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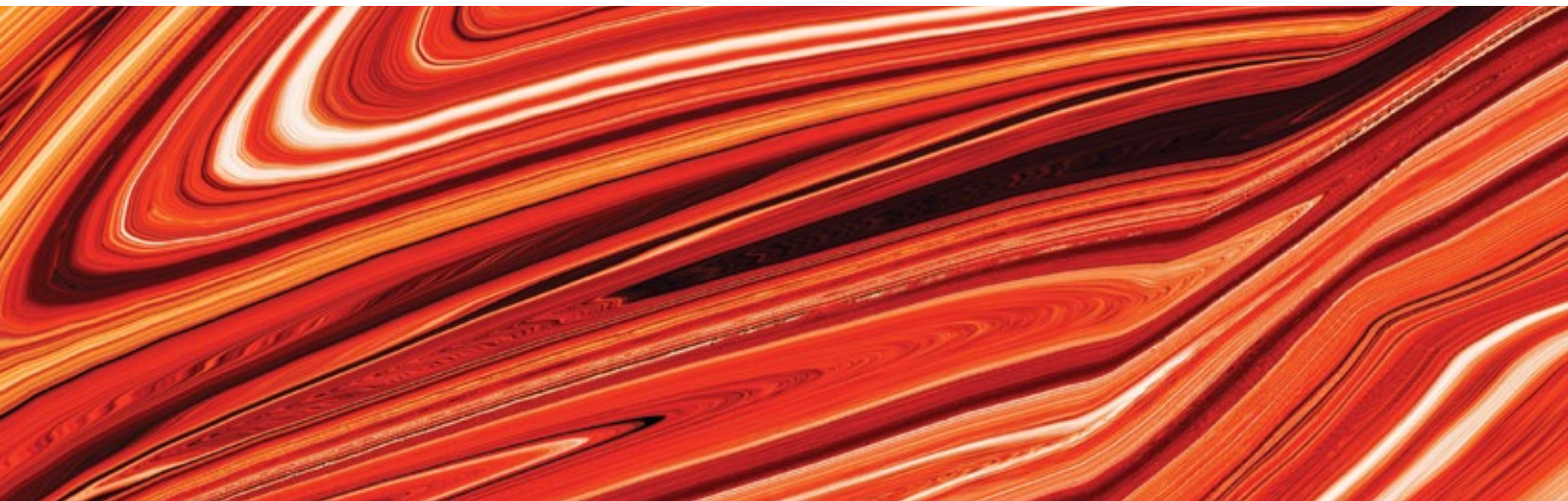
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**Consortium Psychiatricum**

2, Zagorodnoe shosse,  
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Phone/fax: +7 (495) 952-11-14  
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Dear colleagues,

I am pleased to introduce the second issue of Consortium Psychiatricum journal in 2021. It is a thematic issue devoted to the forthcoming ICD-11 implementation and to the chapter on Mental, Behavioural and Neurodevelopmental Disorders. From 2022, country members of the World Health Organization are recommended to start the transition from ICD-10 to ICD-11. Knowledge of changes in the classification is essential for its further adoption along with awareness of attitudes and concerns about ICD-11 innovations among mental healthcare professionals.

In this issue, we collected articles that, from our point of view, highlight the changes in the classification system and at the same time reflect the views of professionals from different countries of the world.

The editorial article on ICD-11 Revision of Mental Disorders is presented by a group of experts including Dr. Melita Vujnovic, WHO Representative to the Russian Federation, and Professor Geoffrey Reed who served as the Senior Project Officer for the ICD-11 chapter on Mental, Behavioral and Neurodevelopmental Disorders and other related chapters.

Cultural aspects of mental disorders that play a substantial role in the new classification are explored in the review article. A report on the participation of Russian clinicians in the ICD-11 development and implementation is followed by two research articles presenting studies of the attitudes of the Russian professional community regarding ICD-11 and the use of ICD-10 by Russian psychiatrists.

From this issue we start a new rubric in the journal – Discussion – where different views on the same problem are presented. We publish two articles on the gender identity issue in relation to the fundamental changes made in ICD-11 depathologizing transgender identities. A detailed review of the transgender concepts that preceded the removal of gender identity from the mental disorders chapter is presented in one article, while another article focuses on the problem of high mental health comorbidity prevalence in transgender people that may require close attention by mental health professionals.

Another new rubric in the journal is named Historical Perspective. We plan to publish keynote papers of the past that influenced progress in psychiatry, accompanied by commentaries by contemporary professionals, or papers by contemporary authors that illuminate the historical background of the concepts that are still developed or discussed in current times. In this issue, we publish an article about the evolution of approaches to schizophrenia diagnostics from Kraepelin to the present.

A commentary on the perspectives of ICD-11 implementation in Russia is made by Professor Valery Krasnov who was a principal in the ICD-11 field studies in Russia.

Our traditional rubric - Special Articles - on the organization of community mental care by countries, is also continued in this issue. The experience of Qatar, Serbia and Italy is shared by distinguished experts from these regions.

I hope you enjoy reading this issue and that the topics raised can provoke a discussion in the professional community. I welcome your views and comments in the Letters to the Editor.

**George Kostyuk,**

*Editor-in-Chief, Consortium Psychiatricum*

# ICD-11 Revision of Mental Disorders: the Global Standard for Health Data, Clinical Documentation, and Statistical Aggregation

Классификация психических расстройств в МКБ-11: единый стандарт для медицинской документации и сбора статистических данных в здравоохранении

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**Melita Vujnovic<sup>1</sup>, Olga Manukhina<sup>1</sup>,  
Geoffrey M. Reed<sup>2</sup>, Pavlos N. Theodorakis<sup>1</sup>,  
Konstantinos N. Fountoulakis<sup>3</sup>**

<sup>1</sup>WHO Country Office in the Russian Federation

<sup>2</sup>Department of Psychiatry Columbia University Vagelos  
College of Physicians and Surgeons, New York, NY, USA

<sup>3</sup>3rd Department of Psychiatry, School of Medicine, Faculty  
of Health Sciences, Aristotle University of Thessaloniki, Greece

**Мелита Вуйнович<sup>1</sup>, Ольга Манухина<sup>1</sup>,  
Джеффри М. Рид<sup>2</sup>, Павлос Н. Теодоракис<sup>1</sup>,  
Константинос Н. Фунтулакис<sup>3</sup>**

<sup>1</sup>Страновой офис ВОЗ в Российской Федерации;

<sup>2</sup>Кафедра психиатрии, Высшая медицинская школа  
Валегоса, Колумбийский университет, Нью-Йорк,  
штат Нью-Йорк, США; <sup>3</sup>3-я кафедра психиатрии, Школа

медицины, факультет медицинских наук, Университет  
Аристотеля в Салониках, Греция

## ABSTRACT

Mental health conditions in the World Health Organization (WHO) European Region affect more than 10% of the population, with 140,000 lives lost annually to suicide. Comorbidity with other diseases is high. However, basic mental health care is received by less than a third of patients. The COVID-19 pandemic has revealed the vulnerability of mental health services to disruptions and underscored the need to integrate mental health into response strategies. One of the flagship initiatives of the WHO European Programme of Work (EPW), 2020–2025: 'United Action for Better Health in Europe' is the establishment of a Mental Health Coalition at the European level. In this framework, reporting of health statistics using the International Classification of Diseases 11<sup>th</sup> Revision (ICD-11) will begin on 1st January 2022. Clinical utility, scientific rigour and wider cultural applicability were all of prime importance in the development of the ICD-11. The 11th Revision was the end product of the most extensive global, multilingual, multidisciplinary and participative process ever undertaken for this task, involving more than 15,000 experts from 155 countries, representing approximately 80% of the world's population. With the adoption of the ICD-11 and the priority being given to mental health, new ideas based on the 30 years of research since the approval of the ICD-10 will be widely adopted and applied.

## АННОТАЦИЯ

Психические расстройства в Европейском регионе Всемирной организации здравоохранения (ВОЗ) затрагивают более 10% населения, при этом ежегодно в результате самоубийств погибает 140 000 человек. Отмечается также высокая коморбидность с другими заболеваниями. Однако базовую психиатрическую помощь получают менее трети пациентов. Пандемия COVID-19 выявила уязвимость служб психиатрической помощи в сложившихся условиях и подчеркнула необходимость интеграции охраны психического здоровья в общие стратегии реагирования. Одна из флагманских инициатив Европейской программы работы ВОЗ (ЕПР) на 2020–2025 годы: «Совместные действия для улучшения здравоохранения в Европе» — это создание Коалиции

по охране психического здоровья на европейском уровне. В этой связи представление статистических данных здравоохранения с использованием 11-й редакции Международной классификации болезней (МКБ-11) начнется 1 января 2022 года. Клиническая полезность, научная строгость и более широкая применимость с учетом культуральной специфики имели первостепенное значение при разработке МКБ-11. 11-я версия стала итогом самого масштабного глобального, многоязычного и мультидисциплинарного процесса пересмотра, когда-либо предпринимавшегося для решения подобной задачи, с участием более 15 000 экспертов из 155 стран, что составляет примерно 80% населения мира. С принятием МКБ-11 и повышением внимания к проблемам психического здоровья новые идеи, основанные на результатах исследований за последние 30 лет с момента утверждения МКБ-10, получают широкое распространение и применение.

**Keywords:** *ICD-11; mental disorders; World Health Organization; Europe*

**Ключевые слова:** *МКБ-11; психические расстройства; Всемирная организация здравоохранения; Европа*

Even before the COVID-19 pandemic, the number of individuals with mental health conditions in the WHO European Region stood at over 110 million people, equivalent to more than 10% of the population.<sup>1,2</sup> Moreover, 140,000 lives are lost each year in the Region to suicide, an unacceptably high figure that includes an increasing number of young people.<sup>3</sup> Comorbidity with other non-communicable diseases (NCDs)<sup>4</sup> and with communicable diseases such as tuberculosis<sup>5,6</sup> and HIV<sup>7</sup> is frequent, with mental health conditions sharing many of the same risk factors. Yet, out of all those in the European Region with the most common mental health conditions – depression and anxiety – the proportion receiving even basic care and support is at best a third, and as low as 5-10% in some European countries.<sup>1,2</sup>

The COVID-19 pandemic has revealed to an even greater extent the vulnerability of public health systems to health emergencies, particularly related to disruptions to mental health services. It has underscored the need to integrate mental health into present and future preparedness and response strategies.

The WHO European Programme of Work (EPW), 2020–2025: «United Action for Better Health in Europe», adopted in Copenhagen last September at the 70th session of the WHO Regional Committee for Europe, consists of four flagship initiatives that complement its three core priorities. They are intended as accelerators of change, mobilizing around critical issues that feature prominently on the Member States' agendas. One of these four flagship initiatives is the establishment of a Mental Health Coalition at the European level. The upcoming World Health Assembly 2021 will devote considerable attention to mental health as a crucial part of a whole-

of-society approach and universal health coverage, and to the WHO's capacity to strengthen its work on mental health at global, regional and country levels, through the updated Mental Health Global Action Plan for 2013-2030.

With the ICD-11 approval by the World Health Assembly in May 2019, after more than a decade of intensive work, the transition from ICD-10 to the new ICD-11 for all Member States of the WHO has officially begun. Member States will be able to begin reporting health statistics using the ICD-11 as a framework from 1<sup>st</sup> January 2022.

The development of the ICD-11 chapter on Mental, Behavioural and Neurodevelopmental Disorders has been informed by several core principles, including clinical utility, international, transcultural and global applicability, and a multidisciplinary approach.<sup>8</sup> Clinical utility was considered to be among the most important elements because it would determine the system's acceptance by practitioners and therefore influence its role in treatment design and various administrative and social functions, including pensions and legal determinations.<sup>9</sup>

The Clinical Descriptions and Diagnostic Guidelines (CDDG) for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders has followed this same approach based on a strong scientific methodology.<sup>10,11</sup> It demanded collaboration among hundreds of international experts in specific fields and extensive collaboration with WHO Member States, funding agencies and professional and scientific societies. This was the most extensive global, multilingual, multidisciplinary and participative process ever undertaken for the development or the revision of a classification system for mental disorders.



It included more than 15,000 experts from 155 countries, representing approximately 80% of the world's population.<sup>12</sup>

Prime features of the development of the ICD-11 CDDG were: 1) the systematic gathering and distilling of data and information; 2) a lifespan approach rather than a cross-sectional conceptualization; 3) a focus on more pragmatic indices, including long-term comorbidity and disability. The sources and the final text of the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition (DSM-5) were also carefully reviewed. While there are considerable differences between the ICD-11 and the DSM-5, these are substantive and intentional rather than accidental, unnecessary or unsupported by data.

Comorbidity is considered to be one of the most problematic issues in modern classification systems along with the excess fragmentation of nosological entities, sometimes referred to as the 'atomization of psychopathology'.<sup>13,14</sup> Some of the changes in the ICD-11 were made to decrease this artificial comorbidity, using broader categories like Bodily Distress Disorder and dimensional approaches, such as in Personality Disorder. A developmental approach to mental disorders has also unified the classification of child and adult presentations, with attention to presentations in older adults. This has facilitated the emphasis within the ICD-11 on a recovery-based viewpoint. Whereas the ICD-10 used a dichotomy between organic and non-organic mental disorders, such a rigid conceptualization was avoided in the 11<sup>th</sup> Revision.

A substantially new structure for the subclassification of mental disorders was followed (Table 1), which is also broadly compatible with the structure of the DSM-5. Regarding the disorders related to sexuality, paraphilic disorders (referred to as disorders of sexual preference in the ICD-10) were retained in the chapter on mental disorders. Sexual dysfunctions and gender incongruence (called Gender Identity Disorders in the ICD-10) were moved to a novel chapter specifically created for conditions related to sexual health.<sup>11,15</sup>

Several new nosological entities were created on the basis of data that had emerged since the approval of the ICD-10. Examples of such new entities are Bipolar II Disorder, Body Dysmorphic Disorder and Hoarding Disorder. Another unique characteristic is the adoption of a dimensional approach; in particular, it is notable that this was used not only for personality

**Table 1. ICD-11 Chapter on mental, behavioural and neurodevelopmental disorders: disorder groupings**

Neurodevelopmental disorders
Schizophrenia and other primary psychotic disorders
Catatonia
Mood disorders
Anxiety and fear-related disorders
Obsessive-compulsive and related disorders
Disorders specifically associated with stress
Dissociative disorders
Feeding and eating disorders
Elimination disorders
Disorders of bodily distress and bodily experience
Disorders due to substance use and addictive behaviours
Impulse control disorders
Disruptive behaviour and dissocial disorders
Personality disorders
Paraphilic disorders
Factitious disorders
Neurocognitive disorders
Mental and behavioural disorders associated with pregnancy, childbirth and the puerperium
Psychological and behavioural factors affecting disorders or diseases classified elsewhere
Secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere

disorders but also for psychotic disorders. The extent to which this revolutionary change will be adopted by practitioners and its impact on reported data remain to be seen.

Cultural applicability<sup>16-18</sup> was also of prime importance and therefore flexibility in clinical judgement was allowed, facilitating the incorporation and utilization of local knowledge when it can aid in clinical decisions.

The ICD-11 represents the first revision of the ICD for nearly 30 years and reflects both an unprecedented

effort and advances in methodological quality. With the end product now in place, the most difficult phase, that of rigorous implementation should begin, with a focus on training and on adoption of the ICD-11 in training and educational curricula.

**Authors contribution:** Melita Vujnovic and Olga Manukhina conceptualized the paper and provided feedback on the manuscript; Konstantinos N. Fountoulakis and Pavlos N. Theodorakis drafted the first version of the manuscript; Geoffrey M. Reed revised and edited the manuscript. All authors approved the final version of the manuscript.

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**Correspondence to:**

**Dr. Melita Vujnovic**  
vujnovicm@who.int

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# Cultural Issues Related to ICD-11 Mental, Behavioural and Neurodevelopmental Disorders

Культуральные аспекты психических и поведенческих расстройств и нарушений нейропсихического развития в МКБ-11

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**Pratap Sharan, Gagan Hans**

*The Department of Psychiatry All India Institute of Medical Sciences, New Delhi, India*

**Пратап Шаран, Гаган Ханс**

*Департамент психиатрии, Всеиндийский институт медицинских наук, Нью Дели, Индия*

## ABSTRACT

The challenge of producing a classificatory system that is truly representative of different regions and cultural variations is difficult. This can be conceptualized as an ongoing process, achievable by constant commitment in this regard from various stakeholders over successive generations of the classificatory systems. The objective of this article is to conduct a qualitative review of the process and outcome of the efforts that resulted in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders becoming a global classification. The ICD-11 represents an important, albeit iterative, advance in the classification of mental, behavioural and neurodevelopmental disorders. Significant changes have been incorporated in this regard, such as the introduction of new, culturally-relevant categories, modifications of the diagnostic guidelines, based on culturally informed data and the incorporation of culture-related features for specific disorders. Notwithstanding, there are still certain significant shortcomings and areas for further improvement and research. Some of the key limitations of ICD-11 relate to the paucity of research on the role of culture in the pathogenesis of illnesses. To ensure a classificatory system that is fair, reliable and culturally useful, there is a need to generate empirical evidence on diversity in the form of illnesses, as well as mechanisms that explain these in all the regions of the world. In this review, we try to delineate the various cultural challenges and their influences in the formulation of ICD-11, along with potential shortcomings and areas in need of more improvement and research in this regard.

## АННОТАЦИЯ

Задача создания классификационной системы, которая действительно бы учитывала региональные и культуральные различия, является достаточно сложной. Это долгий процесс, ориентированный на последующие изменения классификации, с участием всех заинтересованных сторон. Цель данной статьи - представить содержательный обзор этапов разработки и результатов усилий, которые привели к тому, что классификация психических, поведенческих расстройств и нейропсихического развития в МКБ-11 становится поистине глобальной, т.е. применимой во всем мире. МКБ-11 делает важный очередной шаг вперед в развитии классификации. Это связано с такими значимыми изменениями, как внесение новых культурально значимых категорий, обновление диагностических указаний в соответствии с данными, полученными в разных странах, и учет культуральной специфики определенных расстройств.

Несмотря на это, все еще имеются некоторые существенные недостатки и вместе с тем возможности для развития и проведения исследований. Некоторые из ключевых ограничений МКБ-11 связаны

с недостаточным изучением роли культуры в патогенезе заболеваний. Для обеспечения ясной, надежной и полезной с учетом культурного контекста классификационной системы необходимо собрать воедино эмпирические доказательные данные о разнообразии проявлений болезней, а также их патогенеза, в разных регионах мира. В этом обзоре делается попытка обозначить изменения МКБ-11, связанные с различными культуральными аспектами, а также потенциальные недостатки и пути дальнейшего совершенствования с опорой на исследования в этом направлении.

**Keywords:** *ICD-11; WHO; culture; mental disorders; classification*

**Ключевые слова:** *МКБ-11; ВОЗ; культура; психические расстройства; классификация*

## **INTRODUCTION**

The establishment, maintenance and revision of the International Classification of Diseases and related health problems (ICD) is a core constitutional responsibility of the World Health Organization (WHO). Revisions are undertaken at regular intervals to keep abreast of the recent scientific advances in understanding various disorders.

Cultural considerations are important in terms of classification, as they improve diagnostic assessments when cultural issues are involved, reduce iatrogenic harm resulting from the misdiagnosis of cultural problems, improve the treatment of such problems by stimulating clinical research and encourage clinical training centres to address the cultural dimensions of human existence. However, an international classification system has to strike a pragmatic balance between the need for a universal classificatory system that can facilitate the reliable communication of clinical information across geographic and cultural boundaries, while retaining the ability to be contextually and culturally relevant during the clinical encounter,<sup>1</sup> as this encounter translates into health information and health action.

A universalizing approach is detrimental to health information since the multiplicity of cultural expressions of mental disorders lead to difficulties in diagnoses, as exemplified by a 34-fold difference in the prevalence of social anxiety disorder in various cross-national studies, utilizing similar methodologies<sup>2</sup> and by markedly different prevalence rates for ADHD in the regions, utilizing the ICD and DSM classification system.<sup>3</sup> Although these differences could be due to multiple reasons, it is possible that the guidelines that are based on the experiences of a few cultures, fail to capture the expression of the disorders in others. In addition to difficulties in correctly labelling/diagnosing cultural

variants of mental disorders, treating sociocultural manifestations and processes as epiphenomenal, may impact on the understanding of the etiological role of cultural factors in the development of mental disorders.<sup>4</sup> Ignoring the sociocultural aspects of mental illness may have scientific consequences, however, equally important are the social justice repercussions of this approach, e.g., the risk of misdiagnosis and perpetuation of clinical stereotypes, based on race, ethnicity, gender, religion and sexual orientation.<sup>5</sup> There is, therefore, a need to explore the alternate symptom expressions, variations and overlap between the different disorders, risk moderation and exploratory models in diverse cultures for a comprehensive and inclusive nosology.<sup>6</sup>

The objective of this article is to conduct a qualitative review of the process and outcome of the efforts that resulted in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders becoming a global classification.

## **ATTENTION TO CULTURAL ISSUES IN ICD-11**

The ICD-10 Clinical Descriptions and Diagnostic Guidelines (CDDG) has previously noted the presence of cultural variations in the expression of disorders under broad disorder groupings (e.g., somatoform disorder) and in help-seeking and illness-related behaviours. However, considerations related to culture were not systematically incorporated in the manual.<sup>1,7</sup> This led to a situation in which a number of national and regional adaptations were proposed to address cultural variations in the expression of mental disorders, including the Chinese Classification of Mental Disorders, the Japanese Clinical Modification of the ICD-10, the Latin American Guide for Psychiatric Disorders and the Cuban Glossary of Psychiatry.<sup>8</sup>

The ICD-11 has been developed for global application. Reflecting the cultural context in which clinical encounters take place is likely to enhance this goal. Accordingly, ICD-11 has emphasized cultural considerations as impacting all patient encounters rather than focusing on a few exotic (and rare) culture bound syndromes.

## **THE PROCESS OF ICD-11 DEVELOPMENT**

### **Cultural considerations in the overall developmental process of the ICD-11**

The WHO implemented several strategies to enhance the cultural applicability of the ICD-11 mental and behavioural disorders classification. The first strategy was an international and multilingual review of the literature to evaluate major trends, themes and areas of active debate related to the classification of mental disorders, in particular, with regard to clinical utility in low- and middle-income countries<sup>9</sup> (LMIC).<sup>\*</sup> This was carried out in addition to gathering information and recommendations on the alternate descriptions of various disorders. A systematic analysis of country-level and regional diagnostic systems for mental disorders was also conducted along these lines. For example, the Third Cuban Glossary of Psychiatry included several categories, not featured in the ICD-10, which focus specifically on problems related to functioning in the family environment (e.g., among people with intellectual disabilities).<sup>10</sup> This is consistent with a strong cultural emphasis on family in Cuba, as compared with the USA or Western Europe but may also have significant utility for treatment planning, given that the family is likely to be a key vehicle for support and social inclusion, in many countries. The second strategy was significant engagement of the diverse constituency groups and consultation with the representatives of various geographical regions of the world.<sup>11</sup> This information was supplemented with surveys of psychiatrists<sup>12</sup> and psychologists<sup>13</sup> in collaboration with other leading organizations, including the World Psychiatric Association (WPA). The third strategy was to adopt greater flexibility in the description of the various psychiatric disorders to make them more inclusive for varying presentations.<sup>14,15</sup> This strategy also advocated

the utilization of prototypical descriptions, as opposed to lists of criteria, to facilitate the inclusion of cultural variations, as well as contextual and health system factors, affecting diagnostic practice.<sup>16</sup> The fourth strategy was to conduct a series of systematic field studies, focusing on clinical utility and global applicability through a network of field study centres in large LMICs.<sup>9,15</sup> In addition, the field testing of ICD-11 has further enhanced the validity and reliability of various disorders, cutting across cultural groups globally, with regard to its accuracy, consistency and clinical utility. All these developments led to the infusion of sociocultural perspectives, with structural features to support the cultural utility of ICD-11.<sup>14,17</sup>

### **ICD-11 Working group focused on cultural influences**

The WHO constituted a working group, with the primary aim of developing cultural guidance for the ICD-11 CDDG. The 'ICD-11 Working Group on Cultural Influences' formulated certain relevant questions for eliciting the factors which account for cultural variations that were related to: (1) the influence of culture on the presentation of disorders and the mechanisms thereof, (2) whether the differences in the prevalence of various disorders between populations could be attributed to cultural factors and linked to cultural mechanisms and (3) the identification of cultural concepts of distress (idioms, syndromes, explanations/causes) in various cultural groups, which are related to various disorders.<sup>1</sup> An example of the recommendations that emerged from this exercise is presented in Box 1.

### **Discussions in workgroups on specific disorders**

The fact that classification in psychiatry is still essentially based on the best judgement of a group of experts, who tend to rely on data, largely generated from the western populations, make its global applicability questionable.<sup>18</sup> The WHO has sought to include a significant number of members in the different working groups from LMIC, to tap into diverse cultural experiences for inclusive decision-making.<sup>11,19,20</sup> An example of recommendations that emerged from discussions within various workgroups is highlighted in Box 2.

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\* WHO Member States are grouped into four income groups [low, lower-middle, upper-middle and high] based on the World Bank list of classification of economies, which is based on the gross national income per capita estimates<sup>9</sup>

### Box 1: cultural considerations for adjustment disorder:

- Adjustment disorder may be exacerbated by limited family or community support, particularly in collectivistic or sociocentric cultures. In these societies, the focus of the worry may extend to stressors, affecting close relatives or friends.
- Adjustment disorder reactions that include dissociative symptoms may be more prominent in certain cultural groups.
- Symptoms of the disorder may be influenced by local idioms (e.g., *susto* or *espanto* [fright] in Central America) that are associated with fear or subsequent worry regarding a stressor with strong cultural connotations (e.g., becoming suddenly frightened when crossing an unpopulated area alone at night). These idioms are also applicable to anxiety disorders.

### Box 2: cultural variant of rumination-regurgitation disorder: deliberation of the workgroup on eating disorders

A case vignette from South Asia was presented to the work group that did not fit the modal presentation of rumination disorder, along with relevant literature from the region.<sup>21-23</sup>

**The case:** MS, is a 16-year-old boy. He was referred from the gastroenterology outpatient department because of 'persistent vomiting' and loss of weight over a two-year period for which medical-surgical causes could not be established.

He presented with a history of 'vomiting' after meals, initially after an occasional meal and, subsequently, after each meal. He reported a sense of fullness and pain in his abdomen after meals but no nausea. The 'vomiting' was spontaneous and was preceded either by no or minimal retching and was described as 'a filling up of the mouth by the recently consumed food/beverages.' He never induced 'vomiting' and did not try to vomit in secret. The contraction of the abdominal muscles to facilitate 'vomiting' was reported in the initial six months, but 'vomiting' became automatic with the passage of time. He had cut down on food "to avoid vomiting", to 25% of his usual intake. His weight at the time of admission was 40 kilograms and he had lost 37% of his weight, compared with his premorbid state. His BMI was 14.28. He had stopped interacting with anyone other than his immediate family and had not attended school for the last 18 months, because of persistent 'vomiting.'

The patient did not consider himself overweight at his premorbid weight (62 kilograms). He used to exercise regularly before the onset of illness and had continued to do so for the initial six months, when he was 'vomiting' occasionally after meals. Though, he did not report any dismay at his current emaciation, he accepted that an effort to increase his weight was justified. He denied binge eating or a conscious motivation to diet, use of laxatives or diuretics. He did not report sustained sadness or depressive thoughts. He had complained of aches and pains for the last 18 months and had almost stopped walking without assistance for the last three months.

**Discussion in the working group:** MS would not meet the requirement for a typical case of rumination disorder in ICD-11, because although the food comes back up without retching, it is not re-chewed and re-swallowed, or spat out. It is not held in the mouth for any length of time and does not go up and down the oesophagus. Instead, as in the case of vomiting, it comes up and is expelled in one movement.

**The solution:** In the culture-related features (as known and relevant) for rumination disorder, it was clarified that: certain cases of what has been considered to be 'psychogenic vomiting', particularly in South Asia, may actually be cultural variants of rumination disorder, and the latter should be regarded as a differential diagnosis, in cases of psychogenic vomiting.

This cultural variant of rumination disorder is characterized by repeated regurgitation of food, that is usually associated with the emptying of the mouth, rather than re-chewing or re-swallowing. Initially, individuals with this disorder seem to volitionally (usually by contracting abdominal muscles) (as inferred from detailed clinical evaluation of their behaviour) and repeatedly bring up partially digested food back into the mouth (i.e., regurgitation) after being previously swallowed, with relative ease; there is minimal physical discomfort or anxiety, associated with this behaviour. Rumination disorder should only be diagnosed if the behaviour is frequent (at least several times per week), occurs over a period of several weeks (e.g., at least four weeks). The diagnosis of rumination disorder should not be made in the context of an associated medical condition (e.g., oesophageal strictures or neuromuscular disorders affecting oesophageal function), when the medical condition wholly accounts for the behavioural symptoms. Subsequently, effortless regurgitation seems to become automatic, and at times, progresses to regurgitating the entire meal after most meals. If substantial weight loss occurs, evaluation for anorexia nervosa may need to be considered. Compared to psychogenic vomiting, rumination disorder is diagnosed when the regurgitation is relatively effortless in nature and appears to be volitional, at least in the early stages of the disorder.

### Compatibility of ICD-11 with DSM-5

Both ICD-11 and DSM-5 accept that culture plays an important role in the distress, perceptions, coping, support and help-seeking for all patients.

Efforts were also undertaken to make ICD-11 and DSM-5 more compatible with one other in terms of the definitions of mental disorders.<sup>24,25</sup> For example, both ICD-11 and DSM-5 exclude the culturally approved responses to common stressors or losses, such as bereavement and social deviation.<sup>11</sup> These have been mentioned in the definition of the mental disorders in DSM-5; in ICD-11, they have been highlighted in the diagnostic guidelines for the specific disorders, namely, distinguishing bereavement reactions from depression and socially stigmatized sexual behaviours from paraphilic disorders.

### THE PRODUCT

#### Introduction of culturally relevant new categories

The approach, adopted in ICD-11, in which greater significance has been given to the data from the LMICs, has resulted in the inclusion of certain newer categories of disorders. The understanding is that these can result in better recognition of the transcultural representation of such a group of disorders. An example is given in Box 3.

### Modification of diagnostic guidelines, based on culturally informed data

Certain modifications have been made to the diagnostic guidelines, to ensure wider applicability in the different regions of the world, as in the case of social anxiety disorder (Box 4).

#### Culture-related features for specific disorders

There is a dedicated section in the accompanying text relating to the cultural considerations for all the disorders in ICD-11, which summarizes information on cultural variations in terms of describing distress, symptom patterns, dysfunctions and course, with a view to promoting a culturally sensitive application.<sup>16</sup> Certain examples are given in box 5. The focus, here, was on providing pragmatic, actionable material to assist clinicians in their evaluation of patients, using the ICD-11 guidelines and reducing bias in clinical decision-making, by facilitating diagnostic assessment in a culturally informed manner.<sup>1</sup>

### POTENTIAL SHORTCOMINGS IN NEED OF IMPROVEMENT OR AREAS IN NEED FOR RESEARCH

#### Omitted disorders

Certain ICD-10 disorders that were commonly diagnosed in LMICs have been omitted from ICD-11. This could lead to diagnostic, treatment and research uncertainty, as well as causing coding difficulties. Some examples are mentioned in Box 6.

