorders specifically associated with stress

Definition
Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterized by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD have been met at some point during the course of the disorder. In addition, complex PTSD is characterized by 1) severe and pervasive problems in affect regulation; 2) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor; and 3) persistent difficulties in sustaining relationships and in feeling close to others. The disturbance causes significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Synonyms
• enduring personality change after catastrophic experience

Narrower Terms
• Personality change after: concentration camp experiences
• Personality change after: disasters
• Personality change after: prolonged: captivity with an imminent possibility of being killed
• Personality change after: prolonged: exposure to life-threatening situations such as being a victim of terrorism
• Personality change after: torture

Exclusions
Post-traumatic stress disorder’

Matthias Knefel and Brigitte Lueger-Schuster; An evaluation of ICD-11 PTSD and complex PTSD criteria in a sample of adult survivors of childhood institutional abuse; European Journal of Psychotraumatology 2013, 4: 22608 - http://dx.doi.org/10.3402/ejpt.v4i0.22608; August 2014.

‘The recently published Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013) moved PTSD from the previous chapter on “Anxiety Disorders” to include it in a chapter on “Trauma- and Stressor-related-Disorders.” The DSM-5 working group faced the same question as the ICD-11 working group, that is, whether or not a CPTSD diagnosis should be implemented. Therefore, the DSM-5 group reviewed the existing literature on CPTSD (Resick et al., 2012) and concluded that there is not enough empirical support for a distinct disorder, mainly because: (1) there is a lack of definitional consensus within and among researchers and practitioners; (2) there is a lack of reliable, valid measures; and (3) it is not yet clear if CPTSD depicts a separate construct rather than a more severe form of PTSD. However, the lively debate around CPTSD has continued despite the release of the DSM-5.’

‘The ICD-11 working group disagrees with the DSM-5 working group’s conclusion and has countered that the adoption of CPTSD as a sibling diagnosis fosters clinical utility and accommodates the needs of clinicians. The proposed ICD-11 diagnosis comprises the ICD-11 core elements of PTSD, accompanied by affect disturbances, including disturbances relating to self and interpersonal relations.’

‘A CPTSD diagnosis based on fewer PTSD symptoms might increase the chance of survivors of child maltreatment being diagnosed with a trauma-specific diagnosis and thus enhance their chance of receiving appropriate treatment, although other forms of treatment for survivors of childhood sexual abuse provide evidence for symptom reduction (Classen et al., 2011). Since PTSD and CPTSD are distinguished from other psychiatric disorders in that there is a known etiological component, survivors might also profit from the feeling of being less stigmatized compared to having other disorders.’
'The LPA [Latent Profile Analysis] revealed three classes of individuals:

(1) a complex PTSD class defined by elevated PTSD symptoms as well as disturbances in three domains of self-organization: affective dysregulation, negative self-concept, and interpersonal problems;

(2) a PTSD class defined by elevated PTSD symptoms but low scores on the three self-organization symptom domains, and

(3) a low symptom class defined by low scores on all symptoms and problems.

Chronic trauma was more strongly predictive of complex PTSD than PTSD and, conversely, single-event trauma was more strongly predictive of PTSD. In addition, complex PTSD was associated with greater impairment than PTSD. The LPA analysis was completed both with and without individuals with borderline personality disorder (BPD) yielding identical results, suggesting the stability of these classes regardless of BPD comorbidity. Conclusion: Preliminary data support the proposed ICD-11 distinction between PTSD and complex PTSD and support the value of testing the clinical utility of this distinction in field trials. Replication of results is necessary.'

'The organization of trauma-related problems into two disorders, PTSD and complex PTSD may have more clinical utility than the DSM-5 proposal of PTSD in several ways. This categorization scheme may be superior in regards to implementation characteristics. Implementation characteristics include factors such as ease of recall and use, goodness of fit (accuracy of description for any one patient) and time required to use the diagnosis.'