#### Box 3: examples of culturally relevant new categories

##### Avoidant/restrictive food intake disorder (ARFID)

ARFID and anorexia nervosa are both characterized by dietary restriction or food avoidance but the core disturbance in terms of experiencing the body weight or shape, is absent in patients with ARFID.<sup>26</sup> The factors contributing to the eating disturbance in ARFID, include little interest in eating and/or avoidance of multiple food types. The avoidance of specific food types may be based on sensory properties or on perceived adverse consequences. The importance of somatic factors has emerged, as a result of descriptions provided by LMICs.<sup>23</sup>

#### Box 4: example of modification of diagnostic guidelines, based on culturally informed data

##### Social anxiety disorder

It has been established in cross cultural research with *taijin kyofusho* in Japan and *Taein kong po* in Korea, that as part of the symptomology of the social anxiety disorder, the fear of negative evaluation by others can take the form of fear that the individual may offend others in addition to or instead of fear that the person will feel embarrassed or humiliated, as a result of engaging in the social behaviour. Similar findings of the fear of offending others in social anxiety disorder, has also been found in certain studies in western settings.<sup>28</sup> The modifications in the diagnostic guidelines for social anxiety disorder allow for inclusion of these varied transcultural presentations of social anxiety in ICD-11.<sup>11</sup>

### Box 5: examples of culture-related features for specific disorders

#### Depression

Although the symptoms of sadness and anhedonia have been retained as the principal symptoms of depression in ICD-11, clinicians are informed in this section that the somatic symptoms can predominate among patients with depression. This has been demonstrated in studies from LMICs and there may be significant cultural variability as to whether and how patients discuss their emotions with their clinicians.

#### Post-traumatic stress disorder

Culture-related features in PTSD in ICD-11 state that culturally sanctioned and recognized expressions or idioms of distress, explanatory beliefs and cultural syndromes, may be a key element of the trauma response. These may influence the symptomatology and comorbidity, particularly through somatization, as well as having emotional, cognitive and behavioural expressions of distress. These cultural-related features have been based on a number of observations, particularly among patients from LMICs. For example, cultural idioms of distress commonly present as somatic symptoms, such as *ohkumlang* (tiredness) and bodily pain among tortured Bhutanese refugees or as possession states in countries like Guinea Bissau, Mozambique and Uganda. This may take the form of *susto* (fright) among Latino populations, as *kit chraen* (thinking too much) and *sramay* (flashbacks of past traumas in the form of dreams and imagery that pervade one's waking life) in Cambodia. All these cultural idioms can influence the presentation and interpretation of PTSD among the affected populations.<sup>16</sup>

### Box 6: examples of ICD-10 disorders omitted in ICD-11

#### Neurasthenia

The ICD-11 has proposed a simplified category relating to bodily distress disorders to replace all the categories within the group of somatoform disorders, with the exception of hypochondriasis. This simplification of the diagnostic category may result in over-inclusiveness of various cultural phenomena, within the ambit of this category.

Though virtually unused in western countries, neurasthenia was for many years by far the most commonly diagnosed mental disorder in outpatient and community settings in China.<sup>29</sup> The Chinese conceptualization of neurasthenia attaches equal diagnostic weight to somatic, cognitive and emotional symptomatology, and in this respect differs from western diagnostic constructs. A wider application of western classification systems in Chinese psychiatric research, has contributed to the marginalization of neurasthenia as a residual somatoform category in the specialist mental health sector. The fact that the diagnostic category of neurasthenia is still widely used by general physicians and psychiatric practitioners, and is also widely understood by lay people in both urban and rural China,<sup>29</sup> suggests that it has continuing clinical utility that should be examined further.

#### Psychogenic vomiting

Psychogenic vomiting has been removed from ICD-11 as a diagnostic entity, as it is not clear whether it is a mental disorder. While, certain cases of psychogenic vomiting would be diagnosed as cultural variants of rumination disorder (Box 2), other cases of psychogenic vomiting would now be diagnosed as an unspecified eating disorder or as cyclical vomiting (not a mental disorder).

Psychogenic vomiting is the most common eating disorder diagnosis among psychiatric service users in the Indian subcontinent. However, eating disorders like anorexia nervosa, bulimia nervosa and binge eating disorders are uncommon in clinical, as well as community samples.<sup>30</sup> In a chart review of cases of eating disorders in a tertiary care centre in South India, 85.4% were diagnosed as having psychogenic vomiting and 14.6% as having anorexia nervosa.<sup>31</sup> The female to male ratio for psychogenic vomiting (1.33%) was less than that for anorexia nervosa (5%).

Psychogenic vomiting can be a highly disabling condition<sup>32</sup> that is often misdiagnosed.<sup>33</sup> Under-recognition of this disorder can lead to delayed treatment, as well as affecting research efforts. The brain-gut may be involved in the modulation of stress, resulting in unexplained nausea and vomiting, and the association between these needs to be investigated.<sup>34,35</sup>

### Lack of focus on implementation and the client

Significant changes have been made in ICD-11 for inclusion of cultural variables in the nosology. However, guidance on implementation, training and application in diverse settings remain to be fully addressed.

While social science research has demonstrated the importance of culture in shaping psychiatric illness, clinical methods for assessing the cultural dimensions

of illness, have not been adopted as part of routine care. The reasons for limited integration include the impression that attention to culture requires specialized skills, is only relevant to a subset of patients from unfamiliar backgrounds and is too time consuming to be useful. In the DSM-5, the Outline for Cultural Formulation (OCF) provides a framework for clinicians to organize cultural information, relevant to diagnostic assessment and



treatment planning. The Cultural Formulation Interview (CFI) operationalizes the process of data collection for the OCF. A key goal of the CFI is to place the experience of the patient at the centre of the encounter, allowing the clinician to appreciate the personal, interpersonal and larger social contexts in which the problem, its interpretation and clinical presentation, emerge. A framework for the collection of cultural and individualized information, may facilitate culturally competent encounters. However, the ICD-11, as a classification for all illnesses is not intended to provide support for individual evaluation, including for psychiatric purposes. Clinicians wishing to assess cultural issues for ICD-11 could use interviews like the DSM-5 CFI, Brief Cultural Interview,<sup>36</sup> the McGill Illness Narrative Interview<sup>37</sup> or other approaches,<sup>38</sup> along with the ICD-11.

Furthermore, the cultural context and/or clinician values may impact diagnosis regarding cultural issues. Clinicians' awareness of and training relating to the diagnostic implications of cultural issues are necessary, as they may impact potential prognosis. Encouraging clinicians' self-awareness, in addition to being knowledgeable in relation to diversity factors, can aid in furthering diagnostic accuracy. However, this may require the incorporation of the concept of culture in the general training of mental health and primary care professionals.

#### **Lack of guidance on normal cultural variations**

Cultural issues may become pertinent for classification and diagnosis in multiple ways. The ICD-11 provides guidance on the assessment of pathological cultural symbols and expressions (e.g., religious delusions, trance and possession). However, clinicians may also have to manage cases with non-pathological cultural issues, which would be coded under 'Factors influencing health status and contact with health services (Z codes in ICD-10)' (e.g., life-cycle transitions, acculturation difficulties, issues related to sexual attitude, behaviour and orientation, mystical experiences, etc.). Cases may involve concurrent mental disorder with non-pathological cultural issues (e.g., obsessive-compulsive disorder with religious rituals), whereby Z codes may be used in addition to mental disorder diagnosis. ICD-11 describes such conditions but does not provide guidance on their differentiation from pathology and labelling.

The incorporation of cultural consideration in classification should shift from an exclusive focus on pathology (differential diagnosis, source of pathology)

to an understanding of the client's current issues and methods for treating them appropriately. ICD-11 has not adequately addressed this shift. However, an issue in this regard is the limited research available on markers of or criteria for pathology in cultural phenomena (e.g., intense focus on sin vs. scruples). In addition, there is a need to understand how practitioners are utilizing the Z Codes for assessment of cultural issues.

#### **Alternate conceptualizations**

One of the limitations of the international nosology classificatory systems, is the fixation of phenomenological boundaries of the disorders, leading to the exclusion of culturally/contextually influenced variants of symptom expression.<sup>28</sup> As the cartesian mind-body distinction is not recognized worldwide, as suggested by the conceptualization of neurasthenia in China, alternate models regarding the separation of affective disorders, anxiety and somatoform, could be evaluated for validity.<sup>39</sup> Similarly, cultural concepts which overlap with multiple diagnoses like *ataques de nervios* (with panic disorder, posttraumatic stress disorder, intermittent explosive disorder)<sup>28</sup> and *dhat syndrome* (health anxiety, somatoform, depressive and anxiety disorders)<sup>40</sup> could be evaluated as alternate formulations, that may be more valid for capturing the relevant phenomena (in terms of expression, as well as mechanism) within specific cultures.

At the same time, we need to recognize that the global mental health push, including the classificatory systems, are also influencing the cultural diversity in approaches to health and illness. The previously western syndrome of "depression" is becoming a master narrative among clinicians in diverse communities, where cultural syndromes are disappearing (e.g., neurasthenia in China, *dhat syndrome* in India, *Hwabyung* in Korea, and *Taijin-kyofusho* in Japan). The hybridization of cultures may alter the shape of alternate formulations.

#### **CONCLUSIONS**

A truly culturally sensitive classification of mental disorders is difficult to achieve for global use. The ICD-11 represents an important, albeit iterative, advance in this regard. The various changes made in the ICD-11 have added a consistent cultural lens to the diagnostic classification. The guidance for cultural considerations in ICD-11 should enhance the clinical utility of the constituent diagnostic

constructs and help clinicians make culturally informed decisions. However, the limitations of ICD-11 with regard to cultural praxis also have to be understood.

Certain limitations of ICD-11 are related to the paucity of research on the role of culture in the pathogenesis of illnesses in non-western cultures. For a classificatory system that is fair, reliable and culturally useful, there is a need to generate empirical evidence on diversity, as well as mechanisms that explain these from the perspectives of all the regions around the world.<sup>41</sup> This requires a strengthening of the research base for culture informed studies in LMICs, so they can better participate in the development of a culturally-fair, global classificatory system. Future research on the cultural framework of psychiatric conditions is not only important in better understanding these conditions but also makes the classificatory systems more acceptable globally.

Finally, there is a need to understand the limits of a cultural approach to health, which does not systematically address the range of social structural determinants (e.g., political and economic contexts) of health, but may be equally as important for clinical assessment and intervention in terms of cultural knowledge.<sup>42</sup>

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**Correspondence to:**

**Professor Pratap Sharan, MD, PhD**  
pratapsharan@gmail.com

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# Engagement of Russian Mental Health Professionals in the Development of WHO's ICD-11

Вовлечение российских специалистов в области психического здоровья в разработку МКБ-11 ВОЗ

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**Tahilia J. Rebello<sup>1</sup>, Maya A. Kulygina<sup>2</sup>, Valery N. Krasnov<sup>3</sup>, Kathleen M. Pike<sup>1</sup>, Geoffrey M. Reed<sup>1</sup>**

*<sup>1</sup>Department of Psychiatry, Columbia University, Vagelos College of Physicians and Surgeons and WHO Collaborating Center for Capacity Building and Training in Global Mental Health, Columbia University, New York, NY, USA; <sup>2</sup>Training and Research Centre, Mental-health clinic No.1 named after N.A. Alekseev, Moscow, Russia; <sup>3</sup>Moscow Research Institute of Psychiatry – a branch of the V. Serbsky National Medical Research Centre of Psychiatry and Narcology of the Ministry of Health of the Russian Federation, Moscow, Russia*

**Тахилия Дж. Ребелло<sup>1</sup>, Майя А. Кулыгина<sup>2</sup>, Валерий Н. Краснов<sup>3</sup>, Кэтлин М. Пайк<sup>1</sup>, Джеффри М. Рид<sup>1</sup>**

*<sup>1</sup>Кафедра психиатрии Высшей медицинской школы Вегелоса и Сотрудничающий центр ВОЗ по устойчивому развитию и обучению в области глобального психического здоровья, Колумбийский университет, Нью-Йорк, штат Нью-Йорк, США; <sup>2</sup>Научно-образовательный центр, Психиатрическая клиническая больница №1 им. Н.А. Алексеева, Москва, Россия; <sup>3</sup>Отдел клинико-патогенетических исследований, Московский научно-исследовательский институт психиатрии - филиал Национального медицинского исследовательского центра психиатрии и наркологии им. В.П. Сербского Минздрава России, Москва, Россия*

## ABSTRACT

The World Health Organization (WHO) has officially approved the next version of its global diagnostic system, the *International Classification of Diseases and Related Health Problems, Eleventh Revision* (ICD-11). Processes to implement the ICD-11 are now underway. Developing the ICD-11 chapter on Mental, Behavioural and Neurodevelopmental Disorders, in line with WHO's core priorities to enhance the clinical utility, reliability, and global applicability of the guidelines, necessitated a large-scale scientifically-rigorous research program. Such a program of global field studies engaged mental health professionals from across the world, with substantial contributions from clinicians in the Russian Federation.

This paper systematically highlights the substantive roles played by Russian clinicians in all steps of development of the mental, behavioural, and neurodevelopmental disorder guidelines, including their participation in the following: 1) early formative field studies that informed the organizing principles and overarching structure of the ICD-11; 2) large-scale online studies that used a case-controlled methodology to evaluate the guideline's clinical utility and the accuracy with which the new ICD-11 guidelines could be applied by global clinicians; 3) an online network of mental health professionals who provided direct feedback on the ICD-11 to WHO (also known as the Global Clinical Practice Network, [www.globalclinicalpractice.net](http://www.globalclinicalpractice.net)) with over 16,000 members from 160 countries, and with the Russian Federation being in the top five most represented countries in the network; 4) clinic-based field studies that tested the reliability and clinical utility of the ICD-11 diagnostic guidelines; and 5) development and participation in training programs that prepare clinicians in implementing the diagnostic guidelines in clinical settings.

In these many ways, Russian clinicians have substantively and directly contributed to efforts to maximize the clinical

usefulness, consistency, acceptability, and applicability of the ICD-11's mental, behavioural, and neurodevelopmental disorder guidelines. This substantial engagement of clinicians will conceivably facilitate the adoption and use of the guidelines by clinicians in the Russian Federation and other Russian-speaking countries, as the ICD-11 is implemented over the coming years.

## **АННОТАЦИЯ**

Всемирная организация здравоохранения (ВОЗ) официально утвердила очередную версию своей единой диагностической системы - Международную классификацию болезней и проблем, связанных со здоровьем одиннадцатого пересмотра (МКБ-11). В настоящее время идет подготовка к внедрению МКБ-11. Разработка главы МКБ-11, посвященной психическим и поведенческим расстройствам и нарушениям нейropsychического развития, в соответствии с основными приоритетами ВОЗ в отношении клинической полезности, надежности и глобальной применимости диагностических указаний, потребовала крупномасштабной научно обоснованной программы исследований. В этой программе глобальных полевых исследований приняли участие специалисты в области психического здоровья со всего мира, в том числе из России.

В данной статье последовательно освещается существенная роль российских клиницистов на всех этапах разработки диагностических указаний для главы по психическим и поведенческим расстройствам и нарушениям нейropsychического развития, которые включали: 1) первоначальные полевые исследования, способствовавшие формированию организационных принципов и общей структуры МКБ-11; 2) крупномасштабные онлайн исследования на основе заданных клинических случаев для оценки клинической полезности и точности указаний МКБ-11; 3) участие в онлайн сети специалистов в области охраны психического здоровья, созданной при содействии ВОЗ для проведения исследований по МКБ-11, также известной как Всемирная сеть клинической практики, [www.globalclinicalpractice.net](http://www.globalclinicalpractice.net)), объединяющей более 16 000 членов из 160 стран (причем Российская Федерация входит в первые пять стран, наиболее представленных в данном сообществе); 4) собственно клинические полевые испытания надежности и клинической полезности диагностических указаний МКБ-11; 5) участие в разработке учебных программ, подготавливающих клиницистов к внедрению новой версии классификации в практических условиях.

Таким образом, российские специалисты внесли существенный и непосредственный вклад в процесс улучшения клинической полезности, приемлемости и применимости диагностических указаний МКБ-11 по психическим и поведенческим расстройствам и нарушениям нейropsychического развития. Ожидается, что это будет способствовать успешному внедрению МКБ-11 в Российской Федерации и других русскоязычных странах в ближайшие годы.

**Key words:** *classification; ICD-11; WHO; mental disorder; clinical utility*

**Ключевые слова:** *классификация; МКБ-11; психическое расстройство; клиническое применение*

## **INTRODUCTION**

On May 2019, the World Health Organization (WHO) approved the newest version of its global diagnostic classification system, the *International Classification of Diseases and Related Health Problems* (Eleventh Revision; ICD-11). Although implementation processes are still underway, the ICD-11 is considered as the official classification system of all 194 WHO Member States, including the Russian Federation. This approved statistical version of the ICD-11 features a chapter on Mental, Behavioural and Neurodevelopmental Disorders,

whose development was led by the WHO's Department of Mental Health and Substance Abuse (MSD). The development of this chapter and the related *Clinical Descriptions and Diagnostic Guidelines* (CDDG) — a version of the ICD-11 chapter that provides comprehensive and detailed diagnostic guidance on mental, behavioural and neurodevelopmental disorders — was a decade-long, scientifically-rigorous process that involved mental health professionals from across the globe, with appreciable participation of clinicians from the Russian Federation and from other Russian-speaking countries.<sup>1-5</sup> The



substantive participation of mental health professionals from the Russian Federation, and those from across the globe, in developing the ICD-11 was essential in enabling the WHO to ensure that the ICD-11 diagnostic guidelines were in line with its three core priorities.<sup>2,6</sup>

The first priority was to enhance the clinical utility of the guidelines, which reflects their usefulness when applied in the clinical context (e.g., how easily clinicians can apply the guidelines, how well the guidelines fit real-life patients, and how clear and understandable they are to clinicians). Clinical utility is a particular focus, as the ICD has important clinical uses, such as serving as a framework for diagnosis and as a basis for development of guidance on clinical management and standards of practice as well as facilitating research into more effective treatments and prevention. Improved clinical utility is also arguably crucial to the broader public health uses of ICD to facilitate the accurate collection and tracking of health data, to monitor mortality and morbidity, to assess disease burden, and to hold WHO Member States accountable for addressing this burden.

The second core priority was to validate the clinical consistency or reliability of the guidelines, and the third priority was to maximize the applicability and acceptance of the diagnostic guidelines to clinicians working in diverse clinical, geographical, and cultural contexts around the world. In this way, the ICD-11 would serve as a relevant and useful tool that can be used by global mental health professionals upon its implementation. Ensuring that the ICD-11 adhered to these three core priorities prompted a global research program led by MSD, which substantively engaged scientists, clinicians, and researchers from across the globe. Here we specifically highlight the important contributions of Russian mental health professionals in the development and field testing of the ICD-11 guidelines for mental, behavioural, and neurodevelopmental disorders.

### **FORMATIVE ICD-11 FIELD STUDIES**

First, clinicians from the Russian Federation contributed to the early *formative* field studies of the ICD-11,<sup>7,9</sup> allowing them to provide WHO with important feedback and data, which influenced the overarching architecture and linear structure of the ICD-11 chapter on Mental, Behavioural and Neurodevelopmental Disorders. This included a study in which WHO collaborated with Member Societies of the World Psychiatric Association (WPA)<sup>7</sup> in order to assess

global psychiatrists' attitudes regarding mental disorder classifications, such as what they considered to be the most important purpose of a classification system of mental disorders, how they conceptualized severity and the relationship between functional impairment and diagnosis, and their attitudes toward the inclusion of dimensionality in a classification system. The study was conducted in 19 languages, including Russian, allowing for the participation of 4,887 clinicians from 44 countries. A notable number (n = 298) of study participants were members of the Russian Society of Psychiatrists, making the Russian Federation the fourth most represented country in the study sample. In this way, the overall structure and organization of the ICD-11 chapter on Mental, Behavioural and Neurodevelopmental disorders was influenced by feedback from Russian clinicians and others from around the world.<sup>7</sup>

### **EVALUATIVE ICD-11 FIELD STUDIES**

A second notable way in which Russian clinicians contributed to the development of the ICD-11 is through their participation in WHO MSD's large-scale global program of evaluative field studies, which tested whether the proposed versions of the ICD-11 guidelines met the standards of clinical utility, reliability, and global applicability set by WHO.<sup>10</sup> This research program was overseen by international experts with the relevant clinical and research experience to be able to provide scientific leadership throughout the ICD-11 field testing process. These experts formed the ICD-11 *Field Studies Coordinating Group* and included members from the Russian Federation (authors VK and MK). The international representation in this leadership body overseeing the field testing was one of the mechanisms through which WHO aimed at ensuring that the final ICD-11 guidelines would reflect a version that was most useful and applicable to clinicians working in diverse contexts around the world, including the Russian Federation.<sup>2</sup>

### **Global Clinical Practice Network as a platform for ICD-11 case-controlled field studies**

The first subset of evaluative studies, through which Russian clinicians contributed to the ICD-11, used a case-controlled methodology to test how accurately clinicians could apply the proposed ICD-11 guidelines to standardized case vignettes and also captured their assessment of the clinical utility of the guidelines.<sup>11,12</sup>

These studies were implemented online via the WHO's Global Clinical Practice Network (GCPN). The GCPN is a disciplinarily, geographically, and linguistically diverse practice-based research network devoted to mental health, composed of individual mental health professionals who have registered to participate in WHO field studies on ICD-11 and related areas of inquiry.<sup>13</sup> As of February 2021, the GCPN has over 16,000 members from 160 countries. Over a thousand members (about 80% of whom are psychiatrists, representing 6.3% of the total network) are Russian, thus placing the Russian Federation in the top five most represented countries in the network. The GCPN also includes Russian-speaking mental health professionals residing in 24 other countries. GCPN members have an average 19 years of professional experience (SD = 10.8; range 0 to 68 years), and 92% actively see patients and engage in clinical activities. As such, they serve as ideal participants with the relevant clinical experiences to contribute to the online case-controlled studies that test whether the ICD-11 guidelines can be accurately applied in a clinically useful manner.

#### **Case-controlled field studies in Russia**

As part of this evaluative program of field studies, clinicians in the Russian Federation first participated in a comprehensive process of translating the ICD-11 guidelines into Russian. This process involved forward translation (English to Russian) by experts with relevant clinical training and content expertise to be able to capture the technical details and clinical terminology included in the guidelines. This was followed by a back-translation (Russian to English) conducted by other experts. Any areas of confusion or differences in translations were reconciled through a consensus process so that the final version of the Russian ICD-11 guidelines can best capture the clinical nuance intended by the WHO Working Groups and other global experts who developed them.

In this field-testing phase, hundreds of Russian and Russian-speaking mental health professionals participated in major ICD-11 case-controlled studies that cover many of the key mental disorder areas including mood disorders, schizophrenia or other primary psychotic disorders, anxiety or fear-related disorders, obsessive-compulsive or related disorders, and dissociative disorders.<sup>14-16</sup> Russian mental health professionals demonstrated their special diagnostic opinions based on their own clinical traditions and nosological approaches.<sup>17</sup>

Additional case-controlled studies are expected to be implemented in such areas as personality disorders and substance use disorders.

Another related online study that looked into how clinicians used classification systems and technology was also done in Russian,<sup>18</sup> enabling WHO to better understand how the ICD-11 would likely be eventually used in clinical practice (e.g., which ICD version(s) do clinicians use and how do they access this content). In turn, this allowed WHO to potentially plan for additional or supplemental resources on ICD-11, which could be made available to clinicians, thus facilitating the adoption and use of the new classification system in the Russian Federation and in other parts of the world.

#### **Clinic-based (ecological implementation) field studies in Russia**

A second subset of evaluative field studies that allowed Russian clinicians to provide further contributions to CDDG development involved clinic-based field studies (also referred to as "ecological implementation" field studies), which tested how reliably the ICD-11 guidelines could be applied to real patients in natural clinical settings across the world.<sup>21</sup> This study also examined clinicians' ratings of the utility of the guidelines when applied to patients in the clinical context, rather than the standardized cases as was done with the online case-controlled studies.<sup>19</sup>

Clinicians at two study sites in the Russian Federation (Moscow Research Institute of Psychiatry and the First St. Petersburg City Mental Hospital named after PP Kaschenko) participated in the clinic-based study protocol, which specifically tested the reliability of the ICD-11 diagnostic guidelines relevant to psychotic, mood, anxiety, and stress disorders as applied to adult patients. Results demonstrated high ratings of clinical utility and other implementation characteristics of the guidelines.<sup>19,20</sup> Data from these studies were used to further improve the guidelines by identifying potential areas that require clarity or elaboration. In doing so, the improved guidelines can be more reliably and consistently applied in clinical practice in the Russian Federation, and across the world.

#### **ICD-11 TRAINING ACTIVITIES IN RUSSIA: EXPERIENCE AND FUTURE INITIATIVES**

With the participation of Russian clinicians and mental health professionals from around the world in the

development and testing of the ICD-11 guidelines for mental, behavioural, and neurodevelopmental disorders, the CDDG is now close to being finalized and made broadly available. A next key step in the adoption of the ICD-11 is to train clinicians on the guidelines so that they are prepared to effectively use them in clinical practice when the ICD-11 is fully implemented. In-person trainings, led by world experts who had leadership roles in the ICD-11's development, such as members of the Field Studies Coordinating Group, have already taken place globally at scientific meetings or via webinars hosted by professional societies, such as the WPA and the European Psychiatric Association (EPA), and at WHO Collaborating Centers and other affiliated clinical or research institutions around the world. The objectives of these trainings are to orient clinicians regarding key principles, scientific foundations, and innovations introduced in the CDDG; to give clinicians in-depth knowledge of the guidelines and provide clinically-relevant rationales for the ICD-11's diagnostic approach, especially in areas where there may be noticeable differences with the ICD-10; and to expand clinicians' knowledge about psychopathology and the ICD-11 diagnostic classification. Trainings encourage active participation, provide an opportunity for clinicians to apply their knowledge of the ICD-11 guidelines to standardized cases, and offer clinicians the space in which to discuss and clarify diagnostic dilemmas and questions about the guidelines with both training facilitators and other colleagues in attendance. In the Russian Federation, the ICD-11 training activities have been ongoing, with the first programs linked to training clinicians who participated in the clinic-based reliability field studies of the ICD-11. Trainings have also been conducted through workshops as part of several local and national conferences and symposia throughout the Russian Federation.

The first workshop in Moscow was organized in May 2019 under the auspices of Professor George Kostyuk, Chief Expert in Psychiatry of the Moscow Healthcare Department, with the assistance of author MK, and led by authors GMR, KMP, and Professor/Past President of the EPA Dr. Wolfgang Gaebel. The program of this two-day training focused on the new ICD-11 diagnostic guidelines and key changes for several areas, namely, schizophrenia or other psychotic disorders, mood disorders, obsessive-compulsive disorders, anxiety or fear-related disorders, and disorders specifically associated with stress and

personality disorders, followed by the application of new knowledge to standardized cases.

The workshop was held at the Civic Chamber of the Russian Federation in Moscow, conducted in English with simultaneous translation, and was attended by 144 Russian clinicians from 27 cities from diverse regions of the Russian Federation. Attendees included senior specialists or opinion leaders in psychiatry, such as chief doctors, directors, and the heads of departments at research or clinical institutions across the country, as well as postdoctoral trainees or medical residents. Qualitative data collected at the end of the workshop validated that Russian clinicians found the training valuable and that they were willing to serve as ambassadors of the ICD-11 by themselves facilitating broader training and adoption of the ICD-11 guidelines in Russia. The participants also mentioned the necessity of such events in supporting Russian clinicians as they implement the ICD-11 into clinical practice, with an emphasis on the need to consider the ICD-11 diagnostic approaches within the context of Russian clinical traditions. These data will be used to strengthen future training programs, such as the development of online ICD-11 trainings that are currently being pilot-tested and finalized for broader access.

## CONCLUSION

As is evident, mental health professionals from the Russian Federation have played a substantive role in many key phases of the ICD-11's development. Not only have Russian specialists served on the ICD-11 scientific leadership group that guided the ICD-11 field testing process, but thousands of Russian clinicians working in diverse contexts all across the Russian Federation have participated in WHO MSD's large-scale program of global field studies. In this way, Russian clinicians have directly contributed to efforts to maximize the clinical utility, reliability, acceptability, and applicability of the CDDG guidelines. Such efforts can conceivably facilitate the adoption and use of the guidelines by clinicians in the Russian Federation and other Russian-speaking countries as the ICD-11 is implemented over the coming years.

**Authors contribution:** Tahlia J. Rebello: conception, design and writing of article, analysis and interpretation of data, leadership of studies mentioned in article; Maya A. Kulygina: conception, design and writing of article, leadership of studies mentioned in article;

Valery N. Krasnov: review and final approval of article, leadership of studies mentioned in article; Kathleen M. Pike: article review and leadership of studies mentioned in article; Geoffrey M. Reed: article writing, review and final approval of article, leadership of studies mentioned in article.

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#### Correspondence to:

**Tahilia J. Rebello, Ph.D**

tahilia.rebello@nyspi.columbia.edu

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# Toward ICD-11 Implementation: Attitudes and Expectations of the Russian Psychiatric Community

Навстречу внедрения МКБ-11: установки и ожидания российского психиатрического сообщества

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Maya A. Kulygina<sup>1</sup>, Timur S. Syunyakov<sup>1</sup>,  
Ilya A. Fedotov<sup>2</sup>, George P. Kostyuk<sup>1</sup>

<sup>1</sup>Mental-health clinic No.1 named after N.A. Alekseev  
Moscow, Russia; <sup>2</sup>Psychiatry Department, Ryazan State  
Medical University, Ryazan, Russia

Майя А. Кулыгина<sup>1</sup>, Тимур С. Сюняков<sup>1</sup>,  
Илья А. Федотов<sup>2</sup>, Георгий П. Костюк<sup>1</sup>

<sup>1</sup>Психиатрическая клиническая больница №1 им. Н.А.  
Алексеева, Москва, Россия; <sup>2</sup>Кафедра психиатрии,  
Рязанский государственный медицинский университет,  
Рязань, Россия

## ABSTRACT

**Background.** ICD-11 implementation will start in early 2022 in WHO member countries, including Russia. This process should be preceded not only by the official translation and wide distribution of ICD-11 statistical classification and diagnostic guidelines but also by clinicians' training. For recent years ICD-11 development and innovations in the diagnosis of mental disorders were in the focus of attention of mental health professionals in all over the world.

**Objectives.** This online survey aimed to identify the current views of the Russian psychiatric community on the upcoming implementation of ICD-11.

**Methods.** A survey was composed in a Google form and circulated through the website of the Russian Society of Psychiatrists and other professional networks. Statistical and narrative analysis was provided. The sample was represented by 148 psychiatrists working in inpatient or outpatient clinical settings.

**Results.** Expectations for the classification of mental disorders reported by the respondents were wider than the current purpose of ICD-10. In general, the Russian psychiatrists expressed their interests to forthcoming ICD-11 implementation. Positive attitudes to ICD-11 innovations were associated with the familiarity with the ICD-11 draft. Conservative or negative views were related to longer years of clinical experience. Early carrier psychiatrists were more practically oriented than 'old school' clinicians.

**Conclusion.** This survey may help to promote the ICD-11 by focusing on its advantages for clinical practice and develop targeted training programs.

## АННОТАЦИЯ

**Актуальность.** Ожидается, что внедрение МКБ-11 начнется с 2022 года в странах-членах ВОЗ, включая Россию. Этот процесс предполагает не только официальный перевод статистической классификации и диагностических указаний МКБ-11, но и соответствующую подготовку клиницистов. В последние годы разработка МКБ-11 и нововведения для диагностики психических расстройств находились в центре внимания специалистов в области психического здоровья во всем мире.



**Цели.** Данный онлайн-опрос был проведен с целью выявления ожиданий и установок представителей российского психиатрического сообщества в преддверии внедрения МКБ-11.

**Материал и методы.** Опрос был составлен в Google форме и распространен через сайт Российского общества психиатров и другие профессиональные сети. Был проведен статистический и нарративный анализ ответов респондентов. Выборка была представлена 148 психиатрами, работающими в стационарных или амбулаторных клинических условиях.

**Результаты.** Ожидания в отношении классификации психических расстройств, о которых сообщили респонденты, были шире, чем те цели, для которых они используют МКБ-10 в своей повседневной практике. В целом российские психиатры выразили свою заинтересованность новой версией МКБ-11. Позитивное отношение к нововведениям МКБ-11 было связано со степенью осведомленности с данным проектом. Консервативные взгляды или негативное отношение были чаще типичны для специалистов с более длительным клиническим опытом. Психиатры, начинающие свою профессиональную карьеру, были более ориентированы на практическое использование новой версии МКБ, чем клиницисты "старой школы".

**Вывод.** Результаты опроса, отражающие распространенные мнения и взгляды отечественных клиницистов, могут быть полезны для продвижения МКБ-11. Прежде всего потребуется широкое ознакомление профессионального психиатрического сообщества с новыми указаниями данной классификации для диагностики психических расстройств, и привлечение внимания к ее преимуществам для применения в клинической практике. Важное значение имеет также разработка целевых обучающих программ с учетом разной степени готовности к вводимым изменениям.

**Key words:** ICD-11; ICD-10; diagnosis; clinical practice; mental disorders; attitudes; Russian Society of Psychiatrists

**Ключевые слова:** МКБ-11; МКБ-10; диагностика; клиническая практика; психические расстройства; установки; Российское общество психиатров

## INTRODUCTION

After an almost 30-year period, the World Health Organization (WHO) adopted the 11th version of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) in May 2019. The transition to ICD-11 in WHO member countries is expected to begin on January 1, 2022, and may be implemented until 2027. The previous version ICD-10, which is currently up to date, was adopted by the WHO World Assembly in 1990. In Russia, ICD-10 has been officially implemented into the health care system since 1999. The development of the ICD-11 Chapter Mental, behavioural and neurodevelopmental disorders was unprecedented in its scale, multilingualistic, and multidisciplinary features, including a work of the WHO advisory and the coordination groups composed of leading specialists, the activities of the Global Clinical Practice Network, the inclusion of the ICD-11 agenda in all major international congresses, and field

trials.<sup>1</sup> Russian specialists actively participated in the revision process. The meetings of the Russian Society of Psychiatrists (St. Petersburg, 2010, 2019; Samara, 2013; Kazan, 2015) and conferences on mental health issues (Moscow, 2014, 2018, 2020, Kazan, 2021) tackled sections or discussions on ICD-11 innovations. Specific trainings have been conducted for clinicians participating in international ICD-11 field trials.<sup>2</sup> The workshop on ICD-11 diagnostic guidelines for opinion leaders in psychiatry was organized at the Public Chamber of the Russian Federation (Moscow, 2019). The educational course "New ICD-11 guidelines for the diagnosis of mental disorders" was developed within the framework of continuous medical education in the Training and Research Center of Mental Health Clinic No. 1 named after N. A. Alexeev (Moscow, 2019). Lectures on ICD-11 were included in the program of additional professional education named as "Moscow clinician" (2020).



However, a knowledge about ICD-11 innovations in the diagnosis of mental disorders is still insufficient in the Russian professional community. As the process of implementing ICD-10 in the Russian mental health care system was long and had some difficulties, so observing the attitudes and views of Russian clinicians prior to the start of the transition to ICD-11 may be useful.

Large-scale international surveys on the opinion of mental health professionals during the ICD-11 development were conducted by the WPA and WHO in many countries, including Russia.<sup>3,4</sup> Their results have been used to improve the clinical utility of this classification. In international ICD-11 field studies, Russian specialists have good knowledge of the current ICD-10 and show commitment to classic clinical traditions of Russian psychiatry.<sup>5</sup>

The chapter on mental, behavioral, and neurodevelopmental disorders in ICD-11 is different from that in ICD-10. Changes are related to the title and structure of the chapter, the expansion of the dimensional principle in assessing the duration and severity of symptoms, the inclusion of new categories, and the format of Clinical Descriptions and Diagnostic Guidelines (CDDG).<sup>1</sup> Preliminary familiarization with the ICD-11 draft by Russian psychiatrists is often accompanied with comments and objections to certain innovations.

**Objectives.** This online survey was conducted to identify the current views of the Russian psychiatric community on the upcoming implementation of the ICD-11.

## **METHODS**

### **Survey design**

This survey was developed and deployed via Google forms. The link was circulated via social networks (the website of the Russian Society of Psychiatrists and WhatsApp professional groups) and then spread using the snowball technique. Data were obtained online from November 20, 2020, to January 9, 2021.

The survey was composed of 14 obligatory questions partly based on the questions from the WPA-WHO global survey.<sup>3</sup> The questions covered the following blocks of information: sociodemographic characteristics (age, gender, residence, profession, years of clinical experience, and inpatient or outpatient settings); practice of ICD-10 use; familiarity and satisfaction with ICD-11 draft; emotional attitudes toward ICD-11 innovations; general expectations for ICD diagnosis; and evaluation of the

usefulness of different diagnostic classification systems (ICD-9, ICD-10, ICD-11, DSM-IV, DSM-5, and RDoC). Participants could provide their feedback by sharing their views, proposals, or claims on the classification systems expressed in an open type of comments. Responses to all questions were mandatory except the last question on narrative feedback.

The results were collected once the respondents pushed the “submit” button. It was made clear that answering all the questions and pushing the “submit” button would be taken as a sign of voluntary consent to share responses. The survey was completely anonymous, and no identifiable personal data or IP addresses were collected. Ethical approval was not obligatory because of the non-interventional online survey research design.

### **Participants**

A total of 197 responses from medical professionals were collected. A Venn diagram showing the participants’ distribution in terms of specialties is presented in Figure 1. Some specialists had two or more work positions (i.e., psychiatrist and psychotherapist, or psychiatrist, psychotherapist, and physician), each specialty was considered unique. Thus, the sum of all specialties exceeded  $n = 197$ . Altogether, 148 defined themselves as psychiatrists, 36 as psychologists, 26 as psychotherapists, 6 as other physicians, and 7 as non-medical specialists.

Only psychiatrists ( $n = 148$ ) were included in this analysis. The majority live in Moscow ( $n = 59$ ) or Saint Petersburg ( $n = 13$ ), while others were from 51 large Russian/Belarusian/Kazakhstani cities (with all of them speaking Russian). Among them, 54.7% ( $n = 81$ ) were males, and 45.3% ( $n = 67$ ) were females. Psychiatrists of different ages participated in the survey, i.e., 20 (13.5%), 53 (35.8%), 37 (25.0%), 28 (18.9%), and 10 (6.8%) were <30, 30–40, 40–50, 50–60, and >60 years old, respectively. The participants had different durations of clinical experience: 4 (2.7%), <1 year; 17 (11.5%), 1–5 years; 30 (20.3%), 5–10 years; 26 (17.6%), 10–15 years; 20 (13.5%), 15–20 years; and 51 (34.5%), >20 years. The majority of psychiatrists ( $n = 89$ , 60.1%) work in outpatient settings, and 58 (39.2%) work in inpatient settings.

### **Statistical analysis**

The primary endpoint of this study was to describe the use of ICD-10 in practice, attitude toward ICD-11 innovations, and expectations for the ICD diagnosis

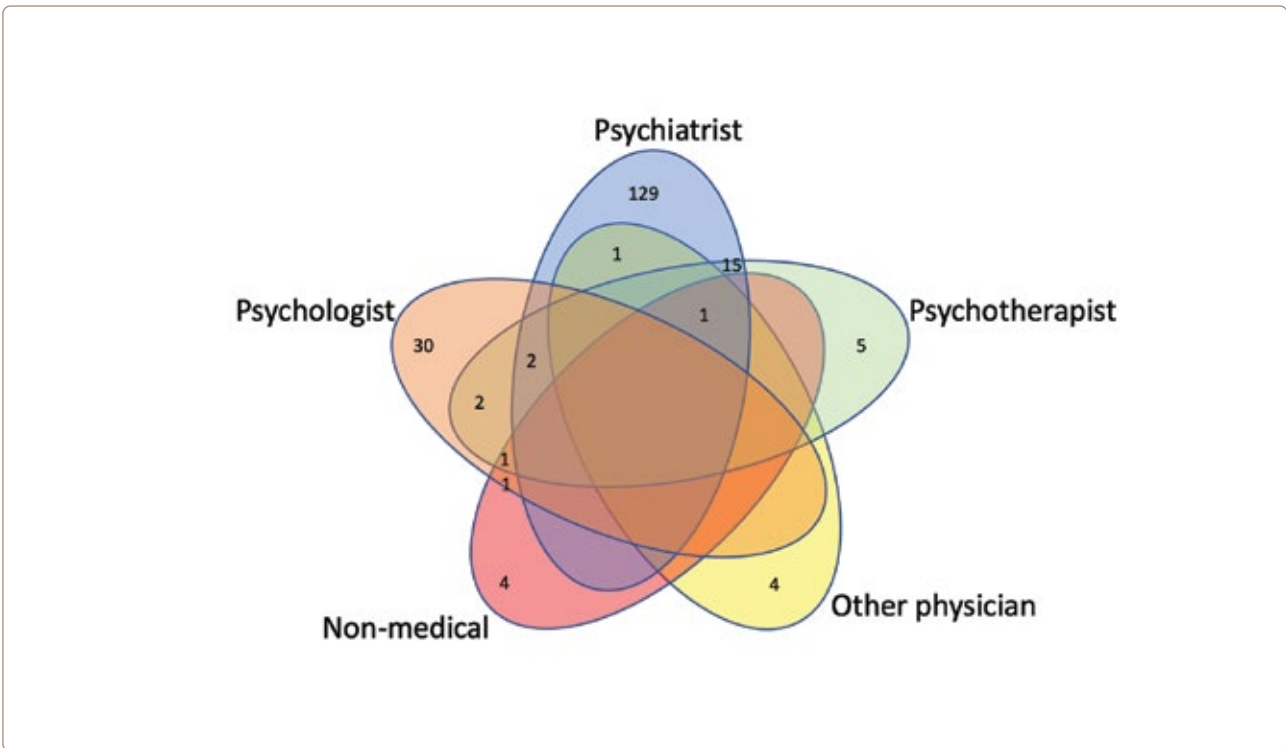


Figure 1. Venn diagram of participant's distribution by the specialties

of mental disorders. Answers were presented in frequency tables. A number of contingency tables were created to characterize the association of responses with other categorical variables (i.e., with gender, age, clinical experience, and clinical settings). These tables were then analyzed via  $\chi^2$ -test with continuity correction or Fisher's exact test if the counts in the cells of the contingency tables were  $<5$ . A Chi-square test and significance determination by cells were performed. The proximity matrix of responses to each question distribution was created and the percentage of agreement was estimated to evaluate the agreement between responses about the use of ICD-10 in practice and general expectations for a diagnostic classification. Data were statistically analyzed using XLSTAT 2020.5.1 (Addinsoft [2021], New York, USA; <https://www.xlstat.com>).

**RESULTS**

**Use of ICD-10 and expectations for ICD diagnosis**

The majority of the respondents used ICD-10 codes (n = 144, 97.3%) and diagnostic guidelines (n = 129, 89%) on the everyday basis. Overall, more than half of them considered ICD-10, along with DSM 5 and ICD-11, to be

the most clinically useful (Figure 2). Only 79 (53.4%) were satisfied with ICD-10 diagnosis, 58 (39.2%) of the participants were partially satisfied, and 11 (7.4%) were not satisfied.

ICD-10 was most frequently used for a patient's medical record (n = 140, 94.6%), followed by communication with colleagues (n = 108, 72.97%), treatment choice and care provision (n = 90, 60.81%), resolving the patient's social problems (n = 83, 56.08%), clinical research (n = 78, 52.70%), understanding the patient's condition and prognosis (n = 77, 52.03%), communication with patients and their relatives (n = 58, 39.19%), and other reasons (n = 28, 18.92%; Figure 3).

The expectations for the usefulness of ICD diagnosis of mental disorders differed from those for the reported current use of ICD-10. The agreement of responses on the corresponding questions varied from 58.1% to 89.2% (Table 1). The largest disagreement between the use of ICD-10 in practice and expectations for ICD diagnosis was observed in the usefulness for "clinical research," followed by the following aspects in a descending order: "understanding of a patient's condition and prognosis," "communication with patients and their relatives," "resolving a patient's social problems," and "treatment

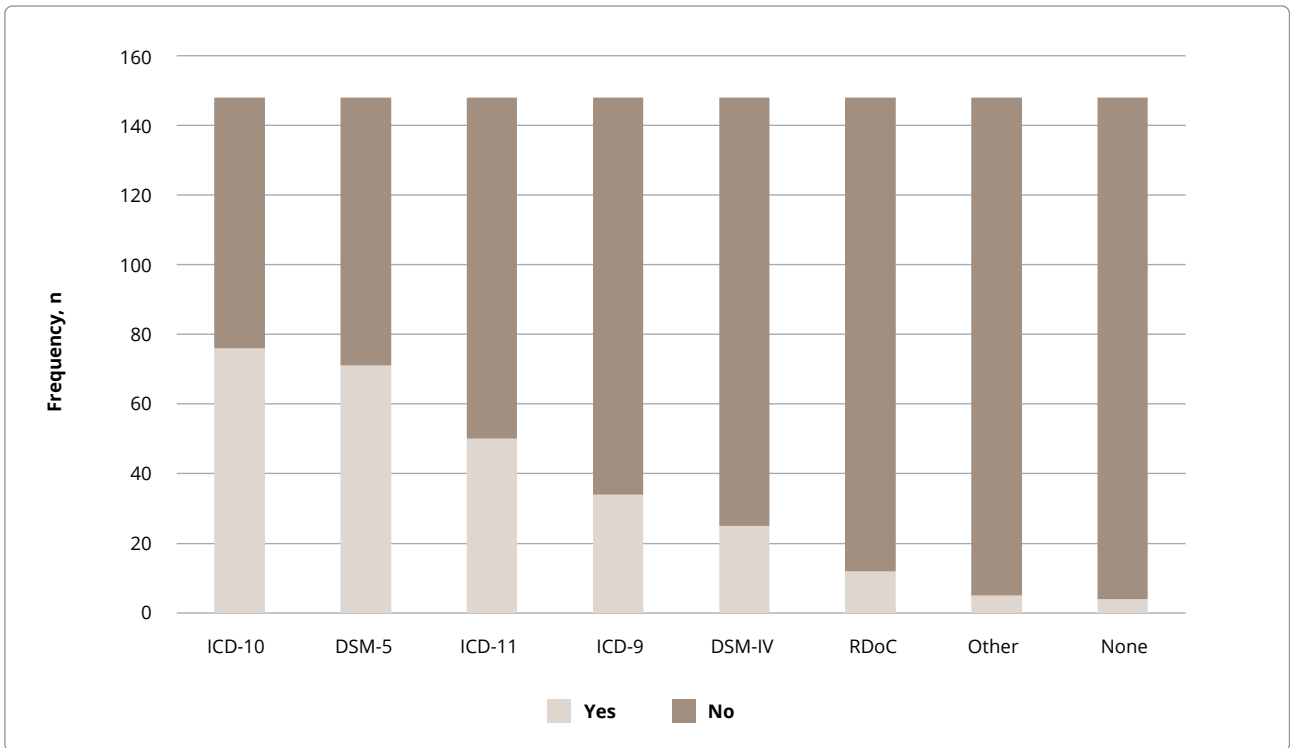


Figure 2. Opinions on clinical utility of different international classification systems

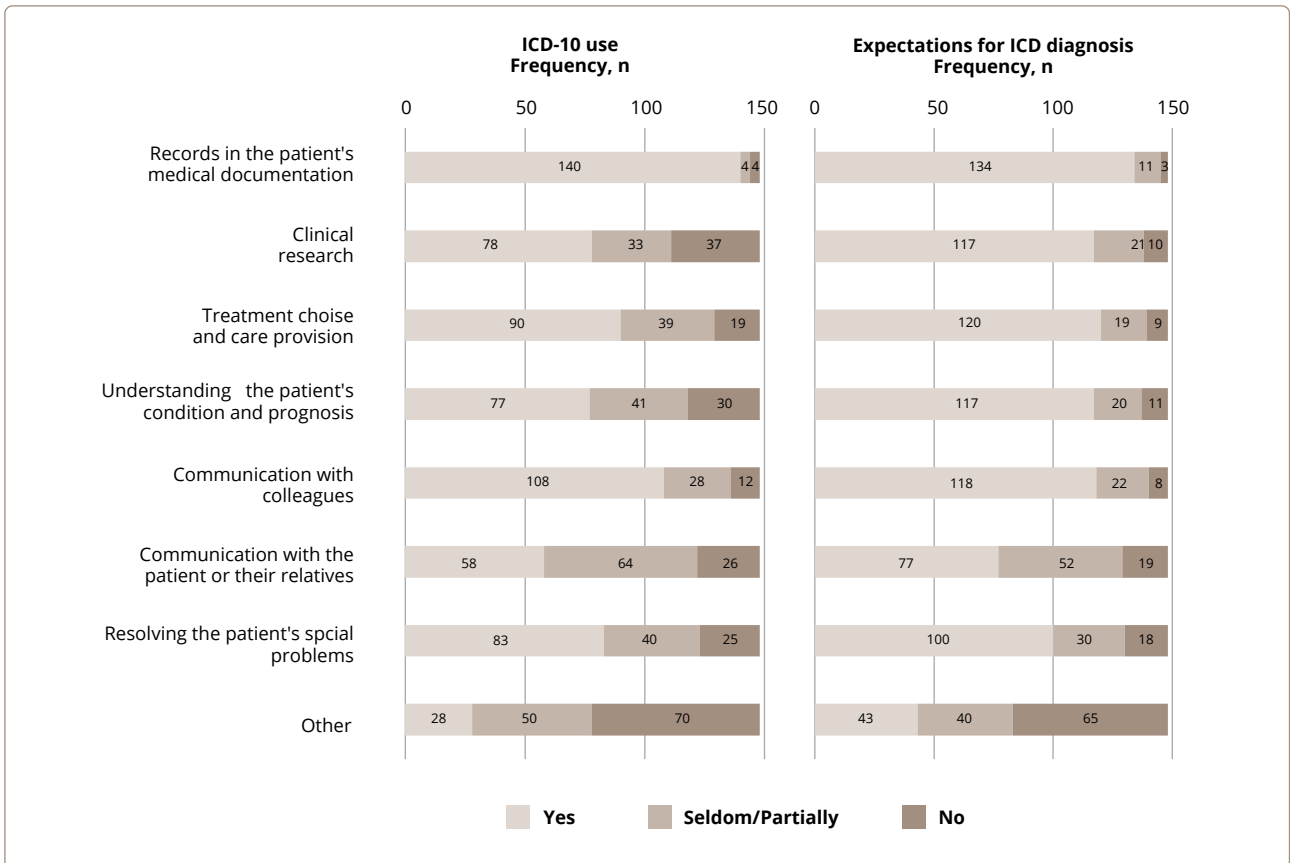


Figure 3. ICD-10 use and expectations for ICD

Table 1. Distribution of responses relating to use of ICD-10 in practice, matched with expectations of ICD's general usefulness

Question		Answer Frequency	ICD-10		Expectations for ICD diagnosis		Agreement %
			Proportion per category	Frequency	Proportion per category		
Used for	recording in patient's medical documentation	Yes	140	94.6%	134	90.5%	89.2%
		No	4	2.7%	3	2.0%	
		Seldom	4	2.7%	11	7.4%	
	clinical research	Yes	78	52.7%	117	79.1%	58.1%
		No	37	25.0%	10	6.8%	
		Seldom	33	22.3%	21	14.2%	
	treatment choice and care provision	Yes	90	60.8%	120	81.1%	71.6%
		No	19	12.8%	9	6.1%	
		Seldom	39	26.4%	19	12.8%	
	understanding of patient's condition and prognosis	Yes	77	52.0%	117	79.1%	62.8%
		No	30	20.3%	11	7.4%	
		Seldom	41	27.7%	20	13.5%	
	communication with colleagues	Yes	108	73.0%	118	79.7%	80.4%
		No	12	8.1%	8	5.4%	
		Seldom	28	18.9%	22	14.9%	
	communication with patients and their relatives	Yes	58	39.2%	77	52.0%	67.6%
		No	26	17.6%	19	12.8%	
		Seldom	64	43.2%	52	35.1%	
resolving patient's social problems	Yes	83	56.1%	100	67.6%	70.3%	
	No	25	16.9%	18	12.2%		
	Seldom	40	27.0%	30	20.3%		
other reasons	Yes	28	18.9%	43	29.1%	77.7%	
	No	70	47.3%	65	43.9%		
	Seldom	50	33.8%	40	27.0%		

choice and care provision." A high agreement between the current practice of ICD-10 and expectations for ICD diagnosis is found in "patients' records" and "communication with colleagues" (Figure 3).

Female respondents were more likely to rely on ICD-10 to understand their patient's condition and prognosis than males (64.18% and 41.98%, respectively, Table S1). Psychiatrists aged 60+ years were almost twice less likely to use ICD-10 to make medical records and communicate with colleagues or patients and their relatives ( $\chi^2 = 19.688$ ,  $p = 0.012$ ;  $\chi^2 = 20.791$ ,  $p = 0.008$  and  $\chi^2 = 26.057$ ,  $p = 0.001$ ; Table S2 Suppl.). Moreover, they were less likely to expect the usefulness of ICD in preparing medical notes (Table S10). Psychiatrists

who work in inpatient settings were less likely to use ICD-10 to communicate with patients and their relatives ( $\chi^2 = 6.653$ ,  $p = 0.036$ ; Table S4, Suppl.).

#### Familiarity and satisfaction with ICD-11 draft

The majority of participants ( $n = 137$ , 92.6%) were familiar with the ICD-11 draft. In particular, 82 (54.4%) answered "yes" and 55 (37.2%) answered "partially" on the question about their knowledge about ICD-11. However, generally, only 40 (27.0%) participants were fully satisfied with ICD-11, and 120 (54.1%) were partially satisfied.

Among those who were fully familiar with ICD-11 ( $n = 82$ ), 41.5% ( $n = 34$ ) were fully satisfied, and 43.9% ( $n = 36$ ) were partially satisfied.

Most of the participants (n = 103, 69.6%) expressed their intention to undergo a special training on the ICD-11 diagnosis of mental disorders. Furthermore, 9 (6.1%) already participated in such education activities, 8 (5.4%) had no intention to undergo training, and 28 (18.9%) responded that they would be compelled to participate. The responses of "I want to undergo training," "I don't want to undergo training," "I already participated in such training," and "I shall be pressed to undergo training" among fully and at least partially familiar with ICD-11 were as follows: 60 (73.2%) and 94 (68.6%), 6 (7.3%) and 8 (5.8%), 7 (8.5%) and 9 (6.6%), and 9 (11.1%) and 26 (19%), respectively.

### Attitudes toward the ICD-11 innovations

The question on specific attitudes to ICD-11 changes and innovations were multivariate choices of the following responses: "interest," "concern," "protest," "indifference," or "other attitudes," which were distributed in 99 (66.9%), 44 (29.7%), 8 (5.4%), 16 (10.8%), and 9 (6.1%) respondents, respectively. A combination of different responses was allowed. Thus, the most common was the simultaneous choice of "interest" and "concern" responses (Figure 4).

The largest proportion of "interest" responses was among psychiatrists who had 5–10 years of practice

(75,0%). Females were more worried than males toward innovations in ICD-11 ("concern" responses: 38.81% vs. 22.22%,  $\chi^2 = 4.827$ ,  $p = 0.028$ , Table S5 Suppl.). More "protest" responses were given by those who work in inpatient settings ( $\chi^2 = 4.475$ ,  $p = 0.034$ ).

On the question about attitude toward ICD-11 innovations among participants who were fully familiar with the ICD-11 draft, the following responses were obtained: "interest", 61 (74.4%); "concern", 19 (23.2%); "protest", 3 (3.7%); "indifference", 4 (4.9%); and others, 6 (7.3%). Among those who were at least partially familiar with ICD-11 (n = 137), the distribution of answers was as follows: 94 (68.6%), 41 (29.9%), 15 (10.9%), 7 (5.1%), and 7 (5.1%), respectively (Figure 5). Among 11 psychiatrists who were not familiar with ICD-11 draft, the following answers were observed: "interest", 5 (45.5%); "concern", 3 (27.3%); "protest" and "indifference", 1 (9.1%); and other attitudes, 2 (18.2%).

### Respondents' views on the classification of mental disorders

Views and comments on the classification of mental disorders freely formulated by the participants were reported by 113 of 197 respondents. The responses containing the suggestions, recommendations, claims,

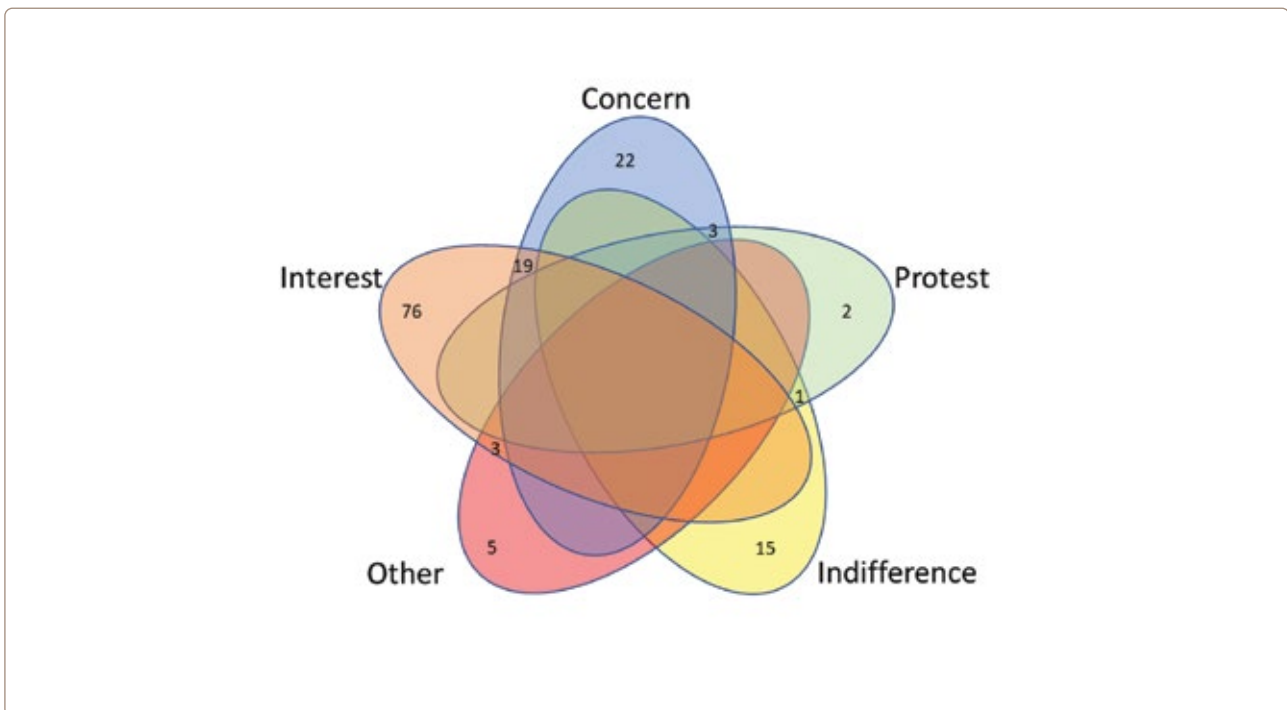


Figure 4. Venn diagram of emotional attitudes towards ICD-11

or other comments of the respondents were separately subjected to narrative analysis. Through this analysis, four types of comments provided by the respondents could be distinguished depending on their basic general views on the diagnostic classification of mental disorders. They may be figuratively named as follows: “traditionalist,” “nihilist,” “practitioner,” and “reformer.” The contingency tables of the types of narrative responses in terms of age, years of clinical practice, work settings, ICD-10 use, and attitude toward ICD-11 innovations are presented in Table S13 (Suppl.).

The “traditionalist” type of comments (n = 39, 34.5%) was characterized by “diagnostic conservatism.” The respondents provided predominantly conservative comments expressed in classic psychopathological views on psychiatric diagnosis. They tended to deny modern trends in diagnosis, requested to preserve old school traditions in the conceptualization of mental disorders, and adhered to ethiopathogenic, “nosological” approach to diagnostic classification. Some of them were against the “psychologization” of psychiatry, while others mainly advocated the priority of the national traditions of systematic psychopathology. For example, “In my opinion, it is very simplified, and the classic approach is lost.” “Classifications should be written by

doctors, not psychologists.” “It is necessary to take into account and combine it with the national classification of mental disorders.”

The “nihilist” type (n = 9, 8.0%) was characterized by “diagnostic nihilism” expressed in negativistic comments. It was the smallest group with total denial or views on the worthlessness of diagnostic guidelines and classification improvement. They perceived the ICD-11 implementation as unnecessary difficulties. For example, “Artificiality, an attempt to draw boundaries where there are none”; “Constant renaming confuses the professionals; it’s time to stop the “classification games.”

The “practitioner” type was characterized by “diagnostic practicisim” (n = 31, 27.4%) with practically oriented comments focused on the clinical utility and usefulness of the new classification. The respondents were looking forward to having a convenient practical instrument for the diagnosis of mental and behavioral disorders. They were also very keen to undergoing an appropriate training. For example, “It is necessary to study, to implement in the work, and to move forward with time.” “There are no complaints; I would like to receive additional training on ICD-11 for the diagnosis of mental disorders in the near future.”