'In summary, the different symptom profiles that describe PTSD and complex PTSD are associated with different subgroups of individuals, different levels of impairment, and different risk factors (trauma history). These data provide evidence supporting the ICD-11 proposal for two distinct disorders, a classification organization that will facilitate clinician identification of the symptom profiles. This approach contrasts with that of the DSM-5 proposal for PTSD which has expanded the diagnosis to include symptoms related to affect dysregulation and negative self-concept (e.g., see Criteria D and E and the specifier or subtype for dissociation). The formulation of a multi-cluster, multisymptom disorder diagnosis with specifiers/subtype is inconsistent with the notion of clinical utility, particularly on a global level. International surveys have indicated that mental health providers prefer diagnoses to have a limited number of symptoms and tend to disregard subtype/specifier information (Reed, Correia, Esparza, Saxena, & Maj, 2011). The proposal to have PTSD and complex PTSD side-by-side as “sibling” disorders is responsive to clinician preferences and consistent with the overall ICD-11 classification plan for mental disorders to be presented in a “flatter” horizontal structure rather than vertical.'


'This is a very thoughtful review by and international expert on Dissociative Disorders who participated in the DSM-5 process. He recommends DSM-5 for setting aside a new category for trauma/stress disorders and argues for inclusion of Dissociative Disorders in that category. He recommends inclusion of a complex PTSD subtype of PTSD in DSM-5 and expresses concerns that the new Dissociative Subtype may be too narrow because it excludes some of the mood and interpersonal symptoms of complex PTSD. “In fact a broader understanding of dissociation would not only support new empirical research and novel treatment modalities on trauma-related disorders, but it would also facilitate formulation of new theoretical paradigms necessary to provide integrated solutions for conceptual dilemmas of the field.”'


'Complex PTSD has been proposed as a diagnosis for capturing the diverse clusters of symptoms observed in survivors of prolonged trauma that are outside the current definition of PTSD. Introducing a new diagnosis requires a high standard of evidence, including a clear definition of the disorder, reliable and valid assessment measures, support for convergent and discriminant validity, and incremental validity with respect to implications for treatment planning and outcome. In this article, the extant literature on complex PTSD is reviewed within the framework of construct validity to evaluate the proposed diagnosis on these criteria. Although the efforts in support of complex PTSD have brought much needed attention to limitations in the trauma literature, we conclude that available evidence does not support a new diagnostic category at this time. Some directions for future research are suggested.'
While important structural and clinical differences continue to distinguish all classificatory systems, and while there still remain some significant national idiosyncrasies in classifications and clinical practice, clinical standardization has been massive in the past decades and might well constitute one of the most striking events in the recent history of psychiatry.

M. Hakan Türkçapar; How will DSM 5 and ICD-11 Affect the Treatment Guidelines?; Abstracts of the Speakers’ Presentations / Konuşmacı Sunum Özetleri; [PS-02]

To classify things in the world is a basic cognitive tendency of human beings. Natural classes are best organized around the prototypes or typical examples. In a good class, all members of the class have to be homogenous and all classes have to be distinguished from each other clearly. Unfortunately, most of the psychiatric diagnosis doesn’t conform to this definition. Most of the diagnostic categories contain proto-type diagnostic categories, which have typical clinical characteristics of that category but on the other hand there are some patients, who don’t exactly match to that category. There are also unclear boundaries between diagnostic categories. Unclear boundaries exist not only between diagnostic categories but also normal and pathological entities. Good examples of this can be found in personality disorders.


As psychology journals continue to have greater international contributions, having two different major classification systems creates more confusion regarding diagnoses. This confusion is somewhat tempered by the fact that the DSM–IV is used more internationally with researchers than with clinicians; however, this increases the gap between international research and practice. Having two different versions of the ICD–10 also adds to the possible confusion.