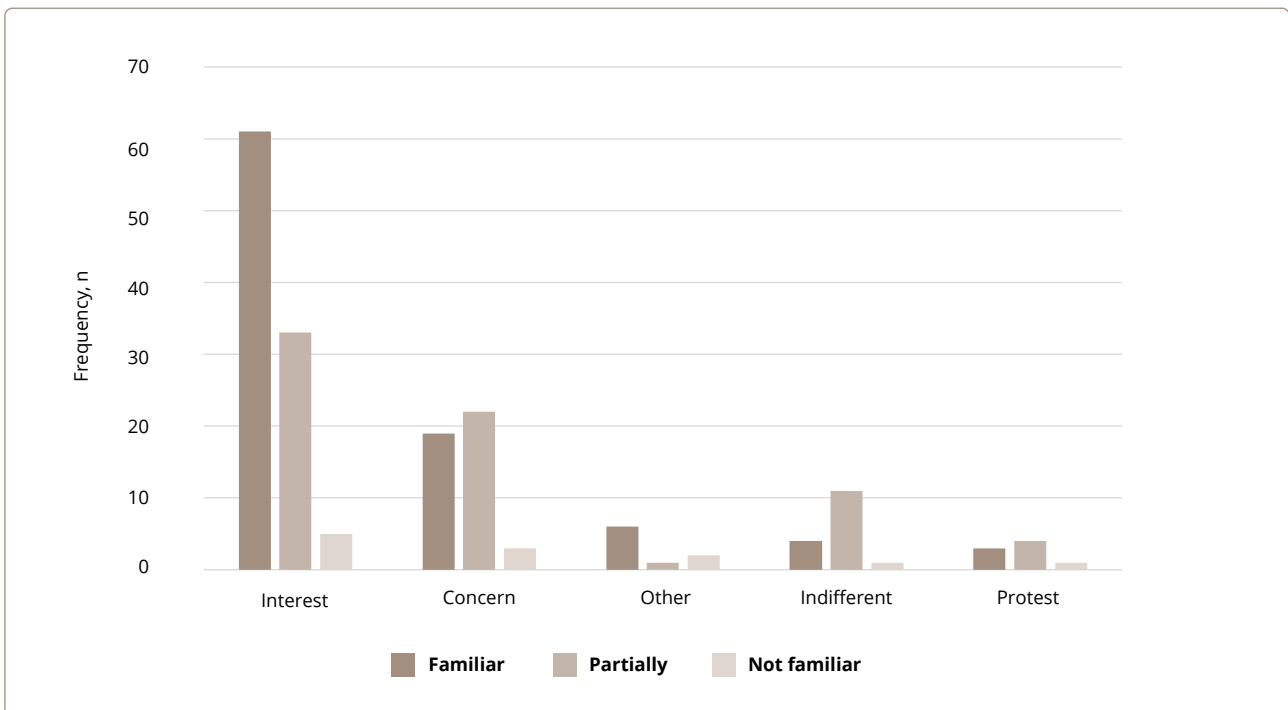


Figure 5. Emotional attitudes towards ICD-11 depends on familiarity with ICD-11



The “reformer” type was characterized by “diagnostic reformism” (n = 34, 30.1%). The respondents expressed through constructive comments and suggestions the need to optimize the classification, add new categories and blocks of disorders (e.g., a special group of gerontological mental disorders or organic disorders in children), and transform the categories of “others” or “unspecified” disorders. For example, “It is advisable to update the classification regularly,” and “I would prefer to see a full, separate section on child psychiatry.”

These types of comments also indirectly reflected a specific attitude to the ICD-11 implementation.

### **Associations between the types of comments and the characteristics of respondents**

The statistical analysis revealed a set of significant associations between these particular types of comments and other responses or characteristics of respondents.

Thus, the psychiatrists either older than 50 years or having longer clinical practice (>20 years) more likely provided conservative comments (50% and 48.9%, respectively) than the others (less than 35% for every other group).

The psychiatrists working in hospitals were more prone to give practically oriented comments (31.1% vs. 20.5% of those working in outpatient settings).

Although almost all psychiatrists used ICD-10 codes in their work, psychiatrists who gave negativistic or conservative comments (1 and 2 responses, respectively) refused to apply the ICD-10 diagnostic guidelines.

The distribution of the satisfaction with the ICD-11 draft in terms of the type of comments significantly differed ( $\chi^2 = 23.998$ ,  $p = 0.001$ ). Specialists who gave conservative and constructive comments more frequently were not satisfied or partially satisfied with ICD-10 diagnostics (20 of 39 and 20 of 34, respectively, compared with 3 of 9 and 14 of 31 of those who provided negativistic and practically oriented comments).

Dissatisfaction with the ICD-11 draft (n = 24) was more evident among those who gave conservative comments (n = 15, 62.5%). Conversely, the majority (n = 14, 53.8%) of those who were satisfied with ICD-11 (n = 26) provided constructive comments, and this distribution was statistically significant. The “protest” responses to the question on attitude toward ICD-11 innovations had significantly independent distribution ( $\chi^2 = 16.807$ ,  $p = 0.001$ ). All “protest” responses (n = 7) were presented

by the psychiatrists who gave either conservative (n = 4, 57.1%) or negativistic (n = 3, 42.9%) comments.

The readiness to undergo additional trainings on ICD-11 had independent distribution as indicated by the type of comments ( $\chi^2 = 17.510$ ,  $p = 0.041$ ). The responses “I don’t want to undergo a training” and “I’ll be pressed to undergo a training” were more frequently given by those who had conservative comments: 5 of 6 (83.3%) and 10 of 20 (50%), respectively.

Among the questions on the purpose of ICD only the responses “understanding the patient’s condition and prognosis” and “resolving the patient’s social problems” showed a significantly independent distribution ( $\chi^2 = 15.012$ ,  $p = 0.020$  and  $\chi^2 = 21.166$ ,  $p = 0.002$ , respectively). Only those who gave conservative (n = 8) and negativistic (n = 2) comments responded “no” to the question on the usefulness of ICD for understanding a patient’s condition and prognosis. Psychiatrists who gave conservative and negativistic comments more frequently denied the possibility of using ICD to resolve the patient’s social problems: 7 of 39 (17.9%) and 2 of 9 (22.2%), respectively. Conversely, psychiatrists who gave constructive and practically oriented comments agreed almost twice more frequently than those who gave conservative and negativistic comments with the use of ICD for addressing the patient’s social problems: 31 of 34 (91.2%) and 25 of 31 (80.6%) vs. 19 of 39 (48.7%) and 4 of 9 (44.4%), respectively.

### **DISCUSSION**

The results had similarities and differences with international studies on attitudes toward mental disorders classification. Thus, communication among clinicians followed by informing treatment and management decisions were reported as the two main uses of a diagnostic classification system by more than 4,000 psychiatrists from 44 countries as respondents of the WPA-WHO global survey in 2011.<sup>3</sup> While in our survey, the records in patient’s documentation and communication among clinicians, were responded as the two leading purposes to the use of ICD-10 in contrast to understanding the patient’s condition or prognosis and communication with patients or their relatives which were of minimal rating. This finding corresponds to the results of another global survey involving 1,700 respondents from 92 countries in 2015 as a part of the development of the ICD-11 classification of mental and

behavioral disorders.<sup>4</sup> The classification systems reported by global respondents were most frequently used for administrative or billing purposes. International field studies on the clinical utility of the ICD-11 diagnostic guidelines also showed that the participating clinicians evaluate the guidelines as less useful for treatment choice and prognosis assessment than for communicating with other health professionals.<sup>2</sup> Meanwhile, in our survey the respondents believed that the ICD diagnostic in general should be extended to facilitating clinical research and conceptualizing disorders.

The attitudes toward ICD-11 expressed by the respondents were of a debatable character. Being positive in general, specific attitudes to the forthcoming classification which have been also expressed in the narrative comments, were of more complex content including not only an interest, but along this also a concern and even a discontent. The typical trends of views on ICD diagnosis – conservative, constructive, practically oriented or negativistic ones – were associated with different factors, such as years of clinical practice, work settings, experience in ICD-10 use, and level of knowledge about ICD-11 innovations. The attitudes also contributed to the willingness to undergo the necessary training.

The tendency to follow “diagnostic conservatism” was mostly inherent in psychiatrists aged >50 years with >20 years of clinical practice. This group was the only one that refused to use ICD-10 diagnostic guidelines (5.26%). They less frequently applied ICD-10 to research work and were characterized by the lowest percentage of knowledge about the ICD-11 draft among the groups. They were more frequently unsatisfied with the ICD-11 draft, had greater protest to ICD-11 innovations, and denied to undergo further trainings on ICD-11.

The tendency to exhibit “diagnostic reformism” was generally inherent in specialists aged 30–40 years with 5–10 years of clinical practice. They were represented by the highest proportion of those who use the ICD-10 for different purposes mentioned in the survey. The respondents who gave constructive comments were generally familiarized and mostly satisfied with ICD-11 draft. They also showed greater interest and less concern on ICD-11 innovations. Moreover, they were interested in further education on ICD-11.

The tendency to have “diagnostic practiciness” was common among young or middle-aged specialists (below 30 years and from 40 years to 50 years) with

a short duration of clinical practice (1–5 years). This group was the only one with females who were slightly over-represented compared with males (54.84%). This group included a higher proportion of psychiatrists from outpatient settings. The psychiatrists who gave practically oriented comments were represented by specialists who had positive experience on ICD-10 use for any purposes. They felt quite acquainted and mostly satisfied with the ICD-11 draft. They showed greater interest in ICD-11 innovations and were highly motivated to have further education on ICD-11.

The tendency to have diagnostic “nihilism” was the rarest. It was observed mainly in specialists aged >60 years or, having 10–15 years of clinical practice, and working in inpatient settings. They accounted for the highest proportion of those who preferred ICD-10 for limited formal purposes. Moreover, they showed higher concern and greater protest to ICD-11 changes.

Therefore, a general negative attitude toward ICD-11 related to discontent or protest was more typical among those who had a longer clinical practice and expressed traditionalist views. They were also more critical of the classification of mental disorders and did not consider it to be useful for understanding the patient’s condition and care provision or resolving the patient’s social problems. Conversely, respondents of more younger age perceived that ICD could be beneficial to solving a wider range of tasks other than formal coding or communicating with colleagues. The majority of respondents preferred to have a classification of mental disorders that could be more acceptable for clinical research, conceptualization of diseases, or communication with patients or their relatives.

A positive attitude was associated with interests in ICD-11 and intention to undergo further special education. Moreover, younger participants or those with less clinical experience were inspired to face ICD-11 with more interest and willingness to participate in appropriate training. This observation corresponded to the results of the online survey conducted by the WPA Early Career Psychiatrists Section in 2019.<sup>6</sup>

The positive expectations of the surveyed participants corresponded to a better familiarity with the ICD-11 draft. The majority of the respondents who were familiar with the ICD-11 draft were satisfied. The more familiar

the psychiatrists were with the ICD-11 draft, the more interested and less concerned they were on ICD-11 implementation.

### Limitations

The limitations of this study are determined by the type of online survey, which was conducted in a Google form. Free access included random responses, although the link to the survey was in the top page of the professional website for 2.5 months. The intention to respond to the survey could be an additional characteristic of participant selectivity. A relatively small sample also raised questions on the reliability of the obtained data disseminated to the entire professional community. Nevertheless, the identified trends were consistent with the oral comments expressed in the presentations of specialists during meetings or lectures on ICD-11.

### CONCLUSION

This survey reveals the main tendencies in the attitudes and expectations of the participating Russian psychiatrists on the forthcoming ICD-11 implementation and diagnostic classification system in general.

More than half of the respondents look forward to facing ICD-11 with positive expectations, whereas some of them with a longer clinical experience foresee some difficulties or express discontent.

Interests in ICD-11 are related to the degree of familiarity with it. As such, familiarizing the professional community with ICD-11 innovations becomes challenging because it requires the correct translation of the classification and diagnostic guidelines and an appropriate education provision. The majority of psychiatrists participating in the survey plan to undergo further training on ICD-11 diagnosis.

The participants prefer to use the ICD diagnosis of mental disorders in a more extended scope. Specifically, they want to apply this diagnosis not only to statistic or formal purposes, but also for the clinical research and understanding of a patient's condition, as well as for practically oriented use to improving contact with patients or for better care provision.

The psychiatrists in this survey have different attitudes toward ICD-11 and its diagnostic trends. They reflect a diversity of opinions on the classification of mental disorders in the Russian professional community. As such, these differences should be considered

in the development of training programs that address professionals' expertise and clinical experience. At least three kinds of ICD-11 education-targeted programs should be considered. (1) Medical students and trainees with lack of clinical experience should be trained in terms of the use of the diagnostic instrument; (2) Clinicians who are qualified in ICD-10 should be trained so that they can appropriately transfer to ICD-11; and (3) The format of continuous medical education should be extended to improve professional qualification regularly.

This survey can be useful for the appropriate organization of ICD-11 promotion campaigns. Such campaigns should focus on the clinical utility of this classification and its evident-based advantages, which have been confirmed by the results of international field studies.

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### Correspondence to:

**Maya A. Kuligina**  
mkulygina@yandex.ru

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# The Use of ICD-10 for Diagnosing Mental Disorders In Russia, According to National Statistics and a Survey of Psychiatrists' Experience

Использование МКБ-10 для диагностики психических расстройств в России: по данным государственной статистики и результатам опроса врачей

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**Ivan A. Martynikhin**

*Department of Psychiatry and Narcology, the First Saint-Petersburg State Medical University, Saint-Petersburg, Russia*

**Иван А. Мартынихин**

Кафедра психиатрии и наркологии, Первый Санкт-Петербургский государственный медицинский университет имени академика И.П. Павлова, Санкт-Петербург, Россия

## ABSTRACT

**Purpose and methods.** In order to assess the specifics of practical use of the ICD-10 Diagnostic Guidelines by Russian psychiatrists, official national statistics on the prevalence of a number of mental disorders in Russia in 2019 were compared with the results of meta-analyses of international epidemiological studies of these disorders. In addition, a number of items in the online psychiatrists' survey, relating to the diagnosis of schizophrenia, were analysed; 807 Russian psychiatrists took part in the online survey.

**Results.** Analysis of national statistics showed that domestic clinicians diagnose some mental disorders significantly less often than might be expected, according to data obtained by international epidemiological studies. The number of cases of bipolar affective disorder registered in Russia is 90–150 times less than that for the prevalence of this disorder, according to meta-analyses of epidemiological studies; for depression, the result is 50–70 times; for anxiety disorders, the number is 25–50 times, and for autism, it is 30 times. Instead of the above disorders, diagnoses of organic non-psychotic mental disorders and schizophrenia might have been used unreasonably often. Between 2005 and 2019, diagnosis of childhood autism changed significantly (an increase of more than 100%), while the frequency of diagnosing other mental disorders remained unchanged. The results of the online survey also showed largely perfunctory use of the ICD-10 Diagnostic Guidelines, with a third of respondents reporting never checking the diagnostic schedules, and another third doing so from time to time. In addition, the low estimates given by survey participants regarding practical utility of the ICD-10 Diagnostic Guidelines, along with a large percentage of respondents who do not directly use diagnostic criteria in their work, indicate the need to improve the clinical usefulness of the diagnostic guidelines in the latest revision of the ICD, including convenience of use in practice.

**Conclusion.** The results of analysis of the Russian national mental health service statistic indicate that at least some diagnostic categories are not used by Russian psychiatrists exactly as ICD-10 suggests. The revealed discrepancy between the principles of diagnostics observed by domestic clinicians and international criteria may interfere with the use of evidence-based treatment algorithms, negatively affecting the quality of psychiatric care. In light of the upcoming transition to ICD-11 and in order to unify approaches to the diagnosis of mental disorders in our country, it is necessary to update and improve educational programmes for psychiatrists.

## АННОТАЦИЯ

**Цель и методы.** С целью оценить особенности практического использования российскими психиатрами диагностических руководств к МКБ-10 было проведено сопоставление официальной государственной статистики о распространенности ряда психических расстройств в России в 2019 г. с результатами мета-анализов международных эпидемиологических исследований данных расстройств. Дополнительно проведен анализ ряда пунктов онлайн-опроса психиатров о диагностике шизофрении. В онлайн-опросе принимало участие 807 российских психиатров.

**Результаты.** Анализ данных государственной статистики показывает, что отечественные клиницисты диагностируют некоторые психические расстройства существенно реже, чем этого следовало бы ожидать, исходя из данных международных эпидемиологических исследований. Так, количество зарегистрированных в России случаев биполярного аффективного расстройства в 90-150 раз меньше, чем распространенность этого расстройства по данным мета-анализов эпидемиологических исследований; депрессии – в 50-70 раз; тревожных расстройств – в 25-50 раз, аутизма – в 30 раз. Вместо этих расстройств неоправданно часто могут использоваться диагнозы органических непсихотических психических расстройств и шизофрении. За период 2005-2019 гг. существенно изменилась диагностика детского аутизма (рост более, чем на 100%), тогда как частоты диагностики других психических расстройств остались без существенных изменений. Результаты онлайн опроса также продемонстрировали во многом формальное использование диагностических руководств к МКБ-10: треть респондентов никогда не сверяется с диагностическими перечнями, треть – делает это время от времени. Кроме того, низкая оценка участниками опроса утилитарных свойств диагностического руководства к МКБ-10 и большой процент респондентов, которые не используют непосредственно диагностические критерии в своей работе, указывают на необходимость улучшения клинической полезности диагностического руководства новой версии МКБ, включая удобство его практического использования.

**Выводы.** Результаты анализа статистики российской государственной психиатрической службы свидетельствуют о том, что как минимум ряд диагностических категорий российские психиатры используются не совсем так, как предполагает МКБ-10. Выявленное несоответствие принципов диагностики, проводимой отечественными клиницистами, современным международным критериям может мешать применению доказательных алгоритмов терапии, негативно влияя на качество психиатрической помощи. В свете грядущего перехода к МКБ-11 и с целью унификации подходов к диагностике психических расстройств в нашей стране, необходимо обновление и усовершенствование образовательных программ для психиатров.

**Keywords:** ICD-10; diagnosis; epidemiology of mental disorders; survey

**Ключевые слова:** МКБ-10; диагностика; эпидемиология психических расстройств; опрос

## INTRODUCTION

Since 1999, by Order of the Ministry of Health of the Russian Federation, Russian health authorities and institutions have moved towards use of the *International Statistical Classification of Diseases and Related Health Problems*, 10<sup>th</sup> version (ICD-10), when "preparing statistical reports".<sup>1</sup> Since this time, published national statistics on the incidence of mental disorders in Russia have been based on ICD-10 diagnoses. However, the issue of how fully and consistently (in practice) Russian psychiatrists follow the criteria of the diagnostic

guidelines prepared by the World Health Organization in the ICD-10 chapter on mental disorders remains open to this day.

During the Soviet period, psychiatry in our country was largely isolated from international practice. Many of the ICD-10 provisions, which suggested a revision of the previously dominant nosological approach and a transition to operational criteria, were completely new for Russian psychiatrists and were criticized by many colleagues who were used to working with a substantially abridged Soviet Union version of ICD-9.



These aspects make it relevant to assess the specifics of practical application of the ICD-10 criteria by Russian psychiatrists. For the said purpose, we: a) compared official national statistics on the prevalence of mental disorders in Russia with the results of meta-analyses of international epidemiological studies on a number of mental disorders; and b) conducted a large-scale online survey of psychiatrists on specific use of ICD-10 in their practice (in relation to the diagnosis of schizophrenia).

In Russia, free medical (including psychiatric) care is guaranteed by the Constitution of the country. Most medical institutions are state-owned, subordinate to the Ministry of Health, and annually provide the Ministry with statistical data on patients treated. Statistical compilations are made on the basis of these reports. The most recent compilation, which contains detailed statistics on the ICD-10 categories of mental disorders, includes data<sup>2</sup> for

2019. The same team of authors published a compilation of data for 2005–2013, using a similar methodology.<sup>3</sup>

## METHODS

We selected a number of disorders (or groups thereof) from different sections of the ICD-10 mental disorders chapter, in the context of which the specifics of the use of this classification in our country are most noticeable (Table 1). For disorders with available, valid international epidemiological studies and meta-analyses, we have provided a comparison of the frequency of diagnosing such disorders (as observed in our country) and the expected rates (based on the results of relevant studies).

A large-scale online survey of Russian psychiatrists on approaches to diagnosis of schizophrenia was conducted on the website of the Russian Society of Psychiatrists (RSP) in 2016. The survey methodology

**Table 1. Comparison of Russian national statistics on the prevalence of a number of mental disorders with data from international epidemiological studies**

Diagnosis	National statistics of the Russian Federation: the number of registered patients per year (% of the Russian population) <sup>2</sup>	Data from meta-analyses of population-based studies - incidence rate per year (% of the population)	Discrepancy ratio
Schizophrenia	F20 - 0.32% (entire section F20–F29 - 0.36%)	0.33% <sup>4</sup>	1:1
Bipolar affective disorder	0.0081%	1.21% (0.71 for BAD type 1 and 0.50 for BAD type 2) <sup>5</sup>	1:90–1:150
Depression	All affective disorders, excluding bipolar affective disorder - 0.083%	Depression - 3.7% of the population per year (in cross-sectional studies - 4.7%, and for eastern European countries - 5.1%) <sup>6</sup>	1:50–1:70
Anxiety disorders	No data, but the entire section F4 - 0.3%	Group of anxiety disorders - 6.7% <sup>7</sup>	1:25–1:50
Autism	0.025%	0.76% <sup>8</sup>	1:30
Organic non-psychotic mental disorders	0.66%	No studies available	
Dementia in Alzheimer's disease	Old-age dementia - 0.03% Among people over 60 years of age - 0.14% of the population <sup>9</sup>	3.9% of people over 60 years of age <sup>11</sup>	1:25–1:30
Vascular dementia	0.09%. Among people over 60 years of age - 0.46% of the population <sup>9</sup>	No available studies in populations corresponding to the Russian ones	

and results have been described in detail in previous publications.<sup>11</sup> Firstly, the questionnaire was sent out in personal letters to psychiatrists registered on the RSP website (<https://psychiatr.ru>), and these invitations led to 616 respondents participating in the survey. At the end of the first stage of the survey, a public link to the questionnaire was posted on the RSP website. During the second stage, another 191 psychiatrists took part in the survey. Thus, a total of 807 Russian doctors (who had completed core training in psychiatry across 78 regions of Russia) became survey participants (with a third of respondents representing the largest cities in Russia, namely Moscow and St. Petersburg). The survey was completed in full by 621 respondents (76%); i.e., all questions in the questionnaire were answered (not taking into account sections for additional comments). The median work experience in the specialty was 15 years; 33% of the participants were hospital employees; 39% were employees of outpatient and consultative units; 25% were scientific, teaching or administrative staff; and 28% of the respondents had an academic degree. When compiling and conducting the survey, the selectivity approach was used. In this case, the first question was "Do you use ICD-10?", followed by "Do you conduct a diagnostic procedure for new patients with psychotic disorders?". Then there was the question of how exactly the ICD-10 diagnostic criteria for schizophrenia are used to diagnose schizophrenia. Those who do not use ICD-10 and those who do not work with new patients with psychosis were excluded from our analysis of this question.

## RESULTS

According to statistics, in 2019, more than 3.93 million people applied to the psychiatric service due to mental disorders (i.e., 2.68% of the Russian population). State healthcare provision units registered 465 thousand patients with schizophrenia (F20), or 0.32% of the population. (Section F20–29 in its entirety accounted for 0.40%.) This frequency almost exactly corresponds to the results of a meta-analysis of epidemiological studies of schizophrenia prevalence, conducted between 1965 and 2002.<sup>4</sup> Patients with schizophrenia accounted for 12% of all people who turned to Russian state institutions for psychiatric care in 2019.

A total of 120 thousand people (or 0.082% of the population) sought psychiatric care for affective disorders. Among those registered, only 12 thousand people had

bipolar affective disorder (BAD; including psychotic and non-psychotic episodes), or 0.008% of the population. A systematic review and meta-analysis of epidemiological studies indicates that the annual prevalence of BAD is 1.21% of the population, of which 0.71% is BAD type I, and 0.50% is BAD type II.<sup>5</sup> Since ICD-10 does not distinguish between types I and II of BAD, it can be assumed that Russian data correlate to a greater extent (but not completely) with the prevalence of BAD type I. Thus, the difference in prevalence ranges from 90 (when compared only with the prevalence of BAD type I) to 150 times (when compared with the overall prevalence of BAD).

Unfortunately, the exact number of people who have sought medical care for depression is not given in statistical compilations, but assuming that the overwhelming majority of all those who were treated for affective disorders in 2019 (minus those with BAD) suffered from depression, it can be seen that no more than 108 thousand people with depression (or 0.074% of the population) sought help from Russian state psychiatric institutions. A systematic review of epidemiological studies shows that depression diagnosis rates in Russia do not reflect the prevalence in the general population, where depression is significantly more widespread: 3.7% of the population suffered from depression within a year; 4.7% of the population had depression in cross-sectional studies.<sup>5</sup> There is no reason to assume that the incidence of depression in Russia for any reason is less than the global average. Moreover, the authors of the review suggest that the prevalence of depressive disorders in eastern Europe is slightly higher than in the rest of the world (5.1% of the population in cross-sectional studies). Thus, the difference in prevalence ranges from 50 (when compared with a prevalence of 3.7% of the population) to 70 times (when compared with a prevalence of 5.1% of the population).

One of the most common mental disorders in the population, along with affective disorders, is anxiety disorder.<sup>7</sup> Unfortunately, national statistics do not account for this group of disorders separately, but there are data for the whole of section F40–F48 (neurotic, stress-related and somatoform disorders). The total number of people who sought medical care and were diagnosed with disorders from this section was 403 thousand people, or 0.27% of the population (10% of all those seeking psychiatric help). A systematic review and meta-analysis

of epidemiological studies<sup>7</sup> showed the annual incidence of anxiety disorders to be 6.7% among the population. At the same time, the authors attributed the following categories to this group of disorders: generalized anxiety disorder, panic disorder, agoraphobia, social phobia, obsessive-compulsive disorder, post-traumatic stress disorder and acute stress disorder. Thus, the difference in prevalence ranges from 25 (when compared with all individuals with section F4 diagnoses) to 50 times (if suggested that the disorders considered in this meta-analysis account for about half of all section F4 diagnoses).

In 2019, 36.6 thousand people, or 0.025% of the Russian population, were diagnosed with childhood autism. The meta-analysis of epidemiological studies indicates that the prevalence of autism diagnosed according to current criteria globally is 0.76%.<sup>8</sup> Thus, the difference in frequency is 30 times.

In particular, we should mention the organic non-psychotic disorders section of the statistical compilation. In total, in 2019, more than 965 thousand people (almost a quarter of all those who were treated), or 0.66% of the population, sought help for disorders in this group. Dementia turned out to be a relatively rarely used diagnostic category in the Russian psychiatric service; 182 thousand people (0.12% of the population) with diagnoses of "Vascular dementia and other forms of old-age dementia" were under observation. Of these, 133 thousand (73% of all patients with dementia) were diagnosed with vascular dementia, and the remaining 48 thousand were diagnosed with "other forms of dementia". Similar figures are given by selective publication of statistics on the prevalence of mental disorders among people over 60 years of age.<sup>9</sup> In 2016, 123 thousand people with vascular dementia and 43 thousand with old-age dementia were observed. (We are providing data for 2016 here as more recent data have not yet been published.) According to the literature sources, the most common cause of old-age dementia is Alzheimer's disease, which has a prevalence of about 3.1% of the population over 60 years of age in eastern Europe.<sup>10</sup> Taking into account the fact that, in Russia, about 22% of people are over 60 years of age (data from the Federal State Statistics Service), the difference in the frequency of diagnosis ranges from 25 (if Alzheimer's disease is taken as the cause of all old-age dementias) to 30 times. (Alzheimer's disease is the most common but not the only cause of dementia in this group of people.)

Unfortunately, epidemiological studies of the prevalence of vascular dementia in populations with similar gender, age composition and risk factors are not sufficient for the purposes of comparing diagnosing frequency.

Table 2 shows the dynamics of registered cases of the above-mentioned disorders between 2005 and 2019.<sup>2,3</sup> The bipolar affective disorder category and the division into vascular and old-age dementias have only been included in statistical compilations since 2010. Accordingly, for those categories that were included in the 2005 data compilation, the table shows the percentage change of the number of registered cases to the number of cases treated in 2005, for those for which the data are available, starting only from 2010 – the percentage change to the number of cases treated in 2010. According to the data provided, the total number of patients registered by psychiatric units and institutions over the past 14 years has decreased by almost 7%, and the number of people who sought help for most of the disorders considered has also decreased, with the exception of those with disorders falling into the categories of organic non-psychotic mental disorders (+7.8%) and vascular dementia (+4.7%). The greatest decrease in the number of reported cases was observed for patients with depression (-16.3%) and neurotic, stress-related and somatoform disorders (-28.6%).

The results of the psychiatrists' survey on use of the ICD-10 Diagnostic Guidelines in the diagnosis of mental disorders showed that most respondents (96%) use ICD-10 codes in their practice, of whom 86% indicated that they specify a detailed (accurate) diagnosis and code for the disorder, with 9% only making a generalized diagnosis (for example, F20 for schizophrenia, without specifying the form and course of the disease). At the same time, of those who use the ICD-10 codes, only 14% check the ICD-10 Diagnostic Guidelines<sup>12</sup> for each schizophrenia diagnosis. Almost a third of respondents (29%) never check the schedule; a little more than a third (36%) check only occasionally (in difficult diagnostic cases); and 21% often check the schedule (Figure 1).

The respondents' average estimate of the usability of the ICD-10 diagnostic criteria schedule for schizophrenia, on a scale from one to five, was 3.44, and the correspondence with their clinical practice was 3.66. However, for specific items in the diagnostic criteria schedule for schizophrenia, most respondents (67%) were in favour of maintaining the schedule in its current

Table 2. Dynamics of patients with selected diagnoses treated by the Russian state psychiatric service<sup>2,3</sup> between 2005 and 2019

Diagnosis	2005		2010		2019		Dynamics from 2005 (2010*) to 2019	
	abs. number	% of population	abs. number	% of population	abs. number	% of population	abs. number	Percentage from 2005 (2010*)
Total patients registered by the service	4,223,694	2.937	4,187,873	2.932	3,934,058	2.680	-289,636	-6.9%
Schizophrenia	515,712	0.359	502,883	0.352	464,761	0.317	-50,951	-9.9%
Affective disorders	138,206	0.096	141,994	0.099	120,122	0.082	-18,084	-13.1%
Depression (psychotic and non-psychotic affective disorders, excluding BAD)			129,198	0.090	108,154	0.074	-21,044*	-16.3%*
Bipolar affective disorder (psychotic and non-psychotic cases)			12 796	0.009	11,968	0.008	-828*	-6.5%*
Neurotic, stress-related and somatoform disorders (F4)	564,772	0.393	499,719	0.350	403,094	0.275	-161,678	-28.6%
Organic non-psychotic mental disorders	895,545	0.623	952,809	0.667	965,368	0.658	69,823	7.8%
Dementia, total	138,580	0.096	177,016	0.124	181,751	0.124	4,735	2.7%
Old-age dementia			49,774	0.035	48,577	0.033	-1,197 *	-2.4%*
Vascular dementia			127,242	0.089	133,174	0.091	5,932 *	4.7%*

\*An asterisk indicates a comparison with 2010; in other cases, it indicates comparison with 2005

form, rather than deleting or rewording it (28%). Only 11% of respondents supported a more generalized wording of the criteria (similar to the DSM criteria) than in the ICD-10 schedule; 68% of respondents were against this because of possible loss of specificity.

The greatest differences among the survey participants were found in relation to the diagnostic significance of negative symptoms, with 51% of respondents recognizing negative symptoms as obligate symptoms of schizophrenia, and 46% considering otherwise.

When asked about the use of other diagnostic criteria (in addition to ICD-10) and classifications of schizophrenia in their practice, 19% of respondents noted that they use only ICD-10 (clinical version);<sup>12</sup> the remaining respondents indicated that they use other classifications and criteria in their work; clarifications were given in free form as comments. Thus, 49% of respondents (398 people) indicated that they use Snezhnevsky's classification of schizophrenia (noting, in their comments, that the approach of A.V. Snezhnevsky is more familiar to them

than ICD-10, since it is simple, logical and prognostically accurate), followed by the criteria of E. Bleuler (32%), criteria of K. Schneider (30%), DSM-IV (20%) and DSM-5 (11%); other versions of the ICD-10 Diagnostic Guidelines (for example, the research version, multi-axial classification of childhood and adolescent psychiatric disorders) were 13% each.

A proportion of respondents (20%) noted that, at least sometimes, they diagnose schizophrenia in patients who do not meet the ICD-10 criteria for schizophrenia in order to justify the disability group they require and to ensure that such patients receive subsidized medicines.

## DISCUSSION

For more than 40 years, since the development of DSM-III in 1980, the issue of the reliability of psychiatric disorder diagnosis has been a keynote idea in the topic of improving the classifications of mental disorders and diagnostic guidelines for these. However, in practice, diagnoses of mental disorders are made in the context of closed interactions between a doctor and a patient, which are difficult to penetrate from the outside. It is also difficult to assess the qualities of such exchanges.

Comparisons of national statistics and the results of epidemiological studies can provide important information about differences between the implicit diagnostic algorithms used by practitioners and structured (or semi-structured) tools used in scientific research, which ensure accurate adherence to diagnostic guidelines. However, such comparison definitely has certain methodological limitations. Thus, the low frequency of diagnosing certain mental disorders, as highlighted in this article, may be associated with several reasons other than the peculiar diagnostic preferences of doctors.

Firstly, the statistical reports reviewed<sup>2,3,9</sup> include data from state psychiatric institutions only. Notwithstanding the fact that most psychiatrists in Russia work in these institutions, psychiatric care is also provided in some departmental institutions that are not subordinate to the Ministry of Health (for example, in military hospitals, private clinics and by individual practising psychiatrists, the numbers of which have been increasing in recent years), data on whose results are not included in the national statistics. Moreover, some mild anxiety disorders and mood disorders can be treated by doctors of other medical specialties. In this regard, it can be assumed

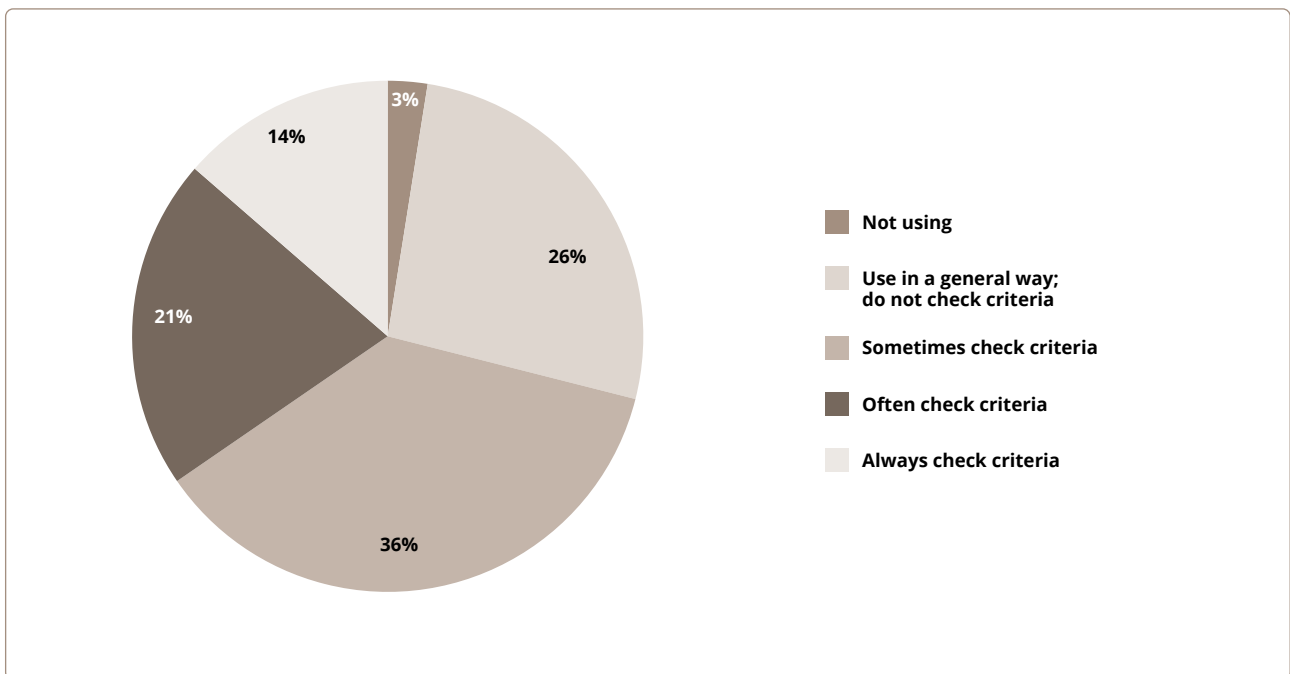


Figure 1. Practical use of general diagnostic criteria for the F20 category (schizophrenia) by respondents (n = 639) who simultaneously a) use the ICD-10 diagnosis codes; b) in the year prior to the survey, had diagnosed new patients with psychotic disorders

that a certain number of people with depression, anxiety disorders and dementia did not seek help from the state psychiatric service during the period studied but might have received the necessary treatment from doctors of other specialties (for example, general practitioners). However, people with severe mental disorders in Russia are mainly observed in state psychiatric units and institutions. In this regard, it can be assumed that, at the very least, persons with BAD (especially BAD type I) and childhood autism are likely to have applied to state psychiatric units and institutions but unlikely to have received proper diagnoses and treatment there.

*Secondly*, data on registered illnesses depend on the population's access to medical care. It can be assumed that many Russians with mental disorders do not seek psychiatric help on their own due to the stigmatization of mental disorders, the low availability of information about the clinical picture of mental disorders, and lack of up-to-date methods to treat them.

*Thirdly*, the actual incidence of mental disorders may vary in different countries, and no qualitative epidemiological studies of the prevalence of specific mental disorders in Russia have been conducted in recent decades. However, there is no reason to believe that there are any specific conditions in Russia that would lead to such significant differences in the actual incidence of mental disorders (as identified above). Some of the mental disorders considered are mainly determined by genetic causes. Thus, schizophrenia, bipolar disorder and childhood autism are more than 80% determined by genetic causes.<sup>13</sup> In many respects, a genetic predisposition towards these disorders is common with schizophrenia,<sup>14</sup> and there is no reason to believe that the population of Russia has the same genetic predisposition to schizophrenia as the population of other countries but is completely different in relation to bipolar affective disorder and childhood autism. Recurrent depression and anxiety disorders are less determined by genetic predisposition<sup>13</sup> and more by unfavourable lifestyle factors. In terms of the number of the latter, it is most likely that the population of our country is not in a more favourable situation than the residents of the United States and western Europe.

Taking into account the above limitations, and having analysed differences in the frequency of diagnosing disorders, we can evaluate the specifics of diagnostic preferences shown by Russian psychiatrists. In addition

to schizophrenia, all the disorders included in the comparison were, by an order, less frequently diagnosed by the state psychiatric service than would be expected, based on epidemiological data. Schizophrenia is a positive exception. How can this exception be explained? Unfortunately, it could be caused by over-diagnosing of schizophrenia. Many people with BAD and childhood autism could receive a diagnosis of schizophrenia (and receive relevant treatment), instead of correct diagnoses. The results of the online survey may partially confirm this thesis. When making a diagnosis of schizophrenia, many clinicians are guided not by state-of-the-art international diagnostic criteria, but by outdated approaches, often involving extensive and subjective diagnosis. In addition, according to the survey, some doctors intentionally diagnose schizophrenia in patients with other mental disorders because a diagnosis of schizophrenia implies the possibility of receiving better social care and free medication.

Indirect confirmation of the importance of diagnostic preferences is provided by the dynamics of diagnosing childhood autism in Russia. This category has only been distinguished in national statistics since 2015, when 17.8 thousand people with a diagnosis of autism (0.0122% of the population) turned to the psychiatric service.<sup>15</sup> At the same time, the Russian Ministry of Health launched a campaign to provide additional training for psychiatrists in the diagnosis of autism, and in 2019, 36.6 thousand people (0.025% of the population) were registered,<sup>2</sup> thus showing a 105% increase over four years.

The dynamics of the registered incidence rate between 2005 and 2019 indicate that significant changes in the diagnostic approaches of doctors occurred only in relation to the diagnosis of childhood autism, while the diagnostic tendencies with regard to other mental disorders reviewed remained unchanged. Moreover, the number of patients with depressive and anxiety disorders in the psychiatric service decreased, and the number of people with organic non-psychotic disorders increased.

Special consideration should be given to the category of organic non-psychotic disorders, which is very popular among Russian psychiatrists. (Almost every fourth person among those who sought psychiatric help in 2019 received diagnoses from this category.) There are no studies focused on the epidemiology of disorders from this category; moreover, the section for "organic" mental disorders was intentionally excluded from DSM-5



and ICD-11 classifications<sup>16</sup> due to the fact that the concept of "organic" does not give a clear explanation for the occurrence of a mental disorder (while "organic", structural changes in the brain are currently identified in most mental disorders, including schizophrenia, which was previously considered a functional disorder). It can be assumed that a significant number of people who sought medical care for anxiety, affective disorders or autism received a diagnosis from any of these categories due to the diagnostic traditions of doctors, who tend to explain the appearance of psychopathological symptoms by the hypothetical presence of any hidden, non-specific "organic" changes in the brain. The fact of prevalence of dementias caused by vascular diseases of the brain over dementias caused by neurodegenerative diseases, such as Alzheimer's disease, is also unusual. This is perhaps due to the tradition of revealing "vascular" causes of dementia in all people who have certain cardiovascular diseases.

The survey of psychiatrists demonstrated widespread, but largely perfunctory, use of ICD-10 by psychiatrists in our country. Respondents noted the low practical utility of the ICD-10 Diagnostic Guidelines for the schizophrenia section. This may perhaps explain the fact that only a small percentage of respondents reported regularly using the ICD-10 Diagnostic Guidelines in their work, which, in turn, can lead to inaccurate adherence to the principles laid down in the guidelines. On the other hand, despite the lack of usability, most respondents indicated that they were not ready to abandon the detailed criteria provided in ICD-10 due to fears of reducing the diagnostic specificity.

The survey revealed significant differences in ideas about "correct" diagnosis of schizophrenia, with one half of the respondents being guided mainly by the traditional approach (in line with the views of Kraepelin-Bleuler-Snezhnevsky) and the other half by approaches similar to the ICD-10 guidelines.

Unfortunately, taking into account the above, it can be assumed that a significant number of Russian psychiatrists do not use state-of-the art international diagnostic criteria in the diagnosis of mental disorders, which may interfere with the use of evidence-based treatment algorithms, negatively affecting the quality of psychiatric care. The use of different diagnostic principles by psychiatrists in Russia, among other things, can create a lack of trust in the diagnostic conclusions of their colleagues.

## CONCLUSION

The analysis of national statistics shows that at least some of the diagnostic categories are being used by Russian psychiatrists, though not quite as provided for by the ICD-10 guidelines. Despite possible distortions associated with collection of statistical data, the number of patients seeking medical care and actual differences in the incidence rate, it is safe to say that bipolar affective disorder, depression, anxiety disorders, autism and dementia in Alzheimer's disease, in Russia, are diagnosed by psychiatrists much less often than they should be. Instead of the above disorders, diagnoses of organic non-psychotic mental disorders and schizophrenia may be used unreasonably often.

The results of the online survey also indicate largely perfunctory use of the ICD-10 Diagnostic Guidelines in our country. In addition, the low estimates given by survey participants regarding usability of the ICD-10 diagnostic criteria for schizophrenia (and the correspondence with the patients they observe in their clinical work), together with a large percentage of doctors who do not directly use diagnostic schedules in their practice, support the need to improve the practical utility of the diagnostic guidelines in the latest revision of the ICD, including, possibly, simplifying, generalizing and adapting it to the diagnostic capabilities in real clinical practice. In light of the upcoming transition to ICD-11, and in order to unify approaches to the diagnosis of mental disorders in our country, educational programmes for psychiatrists should be updated and improved, and the system of continuing medical education should be implemented more actively and widely.

## Correspondence to:

**Ivan A. Martynikhin**

ivan.martynikhin@gmail.com

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# Depathologizing Sexual Orientation and Transgender Identities in Psychiatric Classifications

Депатологизация сексуальной ориентации и трансгендерной идентичности в психиатрических классификациях

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Rebeca Robles<sup>1</sup>, Tania Real<sup>1</sup>,  
Geoffrey M. Reed<sup>2</sup>

<sup>1</sup>Global Mental Health Research Center, National Institute of Psychiatry, Ministry of Health, Mexico City, Mexico;

<sup>2</sup>Department of Psychiatry Columbia University Vagelos College of Physicians and Surgeons, New York, NY, USA

Ребека Роблес<sup>1</sup>, Таня Рил<sup>1</sup>,  
Джеффри М. Рид<sup>2</sup>

<sup>1</sup>Центр исследований глобального психического здоровья, Национальный институт психиатрии, Министерство здравоохранения, Мехико, Мексика;

<sup>2</sup>Кафедра психиатрии, Высшая медицинская школа Валегоса, Колумбийский университет, Нью-Йорк, штат Нью-Йорк, США

## ABSTRACT

**Introduction.** This article presents the history and rationales of conceptualization and classification of homosexuality and transgender identity in both ICD and DSM. We review the efforts that have been made (and those that remain pending) to improve psychiatric classifications with new scientific knowledge, changing social attitudes and human rights standards.

**Method.** We conducted a literature search of the classification of homosexuality and transgender identity as mental disorders.

**Result.** We provide a historical description of these concepts in ICD and DSM, including fundamental points of disagreement as well as arguments that have been effective in achieving changes in both classifications.

**Conclusions.** Fundamental changes have been made in the *International Classification of Diseases Eleventh Revision* (ICD-11) in terms of the classification of sexual orientation and gender identity based on scientific evidence and the ICD's public health objectives. These changes might support the provision of accessible and high-quality healthcare services, and are responsive to the needs, experience and human rights of the populations involved.

## АННОТАЦИЯ

**Введение.** Данная статья представляет историю развития взглядов в отношении концептуализации и квалификации гомосексуальности и трансгендерной идентичности, а также обоснование изменений, которые произошли как в Международной классификации болезней (МКБ), так и в Диагностическом и статистическом руководстве по психическим расстройствам (DSM). С учетом новых научных знаний, смены социальных установок и стандартов в области прав человека проанализированы усилия, которые были предприняты (и те, что еще предстоит предпринять) для совершенствования классификаций психических расстройств.

**Материал и методы.** Проведен поиск литературы по теме классификации гомосексуальности и трансгендерной идентичности как психических расстройств.

**Результаты.** Дано описание этих понятий в различных версиях МКБ и DSM, включая основные расхождения, равно как и аргументы для изменений, произошедших в обеих классификационных системах.

**Выводы.** В МКБ-11 были внесены фундаментальные с точки зрения классификации сексуальной ориентации и гендерной идентичности изменения, в основу которых легли научные доказательные данные, а также цели МКБ в отношении общественного здравоохранения. Эти изменения могут способствовать обеспечению доступной высококвалифицированной помощи для определенных групп населения, а также отвечают их нуждам, собственному опыту и требованиям защиты прав человека.

**Keywords:** *depathologization; homosexuality; transgender identity; ICD-11; DSM-5*

**Ключевые слова:** *депатологизация; гомосексуальность; трансгендерные формы идентичности; МКБ-11; DSM-5*

## INTRODUCTION

According to recent international surveys of psychiatrists from 44 countries<sup>1</sup> and psychologists from 23 nations,<sup>2</sup> the 10<sup>th</sup> version of the *International Classification of Diseases and Related Health Problems* (ICD-10)<sup>3</sup> is the classification system that both groups of clinicians use most in their everyday clinical work (70.1% of psychiatrists, and 51% of psychologists), followed by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM)<sup>4</sup> (23% of psychiatrists, and 43.8% of psychologists).

Although there are several benefits associated with the use of these classifications, their critical examination is important to reduce psychiatry's vulnerability to political ideologies, economic goals, stigmatizing attitudes and other forms of abuse.<sup>5</sup> From this perspective, throughout the history of these classification systems, one of the fundamental points of disagreement has been the conceptualization and classification of conditions related to homosexuality and transgender identity as mental disorders. The classification of homosexuality and transgender identity as mental disorders has been used, for example, to justify the implementation of "corrective" therapies,<sup>6,7</sup> a practice that is now prohibited in a growing number of countries where LGBT-affirmative psychological services<sup>8</sup> are now considered the standard of care.

## A BRIEF HISTORY OF THE CLASSIFICATION OF HOMOSEXUALITY

The ICD and DSM's first classifications of homosexuality conceptualized it as a sexual deviation. ICD-6 was the

first version of the ICD that included a classification of morbidity and the first version to incorporate a classification of mental disorders. Prior to ICD-6 and founding of WHO, ICD was exclusively a classification of mortality, the first version being called *The International List of Causes of Death*. From ICD-6 (approved in 1948), through ICD-7 (approved in 1955), ICD-8 (approved in 1965) and ICD-9 (approved in 1975), homosexuality was included in Chapter V on mental disorders, and also as part of a general category for "Sexual Deviation". Table 1 shows the specific blocks, groups and categories (and corresponding codes) used to classify, in a single group, a set of very different conditions currently understood as conditions related to sexual orientation (e.g., homosexuality), gender identity or sexual preferences.

According to Mendelson,<sup>9</sup> the first ICD definition of sexual deviation was included in the *Glossary of Mental Disorders and Guide to their Classification* (issued in 1974 for use in conjunction with the eighth revision of the ICD) and conceptualized homosexuality, as well as transvestitism, fetishism, exhibitionism, sadomasochism and bestiality, as manifestations of the presence of a persistent abnormality of the sexual impulse. In the ICD-9 expanded glossary, sexual deviations were described as abnormal sexual inclinations or behaviours directed primarily towards people not of the opposite sex, or towards sexual acts not normally associated with coitus, or towards coitus performed under abnormal circumstances.

Regarding the APA's classification, from its first edition (DSM-I, published in 1952) until the sixth printing of its second edition (DSM-II, published in 1968), homosexuality

Table 1. ICD-6 to ICD-9: Categories specifically related to sexual functioning

	ICD-6 and ICD-7	ICD-8	ICD-9
<b>Chapter name</b>	Chapter V. Mental, psychoneurotic and personality disorders	Chapter V. Mental disorders	Chapter V. Mental disorders
<b>Block name and codes</b>	Disorders of character, behaviour and intelligence (codes 320–326)	Neurosis, personality disorders and other non-psychotic mental disorders (codes 300–309)	Neurotic disorders, personality disorders and other non-psychotic mental disorders (codes 300–316)
<b>Group name and code</b>	Pathologic personality (code 320)	Sexual deviation (code 302)	Sexual disorders and deviation (code 302)
<b>Category names, codes and conditions included</b>	320.6 Sexual deviation Includes: exhibitionism, fetishism, homosexuality, pathologic sexuality, sadism, sexual deviation	302.0 Homosexuality Includes: lesbianism, sodomy  302.1 Fetishism  302.2 Paedophilia  <b>302.3 Transvestitism</b>  302.4 Exhibitionism  302.8 Other sexual deviation Includes: erotomania, masochism, narcissism, necrophilia, nymphomania, sadism, voyeurism  302.9 Unspecified sexual deviation Includes: pathological sexuality NOS, sexual deviation NOS	302.0 Homosexuality Includes: lesbianism  302.1 Bestiality  302.2 Paedophilia  <b>302.3 Transvestism</b>  302.4 Exhibitionism  <b>302.5 Transsexualism</b>  302.6 Disorders of psychosexual identity Includes: gender-role disorder  302.7 Frigidity and impotence Includes: psychogenic dyspareunia  302.8 Other sexual deviation or disorder Includes: fetishism, masochism, sadism  302.9 Unspecified sexual deviation or disorder

was specifically included in the rubric of “Sexual Deviation”, together with other conditions related to sexuality such as fetishism, paedophilia, transvestitism and sadism. In DSM-I, sexual deviations were categorized as “Sociopathic Personality Disturbances”. In DSM-II, these conditions were placed in major subdivision V, covering “Personality Disorders and Certain Other Non-Psychotic Mental Disorders”, with “homosexuality” as the category to be used *“for individuals whose sexual interests are directed primarily toward people of the same sex...”*<sup>10</sup>

The underlying assumption was that normal sexual orientation serves approved social and biological purposes, which runs counter to the current international

acceptance of sexual rights (specifically the right to decide whether or not to reproduce).<sup>11,12</sup> Radical changes to the conceptualization and classification of sexual conditions in general, particularly those related to sexual orientation and gender identity, required a major overhaul to bring them into line with the scientific literature.

**The second era of homosexuality classification: Removing or replacing stigma?**

An ambivalent attitude regarding the declassification of homosexuality was observed in the WHO’s ICD-10 (published in 1992). Although it was noted that *“Sexual orientation alone is not to be regarded as a disorder”*,<sup>3</sup>

at least three ICD-10 codes (included in the “Psychological and Behavioural Disorders Associated with Sexual Development and Orientation” block, under the heading of “Disorders of Adult Personality and Behaviour”), specifically F66.0 (“Sexual Maturation Disorder”), F66.1 (“Ego-dystonic Sexual Orientation”) and F66.2 (“Sexual Relationship Disorder”), could explicitly be applied based on a homosexual, heterosexual or bisexual orientation.

Sexual maturation disorder was defined as a mental disorder applied to an individual suffering from “*uncertainty about his or her gender identity or sexual orientation, which causes anxiety or depression. Most commonly this occurs in adolescents who are not certain whether they are homosexual, heterosexual, or bisexual in orientation or in individuals who after a period of apparently stable sexual orientation, often within a long-standing relationship, find that their sexual orientation is changing.*”<sup>3</sup>

Ego-dystonic sexual orientation referred to an individual whose “*gender identity or sexual preference is not in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders and may seek treatment in order to change it.*”<sup>3</sup> “Sexual Relationship Disorder” is a category for those whose “*gender identity or sexual preference abnormality is responsible for difficulties in forming or maintaining a relationship with a sexual partner.*”<sup>3</sup>

Even though heterosexuality is also listed as a variation of sexual orientation that could be subcoded in any of these categories, heterosexual people were not the intended recipients of these diagnoses.<sup>13</sup> Clearly, those who exhibit a same-sex sexual orientation may also experience related distress. However, there is no evidence that same-sex sexual orientation itself is the cause of distress (i.e., a sexual maturation disorder or “ego-dystonic” homosexuality); rather, it seems that distress is a consequence of the social rejection and discrimination caused by stigma associated with their sexual orientation,<sup>14</sup> which unfortunately continues to be very frequent.<sup>15</sup> Moreover, given that ICD-10 does not include specific categories for relationship disorders due to other potential contributory factors, classification of the co-occurrence of relationship problems with a specific sexual orientation (or gender identity) is difficult to justify.<sup>16</sup>

Similarly, although homosexuality was removed from DSM-II in 1973, a category called “Sexual Orientation Disturbance” was included in the subsequent DSM-II

reprints for those “*disturbed by it, in conflict with it, or wishing to change their homosexual orientation*”. The main argument for its inclusion was that the presence of such subjective distress justified a diagnosis of a mental disorder.

Although scientific evidence available at the time challenged the assumption that homosexuality was a pathological condition *per se*,<sup>17-20</sup> this special category remained in DSM-III (published in 1980) under a different name: “Ego-dystonic Homosexuality”. The rationale for its inclusion was changed by adding “inherent disadvantage” as a second element of the definition of a mental disorder.<sup>21</sup>

Moreover, although the term *Ego-dystonic Homosexuality* no longer appeared in DSM-III-R (published in 1987), DSM-IV (published in 1994) or DSM-IV-TR (published in 2000), the category of “Sexual Disorders Not Otherwise Specified” opened the door to classify “*persistent and marked distress about one’s sexual orientation*”.

Table 2 summarizes the major subdivisions, groups and category names in the DSM’s second stage of classification of homosexuality. The example provided for “Sexual Disorders Not Otherwise Specified” to classify the equivalent of ego-dystonic homosexuality is highlighted in bold.

The same criticisms used for the term “ego-dystonic homosexuality” could be applied to “sexual disorder not otherwise specified”. If there are no categories of mental disorders for short people who are unhappy with their height, eye colour or complexion, then why should there be one for distress related to sexual orientation?<sup>22</sup>

As one would imagine, there were several mental health specialists who viewed retention of the ability to assign a mental disorder diagnosis on the basis of sexual orientation as representative of the traditional “homophobic bias” in the nomenclature, while other psychiatrists and psychoanalysts opposed removal of the original category of homosexuality, arguing that this occurred in response to an “*indefensible response to gay pressure*”.<sup>21</sup>

### **Complete declassification of homosexuality as a mental disorder in the DSM and ICD**

Finally, ICD-11 and DSM-5, the current versions of the WHO and APA classifications, do not include a single category that could be applied to people based on their sexual orientation.<sup>23</sup>



Table 2. DSM-II (from 1974 onwards) to DSM-IV-TR: Categories related to homosexuality

	DSM-II (7 <sup>th</sup> and subsequent reprints)	DSM-III	DSM-III-R	DSM-IV and DSM-IV-TR
<b>Major subdivision</b>	Personality disorders and certain other non-psychotic mental disorders	Psychosexual disorders	Sexual disorders	Sexual and gender identity disorders
<b>Group name</b>	Sexual deviation	Other psychosexual disorders	Other sexual disorders	Other sexual disorders
<b>Category names and criteria/examples</b>	Sexual orientation disturbance [homosexuality]	<p><b>Ego-dystonic homosexuality Criteria:</b></p> <p>A) The individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships;</p> <p>B) There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and constitutes a persistent source of distress.</p>	<p>Sexual disorder not otherwise specified</p> <p>Examples:</p> <p>(1) Marked feelings of inadequacy concerning body habitus, size and shape of sex organs, sexual performance or other traits related to self-imposed standards of masculinity or femininity;</p> <p>(2) Distress about a pattern of repeated sexual conquests or other forms of non-paraphilic sexual addiction, involving a succession of people who exist only as things to be used;</p> <p><b>(3) Persistent and marked distress about one's sexual orientation.</b></p>	

The ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health clarified that declassification of the ICD-10 “Psychological and Behavioural Disorders Associated with Sexual Development and Orientation” categories was based on their lack of usefulness for public health surveillance and clinical purposes, and their negative consequences, including mistakes or delays in accurate diagnosis and treatment, and ineffective and unethical “corrective” therapies.<sup>16</sup>

**PSYCHIATRIC CLASSIFICATION OF GENDER IDENTITY**

The history of psychopathological classification of transgender identity in the DSM and ICD has a number of parallels with the one presented above for sexual orientation, mainly in connection with activism and arguments used to call for the removal of transgender diagnoses from mental disorder classifications,<sup>24</sup> although different decisions were taken by the developers of the two classification systems. Given the importance of reducing the stigmatization of this population and ensuring quality

health and mental health services if required,<sup>25</sup> in ICD-11, transgender conditions were moved from the chapter on mental and behavioural disorders to a new chapter on “Conditions Related to Sexual Health”, while DSM-5 changed the name of the conditions, eliminating the word “disorder” but retaining them as mental disorders.

**History of the classification of transgender conditions in the DSM and ICD**

According to Zucker and Spitzer,<sup>26</sup> since the middle of the 20<sup>th</sup> century – particularly the 1960s – awareness of transgender phenomena seems to have increased considerably among health and mental health professionals. During this period, many of them considered transgender identity to be a psychopathological expression of human behaviour<sup>27</sup> or a biological disorder.<sup>28</sup>

However, unlike homosexuality, transgender phenomena were not included in the first editions of either ICD or DSM. It was not until the end of the last century, when ICD-9 (1978) and DSM-III (1980) were published,

**Table 3. DSM-III to DSM-IV-TR: Categories related to transgender identity**

	<b>DSM-III</b>	<b>DSM-III-R</b>	<b>DSM-IV and DSM-IV-TR</b>
Major subdivision	Psychosexual disorders	Disorders usually first evident in infancy, childhood or adolescence	Sexual and gender identity disorders
Category names	Gender identity disorder in childhood  Transsexualism (adolescents and adults)	Gender identity disorder in childhood  Transsexualism (adolescents and adults)  Gender identity disorder in adolescence and adulthood, non-transsexual type	Gender identity disorder (with one set of criteria for children and another for adolescents and adults)

that psychiatric diagnoses related to transgender identity appeared for the first time. Table 3 shows the major subdivisions and categories used to classify transgender conditions through DSM-III to DSM-IV-TR (see Table 1 for ICD-8 and ICD-9 categories, highlighted in bold).

In the ICD-10 chapter on Mental and Behavioural Disorders<sup>3</sup> (specifically section F64 on gender identity disorders), the diagnoses for transgender identity were exactly the same as those in DSM-III (gender identity disorder of childhood and transsexualism for adolescents and adults). Other ICD-10 categories for paraphilias that could be related to transgender phenomena are “Dual Role Transvestism” and “Fetishistic Transvestism”.

Interestingly, Stoller (and other psychiatrists and psychoanalysts who supported the APA’s decision to remove homosexuality from DSM-II) recommended the inclusion of categories related to transgender identity in DSM-III. According to other contemporary experts in this area,<sup>24</sup> this suggestion was based on a psychopathological conceptualization of transgender identity as a separation-individuation problem.<sup>29</sup>

*Current categories related to gender identity: Differences between ICD-11 and DSM-5* ICD-11 and DSM-5 working groups wrestled with two main challenges: how to reduce stigma (which underlies the international call for removal of transgender diagnoses from mental disorder classifications by a number of civil societies, professional organizations and the European Parliament)<sup>23,30,31</sup> while maintaining access to care (when this requires the

existence of a diagnosis in order to obtain needed medical treatment covered by third party payers).<sup>32</sup>

In both classification systems, the name of the categories related to transgender conditions was changed in order to reduce stigma, eliminating the word “disorder” and opting for labels that better express the subjective experience of cross-gender identity.<sup>25</sup> In ICD-11, they are: “Gender Incongruence in Childhood” and “Gender Incongruence in Adolescence and Adulthood”, whereas in DSM-5, these are “Gender Dysphoria in Children” and “Gender Dysphoria in Adolescents or Adults”.

Nevertheless, the need for diagnostic categories that ensure healthcare reimbursement of gender-affirming treatments for transgender people was resolved in different ways by ICD-11 and DSM-5. In the APA classification, consisting exclusively of mental disorders, transgender categories are retained as mental disorders, whereas in the WHO classification system (which comprises and could introduce different chapters for health-related conditions), these categories were moved from the chapter on mental, behavioural and neurodevelopmental disorders to a new chapter on conditions related to sexual health. Consistent with the conceptualization of transgender identity as not being a mental disorder, in ICD-11, distress and functional impairment are identified as commonly occurring in response to experiences of stigmatization and victimization, but they are not diagnostic requirements. In DSM-5, distress or impairment – generally a requirement

for the diagnosis of a mental disorder—is also required for a diagnosis of gender dysphoria.

Moreover, a redefinition of gender incongruence was introduced in ICD-11 in order to describe the condition more thoughtfully in a non-binary way as *“marked and persistent incongruence between an individual’s experienced gender and the assigned sex”*<sup>3</sup> – as opposed to a *“desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one’s anatomic sex and a wish to have hormonal treatment and surgery to make one’s body as congruent as possible with the preferred sex”*.<sup>3</sup>

Additionally, the ICD-11 diagnostic guidelines modified the time required to establish the diagnosis. In the case of the condition in adolescence and adulthood, this involved changing the time limit from “two years” to “several months” (to facilitate access to quality healthcare). The opposite was done for childhood diagnosis by increasing the time required for diagnosis to two years in order to avoid false positives based on gender-variant behaviours, common in early stages of life.