Wikipedia; Classification of Mental Disorders; https://en.wikipedia.org/wiki/Classification_of_mental_disorders

The classification of mental disorders, also known as psychiatric nosology or taxonomy, is a key aspect of psychiatry and other mental health professions and an important issue for people who may be diagnosed. There are currently two widely established systems for classifying mental disorders—Chapter V of the International Classification of Diseases (ICD-10) produced by the World Health Organization (WHO) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) produced by the American Psychiatric Association (APA). Both list categories of disorders thought to be distinct types, and have deliberately converged their codes in recent revisions so that the manuals are often broadly comparable, although significant differences remain. Other classification schemes may be in use more locally, for example the Chinese Classification of Mental Disorders. Other manuals have some limited use by those of alternative theoretical persuasions, such as the Psychodynamic Diagnostic Manual.

The widely used DSM and ICD classifications employ operational definitions. There is a significant scientific debate about the relative validity of a "categorical" versus a "dimensional" system of classification, as well as significant controversy about the role of science and values in classification schemes and the professional, legal and social uses to which they are put.

In the scientific and academic literature on the definition or categorization of mental disorders, one extreme argues that it is entirely a matter of value judgments (including of what is normal) while another proposes that it is or could be entirely objective and scientific (including by reference to statistical norms);[2] other views argue that the concept refers to a "fuzzy prototype" that can never be precisely defined, or that the definition will always involve a mixture of scientific facts (e.g. that a natural or evolved function isn’t working properly) and value judgments (e.g. that it is...
harmful or undesired). Lay concepts of mental disorder vary considerably across different cultures and countries, and may refer to different sorts of individual and social problems.

The WHO and national surveys report that there is no single consensus on the definition of mental disorder/illness, and that the phrasing used depends on the social, cultural, economic and legal context in different contexts and in different societies. The WHO reports that there is intense debate about which conditions should be included under the concept of mental disorder; a broad definition can cover mental illness, mental retardation, personality disorder and substance dependence, but inclusion varies by country and is reported to be a complex and debated issue. There may be a criterion that a condition should not be expected to occur as part of a person's usual culture or religion. However, despite the term "mental", there is not necessarily a clear distinction drawn between mental (dys)functioning and brain (dys)functioning, or indeed between the brain and the rest of the body.'


What is the difference between the ICD and DSM?

The ICD is a core function of the World Health Organization, spelled out in its constitution and ratified by all 193 WHO member countries. The ICD has existed for more than a century, and became WHO's responsibility when it was founded in 1948 as an agency of the United Nations. Before 1980, psychiatric diagnostic systems reflected the dominant psychoanalytic ideas of the time, emphasizing the role of experience, downplaying biology.

"The American Psychiatric Association can really be credited with a revolution in psychiatric nosology with the publication of DSM-III by introducing a descriptive nosological system based on co-occurring clusters of symptoms," said WHO psychologist Geoffrey Reed, PhD.

There was very little international participation in the DSM-III, but at the time it may have been impossible to make such a big shift at the international level, he explained. As a result, DSM-III and ICD-8 (the version in effect at the time) were quite different from one another but as the descriptive phenomenological approach to diagnose mental disorders became dominant, the DSM and ICD have become very similar, partly because of collaborative agreements between the two organizations.

Still, there is widespread sentiment that it is not helpful to the field to have two separate classification systems for mental disorders. Many important distinctions between the two systems remain, Reed said:

- The ICD is produced by a global health agency with a constitutional public health mission, while the DSM is produced by a single national professional association.
- WHO's primary focus for the mental and behavioral disorders classification is to help countries to reduce the disease burden of mental disorders. ICD's development is global, multidisciplinary and multilingual; the primary constituency of the DSM is U.S. psychiatrists.
- The ICD is approved by the World Health Assembly, composed of the health ministers of all 193 WHO member countries; the DSM is approved by the assembly of the American Psychiatric Association, a group much like APA's Council of Representatives.
- The ICD is distributed as broadly as possible at a very low cost, with substantial discounts to low-income countries, and available free on the Internet; the DSM generates a very substantial portion of the American Psychiatric Association's revenue, not only from sales of the book itself, but also from related products and copyright permissions for books and scientific articles.