The main ICD-11 proposals were subjected to field testing in a variety of relevant healthcare settings in different WHO regions, including low-, middle- and high-income countries. Field testing of the transgender category for adolescents and adults focused mainly on assessing: 1) whether or not the transgender condition is a mental disorder (by determining whether distress and dysfunction are more related to social rejection than to gender incongruence); 2) whether the ICD-11 set of criteria are more clinically useful than the DSM-5 criteria (by evaluating whether sex-changing treatment with hormones and/or surgery is predicted by variables related to marked gender incongruence rather than experienced distress or impairment); and 3) the sensitivity and specificity of two sets of diagnostic criteria to establish the presence of gender incongruence (GI), considering distress and/or impairment as diagnostic requirements (DSM-5) or not, in the case of ICD-11.

This was the scope of field testing of the ICD-11 changes in the condition for adolescence and adulthood, given the main arguments of those opposing its declassification as a mental disorder, as summarized by Drescher, Cohen-Kettenis and Winter: *“While reducing the stigmatization of mental disorders is important, the argument to remove a diagnostic category from the mental disorders section*

*of the ICD simply because mental disorders are stigmatized is neither compelling nor persuasive.”*<sup>25</sup>

Field studies confirmed the following: the distress and dysfunction of transgender people are related more to social rejection and violence than gender incongruence *per se*; the inclusion of distress and/or dysfunction as diagnostic requirements (as in DSM-5) does not help to identify transgender people seeking medical treatment or even to distinguish between transgender and non-transgender people;<sup>34,35</sup> the diagnoses received in childhood are non-specific rather than formal gender identity diagnoses, and although such diagnoses are experienced as negative and are used to justify potentially harmful interventions, the ICD-11 category for the transgender condition in childhood is necessary and important and could have a range of personal, familial and social benefits.<sup>7</sup>

Finally, in May 2019, the World Health Assembly approved the new ICD-11, including changes to the name, and the conceptualization (diagnostic requirements) and location of transgender conditions in childhood, adolescence and adulthood.

## **CONCLUSION**

Over the last half-century, social forces and scientific data have made it possible to view homosexuality and transgender identity as non-pathological variants of human experience. It is not surprising that, for example, in surveys of psychiatrists and psychologists prior to the development of ICD-11 (ICD-10 and DSM-IV were in use at the time of the surveys), the category most frequently recommended for deletion was “Gender Identity Disorder”, usually because clinicians regarded it as being based on stigmatization of a way of being and behaving.<sup>34</sup>

Given that ICD is the most widely used classification system worldwide, changes in ICD-11 related to the classification of sexual orientation and gender identity have been particularly important. These changes reflect current scientific evidence and best practice; they support the provision of accessible and high-quality healthcare services; and they are responsive to the needs, experience and human rights of the populations involved. However, further efforts to eliminate stigma, discrimination and violence against sexual and gender minorities are still necessary. These should include health professionals and society as a whole but also new researchers in the

field, in order to make further steps in healthcare more scientifically based and reasoned.

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#### Correspondence to:

**Rebeca Robles, PhD**  
reberobles@hotmail.com

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# Gender Identity Disorders: Current Medical and Social Paradigm and the ICD-11 Innovations

Расстройства половой идентификации: современная медико-социальная парадигма и инновации МКБ-11

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**Anton V. Dyachenko<sup>1,2</sup>, Alexey Y. Perekhov<sup>2</sup>,  
Victor A. Soldatkin<sup>2</sup>, Olga A. Bukhanovskaya<sup>1,2</sup>**

*<sup>1</sup>The Medical and Rehabilitation Research center «PHOENIX», Rostov-on-Don, Russia; <sup>2</sup>Department of psychiatry, narcology and medical psychology, Rostov State Medical University, Rostov-on-Don, Russia*

**Антон В. Дьяченко<sup>1,2</sup>, Алексей Я. Перехов<sup>2</sup>,  
Виктор А. Солдаткин<sup>2</sup>, Ольга А. Бухановская<sup>1,2</sup>**

*<sup>1</sup>Лечебно-реабилитационный научный центр «ФЕНИКС», Ростов-на-Дону, Россия; <sup>2</sup>Кафедра психиатрии, наркологии и медицинской психологии, Ростовский государственный медицинский университет, Ростов-на-Дону, Россия*

## ABSTRACT

**Introduction.** This article presents a review of current concepts of gender identity under normal and pathological conditions.

**Aim.** To analyse the impact of the medical and social paradigm shift for clinical practice.

**Results and discussion.** The modern academic literature devoted to gender identity disorders is characterized by a variety of terminology, a shift in emphasis from clinical judgement to a socially beneficial normocentric approach and a relatively few advanced, evidence-based research. There is also a lack of evidence for the gender theory underlying the new approach, which raises serious doubts about the validity of the medical and social paradigm revision. In the same time, the position of Russian psychiatrists remains to be more clinically oriented.

**Conclusion.** Patients who declare the desire to reassign their gender have to be assessed by psychiatrists for differential diagnosis to exclude a mental disorder. In such cases, the destigmatization of mental disorders is more critical than the depathologization of gender identity disorders.

## АННОТАЦИЯ

**Введение.** В данной статье представлен обзор научной литературы, посвященной современным представлениям о половой идентификации в норме и патологии.

**Цель исследования.** Проанализировать значение смены медико-социальной парадигмы для клинической практики.

**Результаты и обсуждение.** Современная научная литература, посвященная расстройствам половой идентификации, характеризуется терминологическим многообразием, смещением акцентов с клинической оценки данного феномена к социально-ориентированному нормоцентрическому подходу и относительно

низким доказательным уровнем исследовательских работ. Гендерная теория, лежащая в основе нового подхода, до сих пор не нашла научно аргументированного подкрепления. Это обстоятельство вызывает серьезные сомнения в обоснованности произошедшего пересмотра медико-социальной парадигмы. На этом фоне позиция российских психиатров представляется более клинически ориентированной.

**Выводы.** Пациенты, заявляющие о желании изменить пол, нуждаются в тщательной психиатрической дифференциальной диагностике с исключением психических расстройств. При этом дестигматизация психических расстройств оказывается важнее депатологизации расстройств половой идентификации.

**Keywords:** *gender identity disorders; gender dysphoria; transsexualism; transgender; gender reassignment*

**Ключевые слова:** *расстройства половой идентификации; гендерная дисфория; транссексуализм; трансгендер; изменение пола*

## INTRODUCTION

Clinical features, mechanisms of development and methods of correction of gender identity disorders (GIDs) were described in detail in the academic literature of the second half of the twentieth century. The vision of gender-role deviations in human behaviour as a diverse group of mental disorders was formed. These included both congenital and persistent anomalies, and clinically similar but aetiologically variable courses and prognoses of medical conditions.<sup>1,2</sup> However, the revision of the scientific paradigm, the contradictions that have arisen in the medical community and the unprecedented increase in the number of requests for gender reassignment in many countries,<sup>3-5</sup> mean that further research is needed in this field.

The purposes of the present study are to provide a review of current concepts of gender identity under normal and at pathological conditions, and to analyse the impact of the medical and social paradigm shift for clinical practice. The study involved an information search of the Medline academic database and eLibrary in English and Russian, respectively, using the keywords 'gender identity disorders', 'gender dysphoria', 'transness' and 'gender reassignment'. The search identified 164 publications. Of these, 49 publications devoted to the psychological-psychiatric and socio-legal aspects of the problem of GIDs were selected for a content-related analysis. In total, 55 literary sources were used for citation.

In contemporary science, the study of GID is conducted mainly within the framework of 'gender studies', related to the humanities (psychology, sociology, philosophy, etc.). Published meta-analyses have indicated that the information obtained from the field of gender studies

is not unambiguous.<sup>6-11</sup> According to P. W. Hruz et al. (2020), the shortcomings in the current understanding of GID include the limited amount of existing academic literature, the lack of randomized follow-up studies, small sample sizes, imperfect eligibility criteria, short duration of studies, high percentages of discontinued patients and dependence on the opinion of experts.<sup>11</sup>

## PREVALENCE OF GIDS

According to the meta-analysis of J. Arcelus (2015), the prevalence of transsexualism is 4.6 people per 100,000 population; 6.8 for trans women and 2.6 for trans men. There has been an increase in registered prevalence over the past 50 years.<sup>12</sup>

In the systematic review of L. Collin (2016), which covered 27 publications, the incidence of transgender people in medical institutions for hormonal and surgical treatment was 9.2 people per 100,000 population. However, the authors specified an appreciable variation in the data in particular studies.<sup>13</sup>

The prevalence of GID among present-day young people is about 1%.<sup>12-14</sup> K. J. Zucker quotes similar figures (from 0.5% to 1.3%), but with the essential clarification that there is a significantly higher occurrence of GID among children and adolescents compared to adults.<sup>17</sup> This is consistent with data showing that 70-94% of minors who express dissatisfaction with their gender subsequently refuse to perform trans role self-introduction.<sup>18-20</sup>

## GID CLINICAL MANIFESTATION

Current data on GID clinical manifestation are very ambiguous.<sup>20-22</sup> They describe GIDs that are congenital and relatively stable conditions, which develop in parallel

with psychosexual maturation and variants that are characterized by 'rapid' occurrence. Patients may identify themselves inversely with respect to gender, or identify as being outside of the binary gender-role model. Inverse identification is probably more common than non-binary identification. Some patients reject the external characteristics of gender and want to remove them, while others do not experience significant discomfort. In some cases, self-identification, gender-role behaviour, sexual orientation and external attributes correspond with one other, but in others they are inconsistent.

Gender dysphoria, i.e., a state of psychological distress caused by the rejection of one's biological gender and gender-role status, is singled out as the basic clinical phenomenon that determines the treatment for psychological and psychiatric support. Gender dysphoria may be both endopsychic, expressed through pressing emotional experiences (depression, anxiety, internal conflicts, etc.) and exopsychic, expressed through behavioural disorders (addiction, auto-destruction, proneness to conflict, self-isolation, etc.).<sup>17,20</sup> The overwhelming majority of studies indicate a high prevalence of mental disorders in individuals with GID, including high suicide risk.<sup>20,23</sup> Numerous data on the susceptibility of children with gender-role disorders towards self-stigmatization, depression, eating disorders, alcoholism, drug addiction, self-mutilation and suicidal behaviour are presented. L. Nahata et al. (2018) analysed 79 medical records of patients aged nine to 18 years referred to the paediatric endocrinology department in connection with GID. The vast majority (92.4%) were diagnosed with at least one of the following nosological entities: depressive disorder, anxiety disorder, post-traumatic stress disorder, eating disorders, autism spectrum disorder or bipolar affective disorder; 74.7% reported suicidal ideation; 30.4% made one or more suicide attempts; 55.7% confirmed self-mutilation.<sup>24</sup>

R. B. Toomey et al. (2018) surveyed 120,617 adolescents with GID between the ages of 11 and 19. 14% of respondents reported making a suicide attempt in the past. Suicidal behaviour was most typical for girls seeking to reverse transformation (50.8%), as well as for adolescents of both genders with non-binary positioning (41.8%).<sup>25</sup> A survey of 923 young Canadians who identify as transgender found that 65% of respondents aged 14 to 18 had seriously considered suicide within the past year, compared to 13% in the control group. In this case,

young men showed a greater tendency towards self-mutilation and suicide.<sup>26</sup>

L. A. Taliaferro et al. (2019) studied the phenomenon of auto-destruction in adolescents with GID by comparing a group of individuals with and without self-mutilations. Of the 1,635 respondents, more than half (51.6%) reported episodes of self-mutilation during the past year. Children with auto-destructive behaviour were significantly more likely to report mental health problems, depression, episodes of running away from home and substance use.<sup>27</sup>

The systematic review of L. D. DeFreitas (2020) indicated that, on average, 53.2% of transgender people have at least one mental disorder in the course of their lifetime. Affective disorders (42.1%), anxiety disorders (26.8%) and substance use or substance abuse disorders (14.7%) were most frequently identified.<sup>28</sup>

## **SOCIAL PREMISES AND CONSEQUENCES OF GID DEPATHOLOGIZATION**

Gender theory, conceptually related to feminism, social constructivism, transhumanism and postmodernism, has served as the ideological basis for expanding the boundaries of acceptability in relation to gender-role behaviour. It determines gender identity exclusively by upbringing, gender-role behaviour stereotypes accepted in the macro-and micro-social environment, and personality choice.<sup>29</sup> The mechanisms of GID occurrence within the framework of gender theory are explained inconsistently. Without denying the results of earlier studies on the biological nature of GID in transgender people, the new concept asserts the freedom of gender-role positioning for all people. In accordance with this, on the one hand, the right to choose self-identification is asserted, on the other hand, it is said that the identity of transgender people is irrefutable, which makes it necessary to create specific conditions for them to adapt. Proclaiming absolute freedom to choose a model of gender-role behaviour, gender theory devalues the motives of this behaviour and unites all the GID versions into a group of 'transgender' (gender nonconforming people, trans minorities, etc.), regardless of their nature, stability, phenomenology, dynamics of development and timing at which their development occurred.<sup>13,20</sup> Along with transsexuals, transgender people include people with transvestism, some homosexuals and nonconformists who consciously

demonstrate their commitment to liberal values and the ideology of transhumanism by rejecting socially acceptable gender-role stereotypes.

Following the idea of freedom of self-positioning, attempts to study the factors of susceptibility to 'transness' become meaningless. Perhaps for this reason, there are few such works in the contemporary academic literature. It is believed that people with autism spectrum disorders are more likely to be transgender,<sup>30-32</sup> but the nature of the relationship between these conditions is not substantiated. The results of the study of genetic, neuromorphological and neuroendocrine factors are rare and less informative.<sup>33-35</sup>

### **Socio-political and legal effects**

The increase in the number of people seeking to positioning themselves outside of gender may be explained by higher patient referrals against the background of increased availability of medical and psychological care<sup>3</sup> and a fundamental change in the social paradigm in relation to GID.<sup>36</sup>

The principles for the application of international human rights law in relation to sexual orientation and gender identity were adopted by a group of relevant experts on 6-9 November 2006, in Yogyakarta (Indonesia); these are now known as the Yogyakarta Principles.<sup>36</sup> The review group included experts on human rights issues of various profiles from different regions, including judges, scientists, a former United Nations (UN) High Commissioner for Human Rights, Special Rapporteurs of the Commission of Human Rights, members of the human rights treaty bodies and representatives of independent human rights organizations. According to the Yogyakarta Principles, countries should include the principle of universality in their national constitutions and legislation, and should implement educational and awareness-building campaigns aimed at ensuring the full enjoyment of all rights and freedoms for all persons, regardless of their gender identity. Sufficient attention is directed to the right to equality and non-discrimination: "everyone is entitled to enjoy all human rights without discrimination on the basis of sexual orientation or gender identity".<sup>36</sup>

In the UN Declaration on Sexual Orientation and Gender Identity, dated 18 December 2008, non-binary gender-role positioning was ranked as a human right that requires protection. The UN member states were

requested to take legislative and administrative measures "to ensure that sexual orientation or gender identity may under no circumstances be the basis for arrest or detention...and that human rights violations based on sexual orientation or gender identity are investigated and the perpetrators are brought to responsibility and committed to court."<sup>36</sup> This document was signed by 96 of the 193 UN member states, including all the states of the European Union, the United States, Canada and Japan.

In a report from 2009, The Council of Europe Commissioner for Human Rights recommended that states 'train medical professionals, including psychologists, psychiatrists and therapists, considering the needs of transgender people and the requirements for respect for their dignity'; "ensure that body correction procedures, such as hormone therapy, surgery and psychological support, are accessible to transgender people, and ensure that these costs are compensated under the state health insurance system."<sup>36</sup>

### **Exposure of individuals with GID to discrimination and violence**

In 2013, the UN unveiled campaign "Free and Equal", which aimed to protect gay, lesbian, bisexual and transgender people from discrimination.<sup>36</sup> Concurrently, the causes of gender dysphoria stipulating the treatment of 'transgender' people in medical institutions, within the framework of this approach, are usually associated with the inability of an individual to openly identify in the desired way and implement appropriate gender-role behaviour in the conditions of social pressure (discrimination, transphobia, etc.). A statement from the American Psychiatric Association (2012) stated: "Transness or gender diversity does not imply a deterioration in judgment, stability, reliability, general social or professional abilities; however, these individuals are often discriminated against due to a lack of civil rights protection for their gender identity or self-expression.... Such discrimination and lack of equal civil rights harm the mental health of transgender people and gender-diverse individuals".<sup>37</sup> The meta-analysis of S. M. Peitzmeier (2020), which included 85 publications (49,966 participants), showed that compared with cisgender people, transgender people are 2.2 times more likely to be subjected to physical violence and 2.5 times more likely to be subjected to sexual harassment.<sup>38</sup>

The vulnerability of transgender people to discrimination and aggression is also emphasized in the scientific literature. G. R. Murchison et al. (2019) analysed data obtained from 3,673 American adolescents with GID: 26.5% of girls and 18.5% of boys with reverse identity, and 27% of girls and 17.6% of boys with non-binary positioning, reported cases of sexual violence in the past 12 months.<sup>39</sup> Considerable attention is paid to the 'insufficient cultural awareness' of medical professionals regarding the current regulations of gender-role behaviour, which prevent young people with GID from receiving assistance.<sup>20,39</sup> Cases of denial of services, manifestations of rudeness, verbal and physical violence in medical institutions in relation to minors with gender-role disorders are reported.<sup>40</sup> There is evidence that young transgender people are often subjected to violence by both peers and family members. In the study of K. Peng et al. (2019) of 385 adolescents with GID, 295 (76.6%) reported being abused or bullied at school by classmates or teachers due to deviant gender-role positioning. Of the 319 respondents who revealed their experiences to their parents, 296 (92.8%) were subjected to neglect or violence within the family.<sup>40</sup> In general, the rejection of transgender identification by the immediate environment, the opposition to the desire of patients to the desired self-introduction is emphasized as one of the main sources of gender dysphoria.

### **The family's attitude to minor children with GID**

Overcoming parental 'prejudice' is considered to be one of the most essential components for suicide prevention among children with GID.<sup>13</sup> According to R. Travers et al. (2012), who surveyed 433 transgender adolescents, 4% of those whose parents supported them had attempted suicide, compared to 60% of those whose parents did not support them.<sup>41</sup> Many modern experts favour granting transgender children the full right to self-identification, regardless of the opinion of legal representatives.<sup>41</sup> In some countries, monitoring of the right of minors to 'gender expression' is executed by public services: the employees of general education and medical institutions, the police and social workers. A striking example of this practice is the Norwegian 'Barnevernet' state service for assistance and support for children and adolescents, which has broad powers up to the deprivation of parental custody.

Under these circumstances, it seems paradoxical that there is an extremely small amount of academic studies exploring the problem of GID in minors from the perspective of parents. In the course of a study conducted in 2018 at Brown University (USA), 256 questionnaires of parents for children with 'rapid' development of GID were analysed. Adolescents (the average age at the time of the study was 16.4 years) reported their 'transgender identification' on average at the age of 15. Some 41% expressed a non-heterosexual orientation before they began to identify as transgender; 62.5% were diagnosed with at least one psychogenic disorder or nervous system disturbance of development prior to complaining of gender dysphoria. The number of established diagnoses varied from one to seven. Nearly half (47.2%) of children reported a psychologic decline in mental health to their parents. More than half (57.3%) noted a deterioration in the attitude of other children towards them. Other behavioural changes were also observed, including expression of distrust towards non-transgender people (22.7%), refusal to spend time with non-transgender friends (25.0%), desire to be isolated from family members (49.4%) and significant trust related to information about GID that is received from 'transgender' sources (46.6%). The majority (86.7%) of parents reported that, along with the sudden or rapid occurrence of GID, their child either spent more time on the Internet and social networks, or socialized in a group where one or more friends has become transgender.<sup>21</sup>

### **DIAGNOSIS OF GID IN ICD-11**

In accordance with the new social paradigm in current medicine, approaches to the diagnosis of GIDs have been radically modified. According to the official position of the World Health Organization (WHO), gender identity itself is not the subject of psychiatric analysis and, like political or religious beliefs, should be considered exclusively in the context of civil liberties and individual psychological diversion.<sup>36</sup> The conditions identified in the International Classification of Diseases 11th Revision (ICD-11) as 'gender incongruence', which replaced 'gender identity disorders', are found in Chapter 17 (in the section 'Conditions related to sexual health'). This new grouping includes three categories: gender incongruence of adolescence or adulthood (HA60); gender incongruence in childhood (HA61); and gender incongruence, unspecified (HA6Z).<sup>42</sup> Gender incongruence



of adolescence and adulthood is described as a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. Gender incongruence of childhood is characterized by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about two years.<sup>42</sup>

### **IMPACT OF MEDICAL INTERVENTIONS FOR GENDER REASSIGNMENT ON THE MENTAL WELLBEING OF INDIVIDUALS WITH GID**

In the context of earlier requests for gender reassignment, the issue of aiding minors is actively discussed. The American Psychological Association (APA) and the American Academy of Paediatrics (AAP) have proposed a 'gender-affirmative care model'. This approach, which is focused on "understanding and evaluating the gender experience, unbiased partnership with young people and their families", proclaims the following:

1. Transgender identity and diverse gender expressions do not constitute a mental disorder.
2. Variations in gender identity and expression are normal aspects of human diversity and binary definitions of gender do not always reflect emerging gender identities.
3. Gender identity evolves as an interplay of biology, development, socialization and culture.
4. If a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child.<sup>37</sup>

In a number of countries, the issue of reducing age-related contraindications for medical interventions for gender reassignment is being discussed. Among other measures, this refers to the possibility of conducting hormonal replacement therapy for people who have not reached puberty age.<sup>43,44</sup> Various public organizations that take a stand in favour of the liberalization of indications for gender reassignment argue that the age of medical intervention should depend on the treatment reversibility level. According to this proposal, hormonal blockade, considered 'reversible' by the World Professional Association for Transgender Health, can be performed with children as young as nine years old, while procedures that are considered 'irreversible', such as genital surgery, should be restricted to adults.<sup>20</sup> Some authors insist on the need to approve the right to perform hormonal blocking of puberty without parental consent.<sup>44</sup>

A large amount of data has been published in support of the statement that the implementation of gender reassignment measures contributes to improving adaptation and reducing the indicators of anxiety, depression and suicidal risk in children.<sup>8,14,15</sup> In general, most research shows a high level of satisfaction among individuals with GID without clinical differentiation performed by transformation.<sup>9</sup> However, there are also procedurally similar frameworks that demonstrate negative results. S. L. Reisner et al. (2015) conducted a retrospective cohort study of the medical records of 180 patients with GID aged 12 to 29 years, examined between 2002 and 2011 at a hospital in Boston (USA). People with GID reported depression, anxiety, auto-destructive experiences and experience of inpatient and outpatient psychiatric treatment two to three times more than the group of people not experiencing gender-role disorders. However, there were no statistically significant differences in the results of assessing mental health indicators when comparing patients of different genders, when correcting for age, ethnicity and hormonal medication use.<sup>12</sup> It is noteworthy that, despite the unprecedented liberalization of gender-role behaviour in a number of countries, suicide rates among people with GID remain extremely high, at 50-93%.<sup>20,23</sup>

### **VIEWS OF RUSSIAN CLINICIANS**

The scientific validity of the modifications that have taken place in the approaches to the systematics, diagnosis and therapy of GID have raised doubts among a significant



body of Russian specialists. G. E. Vvedenskiy and S. N. Matevosyan (2017), analysing the modification in the approach to the diagnosis of GID in the ICD-11, stated the following: "...the proposals of the Work Group to change the categories of gender disorders in the ICD-11 are largely based on the social consequences of diseases and "legal considerations" in a subjective ideological interpretation when trying to ignore clinical psychopathological phenomenology and a pronounced tendency to depathologize it, that will negatively affect the possibility of using the classification in the work of practising psychiatrists and sexologists".<sup>45</sup> N. D. Kibrik and M. I. Yagubov (2018) stated a similar forewarning: "...such depathologization of the individuals who desire to assign their gender can lead to serious consequences, since the fact that this condition can often be combined with mental disorders or be their manifestation, as well as contain an obvious or potential risk of suicide is not considered".<sup>46</sup>

In Russian sexology, the perception of the human sex as a three-dimensional structure, including the biological component and social and mental determinants, has been strengthened.<sup>1,47</sup>

Sociocultural segregation of sex (social gender) manifests itself in various spheres of social interaction, including civil law, morals and ethics, material and household concerns, pedagogy, professional, religion, sexual, language, behaviour style and appearance.<sup>47</sup> Social gender has a connection with the cultural environment and therefore there is a range of evidence in different countries and in different time periods.

Mental sex dimorphism (mental gender) is represented by a complex arrangement of mental and behavioural properties which distinguish men from women. At the subjective level, mental gender forms the feeling of identity with one of the genders that is characteristic of most people, the consciousness of one's 'Self' as a man or woman, the awareness of gender-related personality traits and the desire to regulate gender-role behaviour in accordance with the perceived gender. This phenomenon was defined as gender self-awareness by G. S. Vasilchenko.<sup>47</sup> In more contemporary literature, the term 'gender identity' is used in a similar sense.<sup>48-50</sup> The character of this phenomenon remains understudied. It is considered to be a complex mental structure, determined by both biological and social effects, including innate and acquired, and stable and variable

parameters. According to Russian scientists, gender self-awareness, potentials and abilities of the individual involved in the establishment of gender-role behaviour, as well as physical gender characteristics, are biologically determined.<sup>1,2</sup> Thus, in the case of mental gender congruence to the chromosome set, we should speak of a 'standard' gender identity and for incongruence, we should speak of a 'gender identity disorder (violation)'. The latter can be congenital, due to hypothetical intrauterine effects during the sexual differentiation of the foetal brain, or acquired, arising under the impact of social conditions, individual personality characteristics or mental disorder.

### **Views on transsexualism in Russian psychiatry**

Asserting the coincidence of sex and gender identity as a standard, within the framework of the approach shared by Russian psychiatrists, it is proposed to distinguish two large groups of GID: stable mental anomalies and dynamic disorders.<sup>2</sup> The group of stable mental anomalies includes a single condition – transsexualism. As a pathognomonic feature, it is distinguished by an innate and persistent inversion of gender identity, accompanied by the rejection of corresponding genotype gender characters, the desire to assimilate in society among persons of the opposite gender, as well as the desire to transform physical appearance and social status in the image of representatives of the opposite gender.

There are no official statistics on the prevalence of transsexualism in Russia, but this state is considered to be very rare and the number of people experiencing it is relatively stable. According to S. N. Matevosyan et al. (2008), the number of referrals to specialized institutions that provide assistance to persons with GIDs is on average about 60 per year (gender ratio 1:1), of which the diagnosis of 'transsexualism' is established in 52.5% of cases among men and 69.2% of cases among women.<sup>51</sup>

Based on the data that transsexualism occurs in all ethnic groups, in different cultures and does not depend on education, financial security or psychosexual upbringing,<sup>1,2</sup> most researchers tend to believe that it is mainly based on biological factors associated with a violation of sexual differentiation of the brain under the abnormal effect of foetal androgens.<sup>52-54</sup> The result of this disorder is, according to some authors, the

'inverse' formation of a number of brain structures, primarily the hypothalamus.<sup>1,52</sup>

Clinical manifestations of transsexualism arise from the basic characteristic of this state — innate and persistent inversion of gender identity. Depending on the severity of gender-role disorders, two variants of transsexualism are distinguished, nuclear and acentric.<sup>1,2</sup>

Nuclear transsexualism manifests itself from early childhood (up to five years of age) with behavioural disorders caused by a sense of belonging to the opposite gender. The social environment has almost no effect on the formation of gender-role behaviour. Further psychosexual development occurs in accordance with stereotypical characteristics of the opposite gender, accompanied by a difficult experience of the occurrence of secondary gender characters in puberty and incessant attempts to correct the appearance so that it has maximum similarity with the representatives of the opposite gender. The sexual behaviour of nuclear transgender people is exclusively homosexual in relation to the biological gender. Socialization is dilemmatic, due to the active desire of transsexuals to adapt in society exclusively in the desired field: their appearance, lifestyle, professional activities and habits are subordinated to the gender-role stereotypes accepted in society that relate to the opposite gender.

Acentric transsexuals are described as characterized by a higher ability to self-control gender-role behaviour under the influence of micro-social conditions, which in some cases gives the impression of 'standard' gender-role behaviour and sufficient social adaptation. In these cases, violations of gender-role stereotypes are observed from childhood, which, however, are suppressed by the micro-community. The inverse libido is also suppressed because of the individual's commitment to social standards. In some cases, acentric transgender people may maintain heterosexual relationships, but these may not be harmonious and satisfying. Compensation and adaptation are based only on the self-control of patients and their incessant internal struggle with the inverse self-consciousness, which leads to disharmony of the personality and its pathocharacterological formation. A. O. Bukhanovskiy distinguished two groups of symptoms of transsexualism, which are in hierarchical subordination: the basic (main) and derived.<sup>2</sup>

The basic symptoms include:

- Inversion of gender identity: identification of oneself as a person of the opposite gender while maintaining a rational assessment and understanding of both biological and social sex.
- Inversion of sexual socialization of the individual: the assimilation, often exaggerated, by the patient of personal and psychological qualities (temperamental attributes and orientation of the individual, value orientations, worldview, moral and ethical standards, family and professional aspirations, habits, behavioural characteristics), which are considered characteristic of persons of the opposite gender in the socio-cultural environment of transgender people.
- Inversion of psychosexual identity: homosexuality, the orientation of erotic and sexual libido exclusively to heterosexual same-sex partners, the desire to perform an inverse sexual role in sexual relationship.
- The derived symptoms of transsexualism include:
- The symptom of gender rejection is a feeling of discontent, reaching the point of hatred, for the gender characteristics of one's body and for the manifestations of their functioning.
- Multiple presentations of psychosocial maladjustment.
- Auto-destructive behaviour, including suicidal.
- Transsexual attitudes to the gender reassignment take on various intensities (from fantasies to unambiguously expressed decisions about the need to reassign the gender):
  - Experiences that devalue the genitals are phenomenologically close to the symptom of gender rejection.
  - Passive thoughts and ideas about one's own sexual life in the absence of a goal-setting intention to achieve a real transformation.
  - Transgender intentions: the gradual formulation and justification of the idea sexual metamorphosis. This is a fundamentally important stage in the development of the transsexual attitude to gender reassignment, as awareness of the goal appears and a system of evidence is developed.
  - The transsexual decision is an attachment to the ideational component of the willing incentive. From this point on, the behaviour starts to resemble the overvalued.

### **Sexual transformation in GID and similar mental disorders**

As a rule, sexual transformation is considered as the only effective way to correct gender dysphoria in transsexualism.<sup>2</sup> On the one hand, gender reassignment is a method of psychocorrection that allows not only to reduce the risk of suicide, but also to significantly improve the quality of life and psychoemotional state of patients with GID. On the other, it is a set of measures associated with a radical change in the social and legal status of a person, carrying out cardinal and only partially reversible medical interventions, proven effective only in cases of transsexualism. This condition imposes a special responsibility on the doctor: a mistake in this issue is fraught with the most tragic consequences to the patient.

Differential diagnosis is carried out with disorders and conditions in which violations of gender identity and gender-role behaviour can also be observed. Such disorders include ego-dystonic homosexuality, fetishistic transvestism, personality pathology and schizophrenic spectrum disorders.<sup>2</sup> The gender-role disorders observed in these disorders were designated by A. O. Bukhanovskiy as "states similar to transsexualism".<sup>2</sup> Having related clinical manifestations, they are not accompanied by a true violation of identity and, accordingly, are based on completely different motives, due to a psychological crisis or psychopathology. It is the existence of 'similar states' and their significantly greater prevalence in comparison with transsexualism in this approach that explains the high frequency of psychopathology and auto-destructive behaviour among transgender people, the existence of gender-role diversity, cases of incongruity of sexual orientation and gender-role identity.

In recent years, schizophrenia spectrum disorders that occur with gender-role disorders have acquired special medical and social significance. According to our statistics, the number of patients with schizophrenic spectrum disorders who are dissatisfied with their gender has increased dramatically over the past decade. A study at the Phoenix Medical Centre (Rostov-on-Don city, southern Russia; one of the oldest institutions in Russia that provides mental health care to people with GID) demonstrated a 46-fold increase in the number of patients with schizophrenia-related disorders with complaints of gender dysphoria from 2011-2020, compared to 1991-2000 and 2001-2010. Apparently, this is due to a change

in the cultural environment, an increase in the availability of information and an increase in public interest in the phenomenon of transness.<sup>55</sup> Patients with schizophrenia spectrum disorders therefore potentially constitute a group of patients most vulnerable to medical errors when implementing the ICD-11 diagnostic requirements. The correction of GIDs in mental disorders similar to transsexualism through gender reassignment measures has no scientific basis in view of the complete lack of data on the positive impact of sexual transformation on the mental disorders course and prognosis.

### **CONCLUSION**

It should be recognized that the problem of transness has clearly revealed procedural problems in modern psychiatry, especially related to the group of so-called 'behavioural' disorders. The exclusion 'transsexualism' from the new editions of the international medical classifications is arguably justifiable since this phenomenon is not related specifically to 'states related to sexual health' and is not a true mental disorder due to the absence of psychopathology. However, this health condition was diagnosed earlier and procedurally should have been diagnosed further by psychiatrists, who, due to their specific knowledge, are able to make a differential diagnosis and distinguish transsexualism from clinically similar but aetiologically variable courses and prognoses of medical conditions. Do not allocating a proper place for transsexualism in the classification system, the ICD-11 developers apparently ignore the very existence of this category that is not a proper decision on our opinion.

The modified diagnostic approaches create new arrangements for psychiatrists to work with patients who request gender reassignment. However, this work still requires a differentiated, ideologically neutral approach. Regardless of the current medical and social paradigm or political standpoint, patients who declare a desire to reassign their gender need a thorough clinical diagnosis to exclude a mental disorder. We believe that the direction of modern psychiatry development should be associated not with the depathologization of some nosological entities, but with the destigmatization of mental disorders. Such attitude seems to be the only promising approach that fully corresponds to the goal of reconciling the two components of the concept of GIDs that are currently disjointed: the socially oriented and the clinically scientific.

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**Correspondence to:**

**Anton Dyachenko**

avddoc@yandex.ru

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# The Evolution of Approaches to Schizophrenia Diagnostics: from Kraepelin to ICD-11

Эволюция подходов к диагностике шизофрении: от Крепелина до МКБ-11

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## Alexander B. Shmukler

*Moscow Research Institute of Psychiatry – a branch of the V. Serbsky National Medical Research Centre of Psychiatry and Narcology of the Ministry of Health of the Russian Federation, Moscow, Russia*

## Александр Б. Шмуклер

*Московский научно-исследовательский институт психиатрии - филиал Национального медицинского исследовательского центра психиатрии и наркологии им. В.П. Сербского Минздрава России, Москва, Россия*

## ABSTRACT

This article presents the evolution of views on schizophrenia diagnostics over the course of 150 years, beginning from the pre-Kraepelin period and ending with concepts developed in recent decades. Consideration is given to the merits and demerits of contemporary official classifications (DSM-5 and ICD-11) as well as to alternative approaches, particularly in relation to scientific research, and their prospects for development. Special attention is paid to the Research Domain Criteria Project (RDoC) of the National Institute of Mental Health (NIMH). Another promising area discussed in this paper relates to network analysis as a method for the investigation of psychotic disorders, particularly schizophrenia.

## АННОТАЦИЯ

В статье представлена эволюция взглядов на диагностику шизофрении на протяжении 150 лет, начиная с докрепелиновского периода и заканчивая концепциями, развиваемыми в последние десятилетия. Рассматриваются сильные и слабые стороны современных официальных классификаций (DSM-5 и ICD-11), а также альтернативные подходы, в том числе касающиеся научных исследований и перспективы их развития. Специальное внимание уделено the Research Domain Criteria Project (RDoC) of National Institute of Mental Health (NIMH). Другое перспективное направление, представленное в работе, касается сетевого анализа как метода изучения расстройств психотического спектра и, в частности, шизофрении.

**Keywords:** *schizophrenia; mental disorders; diagnostic criteria; classification of mental disorders*

**Ключевые слова:** *шизофрения; психозы; диагностические критерии; классификация психических расстройств*

The history of describing schizophrenia as an independent clinical entity traces back to the *dementia praecox* concept of Emil Kraepelin.<sup>1,2</sup> However, the term itself was not originated by Kraepelin but by Bénédict Morel who introduced it (*démence précoce*) to designate primary dementia.<sup>3</sup> Prior to Morel, a point of view deriving from

the theory of *vesania* developed by William Cullen, an English physician, dominated in psychiatry; in accordance with this theory dementia developed as a secondary phenomenon – a consequence of the destructive process, manifesting with different symptoms and signs, particularly affective disorders, followed by the addition



of excitement ("intermittent insanity", in accordance with the terminology of French psychiatrists), with dementia developing only at the final stage.<sup>4</sup> By contrast, Morel discussed primary dementia, moreover associating its early manifestation with degeneration and degradation. It was the latter idea, with its significant ideological overtones, that provoked antagonism in Morel's contemporaries and resulted in the neglect of the early dementia concept.

While Kraepelin borrowed the term from Morel, he virtually erased the author's intended content, as was noted by some psychiatrists at the time. Consolidating three types of mental condition: "chronic delusion with systematic evolution" (Magnan, 1893),<sup>5</sup> catatonia (Kahlbaum, 1874)<sup>6,7</sup> and hebephrenia (Hecker, 1871),<sup>8</sup> with the subsequent addition of a fourth type – "dementia simplex" (Diem, 1903),<sup>9</sup> Kraepelin identified a new clinical entity – early dementia. This identification was based on the following fundamental provisions: the endogenous nature of disorders, that is, the development of the disease in connection with the internal factors that aetiologically facilitate its occurrence (in contrast with exogenous factors related to external "hazards"); and the steady, progredient type of dementia development.<sup>1,2</sup> Thus, the identification of this clinical entity was based on the combination of the disease aetiology, course and outcome.

Despite the fact that Kraepelin's scientific views underwent certain changes over time, deriving from the accumulation of new data, this did not alter the clinical approach, which implied the determination of patterns that would enable the interrelation of psychopathological symptoms, their dynamics, the overall course of the disease and its anticipated outcomes in the form of "extensive anomie with predominant emotion and will disorders, impotence of judgment and mental depletion".<sup>1</sup> According to Kraepelin's concept, the basic symptoms of the disease included "disruption of interrelation between mental processes", disintegration of mentation, emotional depletion, passive dependence, negativism, stereotypies, mannerisms and impulsiveness. Thus, a dichotomy in mental pathology was substantiated through contra-distinction of dementia praecox and another endogenous disease: manic-depressive psychosis characterized by predominance of affective symptoms in clinical presentations, cyclical course and favourable prognosis.<sup>1,2</sup>

One of Kraepelin's key ideas was the necessity for dynamic consideration of the disease structure in contrast with the identification of permanent pathognomonic symptoms: "only the entire pattern in the aggregate within the whole period of development from the beginning to the end may give us the right to consolidate this observation with other homogeneous cases... the disease course and outcome correspond strictly to its biological essence".<sup>1</sup> In contrast to this approach, many well-known psychiatrists critical of Kraepelin's position persisted in attempts to identify "psychologically non-derivable" primary disorders that reflected the essence of this disease. These basic disorders were described as "intrapsychic ataxia" (Stransky),<sup>10,11</sup> "volitional weakness" (Mayer-Gross),<sup>12</sup> and "hypoactivity of consciousness" (Berze).<sup>13,14</sup> Bleuler's classification<sup>15</sup> of the basic disorders included associative process splitting (association schism), affective apathy, autism and ambivalence ("the four As") as well as volition disorders (abulia) and disruption of cognitive processes (active attention, memory, unproductivity of intellectual activities). These symptoms and signs were considered in a static way, without any evaluation of the "primary disorder" and the disease outcome dynamics. Moreover, the nosological unity of the "schizophrenia group" was denied. But as in the case of dementia praecox, the diagnostic approach was based on negative symptoms.

The concept of positive and negative symptoms was introduced for the first time by John Russell Reynolds<sup>16</sup>, an English neurologist and psychiatrist, who considered these disorders as signs of the same abnormalities as occurred in case of epilepsy. He understood negative symptoms to mean those lacking functional manifestations, for example, in the form of sensory loss, paralysis or coma. From his point of view, positive symptoms were those that related to excessive functional manifestations: clonic convulsions, abnormal movements, hallucinations and delusion.

Further development of the concept of positive and negative symptoms was associated with the name of John Hughlings Jackson<sup>17</sup> who not only considered positive and negative symptoms as different manifestations of the disease but also highlighted their interrelatedness. He considered negative symptoms as the core presentations of the disease – signs of degradation following from abnormalities in certain areas of the brain which are evolutionarily higher than other zones, responsible for

the appearance of positive symptoms developing due to their excessive activity caused by lack of inhibitory influence from the affected areas. Thus, in accordance with the opinion of Hughlings Jackson, positive symptoms represent a secondary phenomenon, being the brain's reaction to the functional decline in the affected areas.

This point of view was dominant in diagnostics from the very beginning of schizophrenia's identification as an independent clinical entity, and persisted for many decades subsequently. Indeed, Kraepelin, Bleuler and other major psychiatrists of the 20th century particularly specified negative symptoms as the core presentations of schizophrenia. In this regard, the concept of schizophrenia developed by the Moscow scientific psychiatry school headed by Andrei Vladimirovich Snezhnevsky<sup>18,19</sup> cannot be ignored. Within the framework of this concept, the idea of the "basic" mental disorder in the case of schizophrenia according to Bleuler was considered from the viewpoint of the dynamic approach proposed by Kraepelin and took into account interrelated patterns of the clinical signs and symptoms development, course and outcome of the disease. In this approach, positive and negative symptoms were described with reference both to each other and to the course of disease. The concept of the layer-by-layer structure of the brain (in its evolutionary aspect) developed by John Hughlings Jackson considered psychopathological symptoms (both negative and positive disorders) on a "layered" basis; in this case presentations at "higher" levels were thought to include underlying layers (for example, affective symptoms at a "lower" level could be included as an element of hallucinations and delusion).

Within the framework of this approach, diagnostics is performed not by the identification of individual disease signs that are connected together due to their specificity and high probability of co-occurrence, but rather with regard to the hierarchical relations of the clinical disease presentations, based on identification of a quite new formation – a complex set of symptoms reflecting the non-separable integrity of the disease components and assuredly representing more than just the sum of their constituents (symptoms and "simpler" syndromes). In this case the elements of a complex syndrome reflect the stage of its development, revealing the disease's anticipable dynamics and enabling predictions of its further development which

are significant for diagnosing the state of the system and selection of treatment management.

However, this approach is becoming increasingly less common, even in the Russian Federation, and remains as an additional option only in a proportion of psychiatric facilities. The diagnostic concepts of the American Psychiatric Association (APA)<sup>20</sup> and the corresponding diagnostic criteria for mental and behavioural disorders in the International Classification of Diseases (ICD) by the World Health Organization (WHO)<sup>21</sup> have become dominant over recent decades.

### **SCHIZOPHRENIA DIAGNOSTICS IN OFFICIAL CLASSIFICATIONS**

It should be noted that initially the APA diagnostic approaches to a great extent corresponded to the classic concepts of "old-school" psychiatry with regard to the "basic" disorder in the case of schizophrenia. Indeed, DSM-I (1952) and DSM-II (1968) paid significant attention to negative symptoms and the disruption of inter-personal relations.<sup>22</sup> But DSM-III<sup>23,24</sup> and DSM-III-R<sup>25</sup> introduced operational criteria enabling the diagnostic requirements to be limited to the presence of chronicity and adverse outcomes of the disease through granting special status to the first-rank symptoms defined by Schneider<sup>26</sup> that include thought echo, thought insertion or withdrawal, thought broadcasting, verbal pseudo-hallucinations in the form of commenting voices and/or their "dialogue", feelings of outside influence and delusional perceptions. In this regard it should be noted that initially these symptoms were proposed by the author to distinguish schizophrenia from manic-depressive psychosis and were not considered as specific to schizophrenia.

Nevertheless, the increase in the significance of first-rank symptoms for schizophrenia diagnostics along with exclusion of the signs of disease progression took place in DSM-IV and DSM-IV-TR.<sup>27,28</sup> Further simplification of the diagnostic approach is noted in DSM-5: psychopathological nuances are ignored, and crucial significance is attached to the following three symptoms without their clinical differentiation: delusion, hallucinations and disorganized speech; while catatonia is referred to as a separate category (any catatonia symptoms are to be coded as co-morbid).<sup>20</sup> Negative symptoms are included into the diagnostic criteria, but they are not mandatory for diagnosis, and their presence without any above-mentioned key symptoms precludes

a diagnosis of schizophrenia. No distinct disease forms and disease course variants are specified.

The section on mental and behavioural disorders in ICD-11 is to a great extent harmonized with DSM-5, which is surely not incidental but rather reflects the deliberate intention of the team who drafted it.<sup>21</sup> It should be noted that neuroscience data and genetic research have not brought about any considerable changes in the description of certain disorders and the general classification structure. The emphasis was placed on field research aimed at establishing a common understanding of disease presentations by clinicians and consistency of diagnostics. The significant efforts input by the drafting team enabled the desired result: the consistency of diagnostics was improved considerably in comparison with ICD-10. However, the atheoretical and consensual nature of this classification (that is, it results from specialist consensus) should not go unnoticed. Schizophrenia variants in ICD-11 are based only on the incidence of repeated attacks: a first episode, multiple episodes and a continuous course; and a distinction is made between cases with current symptoms, and those in partial or complete remission. In this presentation the possibility of recovery is not taken into account, although long-term studies demonstrate a sufficient probability of such an outcome – which happens in at least 16% of cases.<sup>29</sup> In spite of the fact that the presence of affective (manic and depressive) symptoms, psychomotor and cognitive disorders remains possible apart from positive and negative symptoms, hallucination and delusional symptoms and/or disorganization of thinking are to be mandatory for a diagnosis of schizophrenia; negative symptoms are included in the diagnostic criteria but the presence of these symptoms alone does not permit a diagnosis of schizophrenia.

### **ALTERNATIVE APPROACHES TO SCHIZOPHRENIA DIAGNOSTICS**

In the last quarter of the 20th century, Tim Crow, an English psychiatrist,<sup>30,31</sup> proposed distinguishing two sub-types of schizophrenia: variants with either predominantly positive or negative symptoms. The distinction was based not only on the difference in clinical aspects of the specified disease variants but also on pathogenetic differences: in the first case disturbances of dopaminergic system activity were observed, and in the

second case inhibition mechanisms due to neuronal pruning played the key role in the disease pathogenesis.

Interest in negative symptoms has revived over recent years (although not affecting contemporary classifications) resulting in a distinction between deficit and non-deficit schizophrenia, considered to be different in the premorbid functioning of patients, clinical aspects of the disease (particularly the intensity of cognitive disorders), and functional outcomes.<sup>32</sup> Additionally, mild neurological signs are more prominent in case of deficit schizophrenia as compared with the non-deficit variant, and deviations are detected more clearly in the course of neuro-imaging studies.

A two-factor model of negative symptoms in cases of schizophrenia has been developed.<sup>33</sup> Blunted affect and avolition are included into the first group, and anhedonia, asociality and avolition in the second. It is noted that decrease in the expression of emotion on the one hand, and avolition-apathy on the other, actually represent two different dimensions, which although highly correlated to each other have "differentiated predictivity" in relation to the clinical aspects of the disease, its functional outcomes, cognitive and emotional deficiencies as well as neurobiological disorders. Furthermore, it is postulated that primary and persistent negative symptoms include different psychopathological constructs, reflecting dysfunction arising from a different neurobiological formation. It is stated that further deconstruction of negative symptoms into more "elementary" components is necessary in order to understand the neurobiological mechanisms.

Ideas about the need for the "deconstruction" of schizophrenia are of increasingly frequent occurrence in scientific publications.<sup>34</sup> Van Os<sup>35</sup> proposed renaming this disease *salience dysregulation syndrome*, with the identification of three variants: with 1) affective expression, 2) developmental expression – negative symptoms and cognitive deficit, or 3) positive symptoms (hallucinations and delusion) and signs of disorganization. It is proposed that aberrant assignment of motivational salience of objects, people and actions should be considered as the core presentation of schizophrenia – namely a disability in hierarchizing perceived stimuli with inversion of their salience (attribution of inappropriately high significance to any non-significant circumstances). Dopamine dysregulation is suspected to be the pathogenetic basis of such disorders.<sup>36</sup>

Another approach, the complete obverse of that applied in contemporary classifications, is proposed in the Research Domain Criteria Project (RDoC) from the US National Institute of Mental Health (NIMH).<sup>37</sup> Five basic domains are identified within the framework of this project:

- 1) negative valence systems (the systems responsible for reactions to any negative situations - fear, anxiety, loss);
- 2) positive valence systems (the systems responsible for reactions to any positive situations - reward valuation, habits, reward leaning);
- 3) cognitive systems (attention, perception, memory, cognitive control);
- 4) systems for social processes (social cognitions: involvement; social communications, particularly perception of emotional face expressions, non-verbal communications; self-perception and self-conception; perception and understanding of other people);
- 5) activity / regulation systems (systems effecting the organism's sensitivity to any internal and external stimuli, maintenance of the relevant homeostatic regulation, circadian rhythms, sleep / awakening).

It is proposed to study these domains within the framework of seven basic areas: genes, molecules, cells, neural circuits, physiology, behaviours, self-reports.<sup>37</sup>

One more specific feature of this project is that while traditional research in psychiatry deals with the pathophysiology of mental diseases, and studies of their neurobiological markers, the RDoC attempts to understand how violations of the regulation of various systems leads to the clinical and psychopathological presentations of the diseases. The following questions are posed for the researcher: "what is the normal distribution of certain characteristics?", "which CNS system is responsible for these functions", and finally "is it possible to determine the 'quantity' of dysfunction and dysregulation which promotes shifting from the norm to disease at the level of mechanisms?". Within this project, there is an

actual refusal to study schizophrenia as a separate nosological unit in favour of considering a group of psychoses as a whole and trying to highlight their diverse variants, based on the study of the pathophysiological mechanisms of the development of psychopathological symptoms.

## CONCLUSION

At present it should be acknowledged that the psychopathological assessment of a patient's state remains the basis for diagnostics, in spite of abundant studies dealing with investigations of the neurobiological aspects of schizophrenia and schizophrenia-related disorders. In this case the applied criteria, although sufficiently valid and reliable<sup>38</sup> and useful for the purposes of statistical registration and analysis (and thus supported by health officials), turn out to have low acceptability for research and even for application in routine clinical practice. This is largely related to the refusal to differentiate and distinguish between the disease forms and course variants: when cases of various degrees of severity, process intensity and often with different clinical manifestations are analysed "in bulk", the average result produced prevents the identification of any patient sub-groups and more precise diagnostics of disorders detected within them.

It is obvious that further development of schizophrenia studies should be based on more differentiated approaches and the identification of patient groups with different variants of clinical aspects and their associated biological disease markers. It is supposed that the investigation of groups of neurobiological parameters rather than individual ones may turn out to be the most informative for the diagnostic aspect, offering the possibility for disease diagnostics with higher sensitivity and specificity. Network analysis that enables a comprehensive assessment of the existing disorders to be performed, with determination of interrelations between individual signs and their dynamic changes, is one such approach. The early results of these studies are promising,<sup>39</sup> and further development of this area with analysis of extensive findings and an evaluation of a wide spread of parameters is required.

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### Correspondence to:

**Prof. Alexander B. Shmukler, MD**

shmukler.a@serbsky.ru

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# ICD-11 as a Paradigm Shift Phase in the Classification of Mental Disorders

МКБ-11 как этап смены парадигм в классификации психических расстройств

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## Valery N. Krasnov

*Moscow Research Institute of Psychiatry – a branch of the V. Serbsky National Medical Research Centre of Psychiatry and Narcology of the Ministry of Health of the Russian Federation, Moscow, Russia*

## Валерий Н. Краснов

*Московский научно-исследовательский институт психиатрии – филиал Национального медицинского исследовательского центра психиатрии и наркологии им. В.П. Сербского Минздрава России, Москва, Россия*

### Editorial comment:

Professor Valery Krasnov was one of the international leaders in ICD-11 development from the very beginning of this process. Being a Director of the Moscow Research Institute of Psychiatry (at present: a branch of the V. Serbsky Federal Medical Research Centre of Psychiatry and Narcology of the Ministry of Health of the Russian Federation) and President of the Russian Society of Psychiatrists for many years, professor Krasnov was involved with the WHO working groups on ICD-10 revision. From 2014 to 2017, he was the Russian representative in the International Field Study Coordination Group and was a principal of the ICD-11 field studies in Russia.

### ABSTRACT

Classifications of mental disorders change regularly. This fact requires analysis, taking into account changes in the epidemiological situation and changes in the organizational structure of mental health service, and development of its technical and human resources. The preliminary analysis of these changes presented in the article using the example of ICD-11 gives us reason to believe that they are almost unrelated to the diagnostic process improvement. On the contrary, each new classification is characterized by an increasing formalization and simplification of the criteria for separate clinical forms. The inevitable losses of clinical accuracy in psychopathological assessment of disorder are compensated for increasing opportunities to deliver care to a significantly greater number of patients.

### АННОТАЦИЯ

Классификации психических расстройств меняются регулярно. Этот факт требует анализа с учетом изменений эпидемиологической ситуации и изменений организационной структуры психиатрической помощи, развития ее технических и кадровых ресурсов. Представленный в статье предварительный анализ этих изменений на примере ICD-11 дает основания считать, что они почти не связаны с совершенствованием диагностического процесса. Напротив, каждая новая классификация характеризуется все большей формализацией и упрощением критериев отдельных клинических форм. Неизбежные потери точности психопатологической оценки болезненного состояния компенсируются расширяющимися возможностями оказания помощи значительно большему числу больных.

**Keywords:** *classifications of mental disorders; ICD-11; paradigm shift*

**Keywords:** *классификация психических расстройств; ICD-11; смена парадигм*

Each epoch brings significant changes to medicine, including psychiatry. The following major changes have taken place in psychiatry in recent decades:

1. Major epidemiological studies indicate a consistent increase in both the incidence and prevalence of mental disorders, as well as mental health issues, often fraught with mental disorders themselves. Non-psychotic disorders such as depressive, anxiety, adjustment or stress-related disorders and pathological addictions are predominantly intended.
2. Comorbid conditions such as a combination of mental disorders and somatic or neurological diseases have become an important medical challenge.
3. Changes have been made to the institutional structure of psychiatric care: in particular, the expansion of outpatient forms of care while reducing the extent of inpatient care, and increasingly frequent inclusion of psychiatric departments in the structure of large general hospitals.
4. Development of a multi-professional model of mental health care has facilitated the participation of clinical psychologists and specialists in occupational therapy and social work etc.
5. There has been a shift towards delegation of authority to diagnose and provide treatment for non-psychotic, uncomplicated forms of mental disorders (in particular, mild depression and adjustment disorders without an obvious risk of suicidal or aggressive behaviour) to primary care physicians whose patients can access an appropriate care on an outpatient basis. These specialists are a common medical category in healthcare provision in most countries. As a rule, they have basic training in psychiatry, including knowledge of psychopharmacotherapy and the fundamentals of psychotherapy. They perform an important function as the “first filter” for identifying mental disorders and their differentiation, with referral of all patients with psychotic disorders (as well as diagnostically and therapeutically difficult cases) to psychiatric institutions.\*

It was these particular changes, rather than advances in science or our growing knowledge about the complex nature of mental disorders and their connections with other medical issues, that influenced the radical turn from the ICD-9 classification<sup>1</sup> and DSM-IV classification<sup>2</sup> (which were based on scientific systematics, with their taxonomic rigour and consistency, and on the application of more or less homogeneous criteria for categorizing disorders) towards more utilitarian (and therefore simplified and eclectic) principles of diagnosis in the latest DSM-5 classification,<sup>3</sup> and the following (with some minor changes) ICD-11 project.<sup>4</sup>

Given this paradigm shift in understanding and formation of classification, ICD-10 has fulfilled a milestone preparatory role.<sup>5</sup> It has already declared the atheoreticism of the classification to be a rejection of any “ideology”, primarily from psychoanalytic, psychodynamic concepts and, at the same time, from the nosological system in favour of a syndromological differentiation of clinical forms of mental pathology. Moreover, syndromes (in classical psychopathology, hierarchically organized interrelated disorders, as well as possible protective, “hypercompensatory” formations) were often distinguished as symptom complexes, i.e., combinations of symptoms occurring simultaneously, which can be actually heterogeneous when traced over time.

Of course, in contrast to a constantly improving framework as an orderly generalization of scientific knowledge and new facts, classification is the essence of a consensus document. It reflects different expert opinions and different influences – not only clinical but also cultural, legal and organizational. The latest DSM-5 classification and the ICD-11 project demonstrate clear tendencies towards simplification of diagnostic categories and, in addition, the inclusion of separate symptom complexes and even symptoms (most often heterogeneous in nature) in clinical forms. These are, for example, hoarding (excessive collecting of unnecessary things) or excoriation disorder (pathological skin picking). The named classifications are based on explicit diagnostic principles, supported by obvious, explicit manifestations, mainly behavioural.

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\* Unfortunately, there is still no government programme for the training of primary care physicians in Russia. Therefore, all activities delivering care to inpatients and outpatients with any mental disorders are legally assigned to psychiatrists.

Eliminating types of schizophrenia and reducing them to a single form, regardless of the syndromes' structure, a disease's course and outcomes, is the most illustrative example of clinically controversial and even challenging (in relation to the choice of therapy) simplification. However, the ICD-11 project already lists the course options: indication of a currently symptomatic episode; an episode in partial remission; an episode in full remission; or the possibility of a continuous course. Besides, additional qualifiers on symptomatic manifestations presented in different domains can catch an impact and proportion of positive, negative, depressive or manic, psychomotor and cognitive symptoms. Perhaps these are the only guidelines regarding choice of therapy and rehabilitation measures. In general, the new classification does not include prognostic and therapeutic indications.

Psychiatric phenomenology in its classical European tradition (as an empathic, insightful understanding of the patient's experience, in accordance with the views of K. Jaspers<sup>6</sup>) is almost completely replaced by formal registration of the presenting symptoms. In this regard, it is worth recalling that back in 2007, one of the leaders of the American Psychiatric Association, N. Andreasen, published an article which caused a wide response, entitled "DSM and the death of phenomenology in America".<sup>7</sup> The author suggested referring to the vast experience of European psychiatry, believing that simplistic tendencies in US clinical psychiatry are flawed. However, it is apparent that her words have not been heeded. Meanwhile, phenomenological analysis particularly allows psychiatrists to not only reveal the nuances of patients' painful experience but also find opportunities for patients to resist the disease, preserving personal qualities and values that help build a partnership with the patient – the so-called therapeutic alliance.

It seems that the modern classification is addressed mainly to primary care physicians, as well as clinical psychologists involved in modern multi-professional work with patients. The psychiatrist is left with a more complex and responsible function associated with the treatment of "difficult" patients, not only with psychotic forms and socially dangerous tendencies, but also with the phenomena of therapeutic resistance, which,

in recent years, have become an increasingly frequent therapeutic challenge.

Some specialists, trying to create new classifications for the future, offer speculative projects that have already been completely detached from clinical practice. So, in recent publications, the so-called hierarchical taxonomy of psychopathology (HiTOP) is discussed. This represents a multi-level structure. The general factor, which unites the largest number of correlated interrelated symptoms, is located at the upper level; below, there are multi-directional constructs of "internalization" and "externalization"; lower down, there are heterogeneous symptoms.<sup>8,9</sup>

ICD-11 looks more solid in contrast. It is quite useable to provide a statistical registration of nosographic units presenting in the classification. However, in real practical work, a psychiatrist of the European and Russian psychopathological tradition will certainly strive to reveal the vast array of clinical content available, based not on statistical diagnosis (as indicated in the patient's record) but rather on a proper individualized diagnosis in each specific case.

It should be noted that there are some positive trends outlined in the new classification. In particular, these relate to approximation, in some sections, to the building of a functional diagnosis. Particular attention is paid to the possibilities for social functioning before the disease, at different stages of its course and in remission, which represents the strongest aspect of the new classification.

Moreover, while the ICD-11 classification is in progress of translating into national languages, the additional codes and special comments that bring diagnostic categories closer to real practice can be used. This will also help to make the classification more suitable for educational activities.

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**Correspondence to:**

**Prof. Valery N. Krasnov, MD**

valery-krasnov@mail.ru

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# Qatar Community Mental Health Care: Achievements and Challenges

Внебольничная психиатрическая помощь в Катаре: достижения и проблемы

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Mohamed Ali Ahmed,<sup>1</sup> Suhaila Ali Ghuloum<sup>1,2</sup>

<sup>1</sup>Mental Health Services, Hamad Medical Corporation, Qatar;

<sup>2</sup>Weill Cornell Medicine, Doha, Qatar

Мухамед Али Ахмед,<sup>1</sup> Сухайла Али Гулум<sup>1,2</sup>

<sup>1</sup>Служба психиатрической помощи, Медицинская корпорация Хамад, Катар; <sup>2</sup>Медицинский колледж Вейля Корнелла, Доха, Катар

## ABSTRACT

Guided by international best practice and evidence-based medicine, the Qatar mental health service has undergone a major transformation in the last two decades, replacing the institution-based service with an accessible multidisciplinary community-based service.

In this paper, we provide a brief historical background to mental health services in Qatar, and the progress and development towards community-based mental health-care provision.

We also explore the challenges facing this new model of care in Qatar including social and cultural sensitivities, and the various solutions adopted to overcome these challenges.

We outline the comprehensive plans envisaged to further develop Qatar community mental health services, including the provision of accessible, integrated and multimodal mental health care within primary care settings.

## АННОТАЦИЯ

Руководствуясь передовым международным опытом и достижениями доказательной медицины, служба психиатрической помощи в Катаре за последние два десятилетия прошла серьезные преобразования, в ходе которых стационарная модель заменялась доступной мультдисциплинарной внебольничной помощью.

В данной статье представлено краткое сообщение об истории служб охраны психического здоровья в Катаре, а также о прогрессе и развитии внебольничной психиатрической помощи.

Проанализированы проблемы, с которыми сталкивается новая модель оказания помощи в Катаре, включая социальные и культуральные особенности, а также различные решения, предпринимаемые для преодоления этих проблем.