Will the DSM be superseded by the ICD? There is little justification for maintaining the DSM as a separate diagnostic system from the ICD in the long run, particularly given the U.S. government's substantial engagement with WHO in the area of classification systems. But, said Reed, "there would still be a role for the DSM, because it contains a lot of additional information that will never be part of the ICD. In the future, it may be viewed as an important textbook of psychiatric diagnosis rather than as the diagnostic 'Bible.'"

Peter Tyrer; Time to choose – DSM-5, ICD-11 or both?; Archives of Psychiatry and Psychotherapy, 2014; 3 : 5–8

‘ICD 11 will not be published for at least another 18 months, but it has the advantage of being able to respond to some extent to the criticisms that have followed the publication of DSM-5. The main problem with the ICD 11 reclassification system is that it is very poorly resourced compared with DSM, Perhaps this avoids arguments about conflict of interest as there is virtually no financial benefit to be gained by anyone in helping with this revision.’
'It would be premature to outline the current plans for the new diagnostic system as it is some way for publication but the following points ought to be remembered:

I. the International Classification of Diseases is the official world classification of all diseases and DSM has been the only competitor (in the case of psychiatry). The DSM classification was set up in the face of poor use of the earlier ICD classifications and there were good reasons for stimulating a new classification, which was illustrated by the tremendous success of DSM-III when it was published in 1980. We therefore need to be good reasons for continuing

II. with DSM in the longer term, as it represents an anomaly.

III. (Some) have referred, somewhat mockingly, to the letters DSM as standing for either diagnosis for simple minds or diagnosis as a source of money. Like all short summaries. This can be regarded as unfair, but there is absolutely no doubt that the relatively simple way of recording DSM diagnoses is sometimes a substitute for proper thought, and that financial influences of strongly to bear when deciding on the structure of DSM-5.

IV. Both ICD and DSM share much more than they differ, but when they do differ. It is important that practitioners are aware of the reasons for this and can decide to choose.

V. Researchers generally preferred DSM for classification purposes because its criteria are much tighter than those in ICD. ICD-11 will however be published with other material to aid researchers and this will partly compensate for the past deficiencies in the classification.

What is already clear in that there will be many differences between DSM-5 and ICD-11 that cannot be papered over as minor variation.'

Suzanne Bennett Johnson; 2013 APA Past-President; What is the ICD and Why Should Psychologists Care?

<table>
<thead>
<tr>
<th>Other Reasons to Change to the ICD</th>
<th>DSM</th>
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<tr>
<td>Produced by global health agency of United Nations</td>
<td>Produced by single national professional association</td>
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<tr>
<td>Free and open resource to advance public good</td>
<td>Provides large proportion of ApA revenue</td>
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<td>For: 1) countries; and 2) front-line service providers</td>
<td>For psychiatrists</td>
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<td>Global, multidisciplinary, multilingual development</td>
<td>Dominated by US, Anglophone perspective</td>
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<td>Approved by World Health Assembly</td>
<td>Approved by ApA Board of Trustees</td>
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<td>Covers all health conditions</td>
<td>Covers only mental disorders</td>
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Reed 2013

<american psychological association>
Why we should use ICD in South African mental health practice? There are seven good reasons why we should think carefully about favouring the ICD over the DSM classificatory system.

1. The ICD is an international classification system developed by the WHO. The WHO is an organization that has an expressly public health agenda and global credibility.
2. The development of ICD and its revised editions is a highly consultative process, with full international representation on the task teams; with applicability to cross-cultural settings identified as one of its key priorities.
3. ICD provides descriptive “prototypes” to guide diagnosis, rather than arbitrary checklists of criteria that have dubious validity.
4. In South Africa, public health practitioners and institutions are required by law to report clinical “cases” using the ICD-10 coding system.
5. In the private sector in South Africa, medical insurance companies require practitioners to code their patients using the ICD-10 system.
6. The development and revisions of ICD entail a significant overall investment in the process and there are no financial gains reaped by the WHO from its publication and distribution. Ethically, it should be the preferred choice.
7. Finally, unlike DSM, ICD has not attracted widespread criticism and is not vilified in the public mind; unlike its much despised and distrusted cousin!”