Представлены современные планы по дальнейшему развитию внебольничной психиатрической службы в Катаре, включая предоставление доступной и комбинированной полипрофессиональной помощи в области охраны психического здоровья в условиях первичной медицинской сети.

**Keywords:** *community mental health care; psychiatric services; Qatar; primary mental health care; assertive outreach mental health team*

**Ключевые слова:** *внебольничная психиатрическая помощь; службы психиатрической помощи; Катар; первичная психиатрическая помощь; группа по просвещению в области психического здоровья*

## INTRODUCTION

Qatar is a small country situated on a peninsula in the Arabian (Persian) Gulf; the only land border is with Saudi Arabia to the west. The country has witnessed significant

economic and demographic growth over the past 20 years following the discovery and production of gas. As a result, Qatar is now considered to have the world's highest per capita gross domestic product (GDP). The

population has grown rapidly from about 570,000 in 1999 to the latest estimate of 2.639 million in 2017 (World Bank). The majority of the population live in the capital city, Doha, with growing cities located primarily in the north and south. The vast majority of the population (85%) are expatriates.<sup>1</sup>

Hamad Medical Corporation (HMC) is the main public provider of secondary and tertiary health care in the country, with a growing number of general and specialized hospitals under its umbrella, including Mental Health Services. Primary Health Care Corporation (PHCC) provides primary health-care services in 27 health centres distributed across the country.

Shortly after the first hospital opened in Qatar in 1948, psychiatry services were provided by general practitioners.<sup>2</sup> Specialized mental health services were introduced in 1971 as outpatient clinics.<sup>3</sup> Since then, significant progress has been made with the provision of a broad mix of inpatient, outpatient, community, and specialized mental health services. Electronic medical records were introduced within mental health clinics in late 2015, thus facilitating better data availability related to the services. For diagnostic coding purposes, ICD-10 is the main system used. However, many clinicians also use the DSM-5. The DSM diagnostic criteria have become more familiar to trainees as the residency and fellowship training programmes follow the American Accreditation Council of Graduate Medical Education (ACGME) standards for training.

## **COMMUNITY MENTAL HEALTH SERVICES IN QATAR**

### **Background**

Mental health services in the Arab world remain largely institution-based with resources focusing on inpatient hospital settings. Community mental health services vary considerably across the region and are mostly minimal. This is reflected in the scarcity of information in the published literature. Closer to Qatar, the Al-Ain province in the United Arab Emirates started its community team in 1994. The authors are not aware of any residential community mental health facility across the region.<sup>4</sup>

Until the start of a proper community outreach service in 1998, crisis-based home visits were arranged informally on an ad hoc basis, to the then very small population in Qatar.<sup>5</sup> Shortly after this, a separate day-care service was established, run mainly by occupational

therapists. The first dedicated Community Mental Health Team (CMHT) was established in 2001, providing day care, community outreach, and a limited crisis-intervention service. In a highly conservative and reserved society, with significant stigma associated with mental illness, and deep cultural and spiritual factors linked to its aetiology, the population had mixed attitudes towards community outreach services. In addition to this, the mental health workforce was recruited from different ethnic and training backgrounds, often with little psychiatric experience. Aspects of service delivery that are routine practice elsewhere, proved rather challenging. For example, the provision of community nurses dressed in non-uniform attire was seen as very unconventional, and using hospital vehicles with the hospital logo displayed was not welcomed by certain families fearing stigma. In response to these challenges, the preferences of service users were accommodated. Several training programmes were introduced to promote individualized care plans for patients and an interdisciplinary approach towards patient management was adopted.

In 2006, the first residential community-based facility was opened. Fifteen long-stay male patients with schizophrenia, who had been institutionalized within inpatient units, were moved to a large home. Despite scepticism from families and health-care staff alike, the move proved hugely successful. Patients were soon able to attend to their own activities of daily living, and administer their own medication. In addition, these patients required significantly lower doses of medication to stabilize their mental state, and they were able to reconnect with their families. The success of this initiative was instrumental in encouraging the expansion of the residential model to meet the service demands.

In 2013, Qatar's National Mental Health Strategy was launched.<sup>6</sup> This was a five-year strategy with a vision to provide the right care, at the right time, and in the right place. It proposed an ambitious plan for providing services in a range of locations to ensure that people could access treatment in primary care and community settings, instead of a centralized mental health facility.<sup>5</sup>

### **Current Services**

In early 2015, following the Mental Health Strategy recommendations, a better resourced community mental health team started providing services from a new community mental health facility located in the



west of the capital city, Doha. This team provides a range of services including community outreach, psychiatric day-care programmes for male and female patients, residential rehabilitation, and community-based outpatient clinics. In 2019, the second community outreach team was established in the city of Al-Wakrah in the south of Qatar, and subsequently the catchment area was divided between the two teams.

**The mental health community outreach service** is provided by the two dedicated teams covering the whole country. The teams seek to provide effective multidisciplinary outreach intervention for individuals with severe and enduring mental illness who are very likely to disengage from services, stop their medication and relapse. This outreach service aims to ensure medication adherence, minimize relapse, and reduce the need for inpatient admissions. At present there are around 300 patients who are under the full mental health care of the community outreach service.

Moreover, the outreach teams provide home-based crisis intervention for patients with acute psychiatric presentations, and aim to manage such cases in home settings in order to avoid emergency room visits and hospital admissions. Patients and their families are provided with the phone numbers of community nurses to ensure easy access to care. Every patient is scheduled to be followed up regularly by an assigned psychiatrist and a community nurse (key worker) to ensure continuity of care.

Each outreach team is composed of experienced staff in mental health disciplines: three consultant psychiatrists, three trainee psychiatrists, a psychologist, eight community psychiatric nurses, a social worker, a dietician, and an occupational therapist. These teams are resourced with cars and mobile phones to be used for work duties.

Outreach teams receive referrals from the main psychiatric hospital's outpatient clinics and inpatient units, the emergency room in the general hospital and from primary health-care centres. All referrals are discussed in the weekly multidisciplinary team meetings where cases are assigned to psychiatrists and key workers (community nurses) in addition to other appropriate team members.

Home visits are then scheduled in coordination with patients and families, and comprehensive

home assessments are conducted to identify all the psychological, physical, and social needs of patients. This enables the team to formulate a bio-psycho-social management plan and agree on follow-up arrangements with patients and families.

If these referrals are deemed to be urgent, crisis intervention will be provided. In some extremely urgent cases, the assistance of the ambulance service is required, and in rare cases of high risk, the assistance of the community police will be requested in agreement with the family.

Clinical progress of all cases is regularly discussed in the weekly multidisciplinary meetings, and management plans are reviewed. Key workers are responsible for scheduling regular home visits and for the provision of medication to patients.

**The psychiatric day-care service** is provided by a dedicated multidisciplinary team, bringing together all mental health specialties to support patients with chronic mental illness who need structure in their daily activities. Recovery objectives are implemented to rehabilitate patients and reintegrate them back into meaningful life activities such as family life, education, volunteering, and employment.

As part of respecting social and cultural norms in Qatar, there are separate day-care programmes in separate buildings for male and female patients, providing gender-appropriate activities. Day-care activities include group therapy sessions, outings, training on activities of daily living, medical assessments, and multidisciplinary interventions.

A day-care programme is commonly used for patients who require a more intense follow-up than can be provided in a regular outpatient clinic. In this sense, day care is commonly used as an alternative to inpatient admissions with some acutely unwell patients. At present, there is a total of 97 patients receiving full mental health care in the day-care programme: 58 males and 39 females.

**The residential rehabilitation service** includes supervised residential units for female patients with a total of 15 patients, and one supervised residential unit for five male patients. These units are for patients with severe and enduring mental illness who have spent long periods in acute inpatient settings and for whom

discharge home is not an option for a variety of clinical or social reasons.

This residential service puts great emphasis on rehabilitation and recovery aspects such as family and community reintegration, training on activities of daily living including personal hygiene, money handling, shopping, cooking, and social skills.

Families are encouraged to visit their relatives on a regular basis, take them out for home visits and other outings, and engage in their treatment plan. Although very few patients are completely discharged home from these residential units, many spend an increasing amount of time at home during therapeutic home visits.

**Community-based outpatient clinics** receive referrals from 10 primary health-care centres located in the west of Doha. The remaining 27 centres in the country send referrals to the main outpatient clinics in the central psychiatric hospital. The most common diagnoses among referrals to these clinics are depression, anxiety and psychosomatic disorders.

The current caseload of this outpatient clinic is approximately 720 patients and is steadily increasing. These clinics are provided by the three community-based consultant psychiatrists in addition to the trainee doctors under consultant supervision.

### **KEY PERFORMANCE INDICATORS (KPIs) FOR THE COMMUNITY MENTAL HEALTH SERVICES**

The following KPIs are used to measure the impact and quality of care provided within the community mental health service.

1. Reduction in admission rates and duration of hospital stay for the community caseload. Data collected within the service, not published, suggest a significant reduction in rates of inpatient admission and duration of hospital stay for individual patients after their engagement with the CMHT. Follow-up by the CMHT has been a major contributor in facilitating earlier discharge from the acute inpatient settings.
2. Increase in service users' satisfaction. The CMHT receives regular feedback from patients and families to guide and inform service priorities and gauge service users' satisfaction. This feedback indicates that users' satisfaction has been steadily increasing.

### **CHALLENGES FOR COMMUNITY MENTAL HEALTH SERVICES IN QATAR**

**Large catchment area:** This was a major challenge when only one outreach team covered the whole country. However, since the establishment of a second team in the south of Qatar, there has been more efficient caseload management utilizing a clearly demarcated catchment area-based distribution. Plans to start a new community outreach service in the north of Qatar are underway.

**Stigma:** The stigma of mental illness represents a major barrier to seeking and accepting appropriate mental health interventions. This subsequently leads to late presentations with acute psychiatric conditions through the emergency departments of HMC and eventually necessitating acute inpatient care. Stigma can render compliance with medications and clinic follow-up suboptimal.

**Cases with special needs:** Specialized services for people with comorbid mental illness and learning disability are still in their infancy in Qatar. The community team therefore provides care for an increasing number of such patients who require specialized expertise. The team collaborates with non-governmental organizations (NGOs) such as the Qatar Society for People with Special Needs, to assist in the management of these cases.

**Co-morbid physical ill health:** Patients with mental illness often have comorbid physical health problems, however, many of them show reluctance to seek medical care. The community outreach team regularly liaises with physicians and other health-care staff in the local general hospitals, primary health centres and other care providers to ensure mental and physical health-care aspects are provided in an integrated manner.

**Mental health legislation:** Whilst the mental health law was issued in November 2016, it has not yet been implemented, with many administrative procedures pending. Implementation of the law requires extensive training of relevant health-care providers in the country; this training is ongoing. The processes involved in initiating involuntary admission to the services, securing independent expert opinion, submitting relevant forms, and the appeal process, are still to be finalized. The authority in charge of supervising the whole process and

ensuring that patients' rights are protected at all times (referred to in law as 'competent authority') has not yet been confirmed and the coordination with other authorities such as the police service, remains under consideration. Within the law, the presence of a community treatment order will facilitate the management of a certain category of patients once implementation begins, thus facilitating relapse-prevention management approaches.

### **PLANS FOR DEVELOPING QATAR COMMUNITY MENTAL HEALTH SERVICES**

1. Establishing further community treatment hubs in other areas of the country will enable the sectorization of the catchment area and subsequent division of the current outreach caseload. The short-term plan is for two hubs to open within the next couple of years, covering the north and central regions of the country.
2. The provision of specialized mental health clinics in primary care centres will provide more accessible services in a less stigmatized setting. An example of such a clinic has recently started in a primary care clinic located within the capital's education city, which hosts many educational facilities and campuses of international colleges and universities.
3. Establishing a dedicated crisis intervention and home treatment team will minimize the need for emergency room presentations and decrease the number of hospital admissions.
4. The provision of subspecialty community services such as a forensic psychiatry community team and a psychiatry of learning disability community team will facilitate the provision of specialised care that meets the needs of individual patients.

### **PROVISION OF MENTAL HEALTH CARE WITHIN THE PRIMARY CARE SETTING**

Depression, anxiety and psychosomatic disorders are the most common mental illnesses seen in primary care centres in Qatar.<sup>6</sup> Some of these cases are managed within primary care settings whilst others are referred to secondary mental health clinics.

The Primary Health Care Corporation (PHCC), the sole public provider of primary care in the country, has launched a comprehensive plan to optimize the provision of mental health care in primary care settings. This includes upskilling and training of general practitioners in mental

health, provision of psychology services, ensuring the availability of most psychotropic medications within the PHCC pharmacy and the provision of secondary mental health clinics in primary care centres. The current focus is on the provision of mental health care for mild to moderate depression and anxiety disorders.

#### **Correspondence to:**

**Dr. Suhaila Ghuloum, MB BCh, FRCPsych**  
sghuloum@hamad.qa

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# Community Mental Health Care in Serbia: Development and Perspectives

Территориальные центры психиатрической помощи в Сербии: развитие и перспективы

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Dusica Lecic-Tosevski,<sup>1</sup> Maja Milosavljevic<sup>2,3</sup>

<sup>1</sup>Serbian Academy of Sciences and Arts, Belgrade, Serbia; <sup>2</sup>Institute of Mental Health, Belgrade, Serbia; <sup>3</sup>Faculty of Medicine, University of Belgrade, Belgrade, Serbia

Душица Лечич-Тошевски,<sup>1</sup> Майя Милосавлевич<sup>2,3</sup>

<sup>1</sup>Сербская Академия наук и искусств, Белград, Сербия; <sup>2</sup>Институт психического здоровья, Белград, Сербия; <sup>3</sup>Медицинский факультет, Университет Белграда, Белград, Сербия

## ABSTRACT

Community mental health care was developed in Serbia in 1982 at the Belgrade Institute of mental health. Treatment was provided through the primary health care system, with each health centre having its own mental health care team. However, in the process of psychiatric reform and deinstitutionalization, dedicated community centres had to be established, in accordance with the National Strategy for the Development of Mental Health Care. The first community-based mental health centre opened in the southern area of Serbia in 2005 and subsequently, other centres were established. The centres are organized independently of psychiatric hospitals and are located in local, self-government units, providing psychosocial treatment and the continuation of mental health care. In relation to the ongoing reform of psychiatry in the country, there are positive and negative issues. There are 41.41 beds per 100,000 of the population in psychiatric hospitals and 18.33 beds per 100,000 of the population in the psychiatric departments of general hospitals. Day hospitals, established throughout the country, provide patients with good quality care. Mental health care professionals are educated to a high standard and integrative, person-centred treatment is applied in most services. However, the level of stigma directed towards those with mental illness is still high and constitutes a barrier to treatment. Well-developed screening and early detection programmes to identify persons requiring mental health care are lacking, as are the records of patients with mental disorders. The future goal is to further reduce the number of beds in psychiatric hospitals, establish new community mental health care services throughout the country and ensure the prevention of mental disorders, as well as mental health promotion.

## АННОТАЦИЯ

Основы оказания внебольничной психиатрической помощи населению были разработаны в Сербии в 1982 году в Институте психического здоровья в Белграде. Лечение обеспечивалось посредством первичной медицинской сети, при этом в каждом медицинском центре функционировала своя собственная группа специалистов в области психического здоровья. Однако в процессе реформы психиатрии и деинституционализации необходимо было создать специализированные территориальные центры в соответствии с Национальной стратегией развития психиатрической помощи. Первый территориальный центр внебольничной психиатрической помощи открылся в южной части Сербии в 2005 году, после чего были открыты и другие центры. Центры создаются отдельно от психиатрических больниц и располагаются

в территориальных единицах местного самоуправления. В их задачу входит обеспечение психосоциального лечения и дальнейшее оказание психиатрической помощи. Что касается проводимой в стране реформы психиатрии, она имеет и положительные, и отрицательные стороны. Обеспеченность коечным фондом в психиатрических больницах составляет 41,41 койки на 100 000 населения, а в психиатрических отделениях больниц общего профиля 18,33 койки на 100 000 населения. В дневных стационарах, созданных по всей стране, пациентам предоставляется медицинская помощь должного качества. Специалисты в области психического здоровья имеют высшее образование, и в большинстве служб проводится комбинированная персонализированная терапия. Однако уровень стигматизации лиц, страдающих психическими заболеваниями, все еще остается высоким и создает препятствие для проведения лечения. Отсутствуют либо недостаточны должным образом разработанные программы скрининга и раннего выявления лиц, нуждающихся в психиатрической помощи, равно как и учет пациентов с психическими расстройствами. Последующие цели заключаются в дальнейшем сокращении количества коек в психиатрических больницах, создании новых внебольничных служб по оказанию психиатрической помощи по всей стране, а также в обеспечении профилактики психических расстройств и укреплении психического здоровья.

**Keywords:** *community mental health care; mental health care centre; mental disorders; reform of psychiatry*

**Ключевые слова:** *внебольничная психиатрическая помощь; центр психического здоровья; психические расстройства, реформа психиатрии*

## **MENTAL HEALTH CARE IN SERBIA**

The oldest psychiatric institution, “Home for the Insane People” in the Balkans, was established in Belgrade (capital of Serbia) in 1861, with 25 beds. The number of beds in psychiatric hospitals continued to increase until the last decade when, in accordance with national policy, the number began to decrease, primarily in “large” psychiatric hospitals.

According to data acquired in 2002, there were 46 psychiatric hospitals with 7,000 beds; 3,000 of these were in large psychiatric hospitals and the average duration of treatment was 153 days. However, this period was much shorter in university tertiary clinics (around 30 days). The total number of doctors (psychiatrists and neuropsychiatrists) was 947, with 336 of these working in the capital, Belgrade.<sup>1,2</sup>

In 2016 there were seven psychiatric hospitals, 36 psychiatric departments in general hospitals and four community mental health centres.<sup>3,4</sup> There were eight outpatient facilities for children and adolescents (e.g., day care), with departments for developmental disorders, as well as 39 other outpatient services for children and adolescents, and six inpatient facilities for children and adolescents. The total number of mental health care workers (governmental and nongovernmental) in Serbia in 2016 was 2,643 (29.86 per 100,000 of the population<sup>3</sup> (Table 1).

Inpatient care (per 100,000 of the population) included 41.41 hospital beds with 127.07 annual admissions and 18.33 psychiatric unit beds in general hospitals, with 209.97 annual admissions. The number of child- and adolescent-specific inpatient beds per 100,000 of the population was 0.86, with 3.02 annual admissions. More than 75% of discharged inpatients received a follow-up outpatient visit within one month.

## **COMMUNITY-BASED MENTAL HEALTH CARE**

Community-based mental health care in Serbia is under development.<sup>5,6</sup> It began as part of the reform of psychiatry in 2007, along with a process of deinstitutionalization and de-stigmatization. However, community mental health care was developed in the country many years ago. It was organized through the primary health care system, each health centre having its own mental health care team. The activities aimed at bringing mental health care services closer to patients was already in existence in previous decades in certain psychiatric institutes and clinics. The day hospital for substance abuse treatment (community centre) was founded in 1978 as a part of the Institute of Mental Health (IMH), which was the first psychosocial psychiatric institution in Serbia, established in 1963 in the centre of Belgrade and currently recognized as an institution of excellence.<sup>7</sup> This was essentially a community centre, transferred to another municipality

Table 1. Mental health care staff in Serbia

Mental health care staff	Rate per 100,000 of the population
Psychiatrists	8.64
Child psychiatrists	0.21
Other specialists	0.46
Nurses	13.17
Psychologists	4.55
Social workers	0.36
Occupational therapists	0.23
Speech therapists	0.14
Other mental health workers	2.09

in 1982 (from the Institute). It consists of two elements, one for treating alcohol abuse in adults and pathological gamblers, the other for the treatment of young, poly-substance abusers, between 12 and 18 of age.<sup>8</sup> In addition to these services at the IMH, there are clubs for specific groups of patients (those suffering from psychotic disorders or alcoholism, elderly patients (we refer to this group as the “third age”, in order to overcome stigmatization), families of adolescents, etc.), organized as outpatient services.<sup>7,8</sup>

In 2003, Serbia was involved in the Stability Pact Mental Health Project of South-Eastern Europe, along with another eight countries within the region. The project was entitled, “*Enhancing social cohesion through strengthening community mental health services*”, with the primary aim of standardizing mental health care in the region.<sup>1,5</sup> It was coordinated by the World Health Organization (WHO) and by national committees, responsible for mental health. The national policy, “*Strategy for the Development of Mental Health Care*”, was prepared as part of the project and was approved by the government of the Republic of Serbia in January 2007. The policy is in accordance with the WHO recommendations from 2001 concerning mental health care, and with the Declaration on Mental Health for Europe, approved at the European Ministerial Conference in Helsinki, in January 2005. As a key obligation of the project, the first centre for mental health care in the community in Serbia, was established.

This pilot project in Serbia consisted of the opening of the first community-based mental health centre

in October 2005 in Niš (in the southern region of Serbia).<sup>9</sup> The centre formed part of the Special Hospital for Mental Disorders “Gornja Toponica”. Its establishment was a result of the collaboration of the Serbian Ministry of Health, the Stability Pact for South-Eastern Europe and the NGO, Caritas Italiana.<sup>10</sup>

The mental health centre in Kikinda, a city in the autonomous province of Vojvodina (in the northern region of the country) opened at the end of May 2015, as an organizational unit of the Special Hospital for Mental Disorders, “Sveti Vračevi” in Novi Kneževac.<sup>11</sup> The third community-based mental health centre in Serbia opened in 2015 in Vršac (in the north-eastern region of the country), associated with the Special Hospital for Mental Disorders “Dr. Slavoljub Bakalović” in Vršac.<sup>12</sup> All the centres are situated outside the psychiatric hospitals and are located within local self-government units. They are led by multidisciplinary teams, consisting of case managers, psychiatrists, psychologists and social workers, who provide psychosocial treatment and the continuation of mental health care. The funding of the project for the centre in Kikinda totalled 141,645.14 EUR. Part of this fund was provided by the Provincial Secretariat for Finance, and part by the Provincial Secretariat for Health, Social Policy and Demography.<sup>11</sup> An amount of 155,000.00 EUR was approved for the realization of the project for the mental health centre in Vršac, 85% of which was a donation from the European Union, while the remainder of the money was transferred from the funds of the hospital or from the two provincial



secretariats.<sup>12</sup> The establishment of these centres formed part of the project entitled, *"Improving the position of users of residential institutions with intellectual and mental disorders, creating conditions for their inclusion in society and the local community – Open Hug"* in collaboration with the Ministry of Health. The partners in the project were the local municipalities and the Provincial Secretariat for Health, Social Policy and Demography. The project was also supported by the NGO, "International Aid Network – IAN" in Belgrade.<sup>11,12</sup>

### **STRENGTHS AND WEAKNESSES**

The mental health care system in Serbia demonstrates many positive characteristics, such as the provision of a number of day hospitals, providing patients with high quality mental health care. The involvement of persons with mental disorders and their family members in mental health policies, laws and service development, is increasing. Mental health care professionals are educated to a high standard and integrative, person-centred treatment is applied in most services, especially in university clinics. Specialization in both adult and child psychiatry requires a four-year training period and is developed in accordance with European standards.<sup>1</sup> Postgraduate psychiatry training includes subspecialties in psychoanalytical psychotherapy, forensic psychiatry, clinical pharmacology and substance abuse. Psychotherapy has a long tradition in the country with various approaches – psychoanalytical, group analysis, systemic family treatment, cognitive-behavioural, etc.<sup>13</sup> Continuing medical education is obligatory for all mental health care workers. Professionals from Serbia publish in the leading psychiatric journals, books and textbooks of international publishing houses.<sup>1</sup> All the institutes, clinics and psychiatric departments have ethical committees and are obliged to apply ethical codes in their treatment and research. The health care service is financed by the state through the Republic Office of Health Care (health care is free of charge).

As an example of good clinical and research practice in Serbia, the Institute of Mental Health was designated as the WHO Collaborating Centre for Mental Health in 2009 (renominated in 2018). The government recognized its importance and supported the IMH programmes, aimed at the prevention of suicide and violence among children and young people, child abuse, as well as substance abuse and alcoholism.<sup>1</sup>

During the past decade national guidelines for good clinical practice were developed and published for the treatment of schizophrenia,<sup>14</sup> depression<sup>15</sup> and alcoholism,<sup>16</sup> as well as protocols for the prevention of child abuse.

However, certain weaknesses exist, such as a high level of stigma directed towards those with mental disorders among the general public, which constitutes a barrier to treatment.<sup>17</sup> Screening and early detection programmes to identify persons requiring mental health care are needed, and there is a lack of an integrated information system for registering and monitoring mental disorders, as well as limited records of mental disorders. The collaboration between primary, secondary and tertiary health care is not satisfactory, similarly between psychiatric and social welfare institutions. The network of mental health community centres should be expanded. It is well known that the importance of community mental health care may have even greater relevance in low- and middle-income countries (LMIC) compared to high-income countries (HICs).<sup>18</sup>

### **PERSPECTIVES**

The future perspective of mental health care in Serbia is inextricably linked to the social, economic and legal transition of the country. This goal has ten steps plus one and incorporates several domains: legislation and human rights; organization of services; prevention of mental disorders and mental health promotion; work force development; research; evaluation of services; improvement of quality; information systems; intersectoral cooperation (partnership for mental health); advocacy and public representation; reform of psychiatry and psychiatrists.<sup>5</sup>

As previously noted, the mental health care system in Serbia needs to be adjusted to meet many different challenges. It should be stressed that the establishment of new community centres is not the only development that will improve the treatment of mentally ill persons. Humanization and individualization of treatment, as well as person-centred psychiatry, are also significant and are already applied in many psychiatric services in Serbia.<sup>8</sup>

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with input from the first author, did the literature search. Both authors discussed the results and contributed to the final manuscript.

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#### Correspondence to:

**Prof. Dusica Lecic-Tosevski, MD, PhD**

dusica.lecictosevski@gmail.com

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# Community Mental Health Services in Italy

Внебольничные службы охраны психического здоровья в Италии

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**Gaia Sampogna, Valeria Del Vecchio, Corrado De Rosa, Vincenzo Giallonardo, Mario Luciano, Carmela Palumbo, Matteo Di Vincenzo, Andrea Fiorillo**

*Department of Psychiatry, University of Campania "Luigi Vanvitelli", Naples, Italy*

**Гайя Сампонья, Валерия Дель Веккьо, Коррадо де Роса, Винченцо Джаллонардо, Марио Лучано, Кармела Палуммо, Маттэо Ди Винченцо, Андреа Фиорилло**

*Кафедра психиатрии Университета региона Кампания «Луиджи Ванвителли», Неаполь, Италия*

## ABSTRACT

In 1978, in Italy, approval of Basaglia's reform law marked a shift from an asylum-based to a community-based mental health system. The main aim of the reform was to treat patients in the community and no longer in psychiatric hospitals. Following the Italian model, similar reforms of mental health care have been approved worldwide. The community-based model aims to promote integration and human rights for people with mental disorders on the basis of their freedom to choose treatment options.

By 2000, all psychiatric hospitals had been closed and all patients discharged. Mental health care is organized through the Department of Mental Health, which is the umbrella organization responsible for specialist mental health care in the community; this includes psychiatric wards located in general hospitals, residential facilities, mental health centres, and day-hospital and day-care units.

Approval of Law 180 led to a practical and ideological shift in the provision of care to patients with mental disorders. In particular, the reform highlighted the need to treat patients in the same way as any other patient, and mental health care moved from a custodialistic to a therapeutic model.

Progressive consolidation of the community-based system of mental health care in Italy has been observed in the past 40 years. However, some reasons for concern still exist, including low staffing levels, potential use of community residential facilities as long-stay residential services, and a heterogeneity in the availability of resources for mental health throughout the country.

## АННОТАЦИЯ

В 1978 году в Италии принятие Закона Базальи, предусматривающего реформу психиатрии, ознаменовал переход от стационарной к внебольничной системе оказания помощи в области охраны психического здоровья. Основная цель реформы состояла в том, чтобы пациенты получали лечение по месту жительства, а не в психиатрических больницах. Следуя итальянской модели, аналогичные системы оказания психиатрической помощи получили широкое распространение в мире. Внебольничная модель оказания помощи ориентирована на содействие интеграции в общество и соблюдение прав человека в отношении лиц с психическими расстройствами, т.к. она предусматривает свободу выбора пациентами вида лечения.

К 2000 году все психиатрические больницы были закрыты, а все пациенты выписаны. Психиатрическая помощь осуществляется через Департамент психического здоровья, который является головной организацией, отвечающей за соответствующую специализированную помощь по территориальному

принципу; сюда входят психиатрические отделения, открытые в больницах общего профиля, учреждения интернатного типа, центры психического здоровья, дневные стационары и отделения дневного пребывания.

Принятие Закона 180 привело к практическому и идеологическому сдвигу в том, что касается оказания помощи пациентам с психическими расстройствами. В частности, реформа подчеркнула необходимость лечить такого рода пациентов так же, как и любого другого пациента, а психиатрическая служба перешла от модели, предусматривающей оказание помощи в закрытом учреждении (недобровольная госпитализация), к модели терапевтической.

В Италии на протяжении последних 40 лет наблюдается последовательное совершенствование внебольничной психиатрической помощи. Однако некоторые причины для беспокойства все еще существуют, в том числе недостаточная укомплектованность персоналом, потенциальное использование общественных жилых объектов для долговременного проживания, а также неравномерность доступности ресурсов, обеспечивающих психическое здоровье, применительно ко всей стране.

**Key words:** *mental health care; community mental health system; mental health centres*

**Ключевые слова:** *психиатрическая помощь, система внебольничной психиатрической помощи; центры психического здоровья*

## BACKGROUND

In Italy, the shift from asylum-based to community-based mental health services was marked by approval of Law 180 (also known as the “Basaglia law”) in 1978. The approval of this reform law led to the development of community mental health services, with the aim of treating patients in the community and no longer in hospitals. Following the Italian model of mental health care, similar initiatives have been carried out in other countries worldwide.<sup>1</sup>

Law 180 started the dismantling of psychiatric asylums and development of community-based mental health centres, with a focus on people with severe mental disorders being treated in the community.<sup>2</sup> Mental health services were established in order to cover a given geographic area and with an emphasis on possible reduction of rates of inpatient care. The community-based model aims to promote integration and human rights for people with mental disorders on the basis of their freedom to choose treatment options.<sup>3</sup>

In Italy, the National Health System (NHS) was established on December 23, 1978, and a comprehensive public health policy was adopted. The NHS is tax-funded, covers all citizens, and absorbs approximately 7% of the whole gross domestic product. A further 2% of the gross domestic product is spent on private health services by individual citizens on a voluntary, additional basis. Approximately 5% of NHS resources are allocated to child and adult psychiatry, excluding services for drug abuse

and learning disabilities. The National Health System consists of 206 local health trusts, each caring for a geographically defined population of 200 to 800,000 inhabitants.

Italy is characterized by several regional differences in terms of income, economic activity, distribution of wealth, rates of unemployment, development of welfare services, and other social determinants of mental health; these disparities are also reflected in the services offered by the NHS.

It took nearly 20 years to complete the de-institutionalization process, which started in 1978 and terminated in 2000. Learning from our experience of the historical and decisive anti-institutional movement in this country is fundamental, especially if we are to understand the extent to which it is possible to change the nature of psychiatry and promote more respectful care.<sup>4</sup>

Law 180/1978 was absorbed in the general 833/78 law, through which the organization of a new National Health System was established. The structural organization of mental health departments, with a specific focus on prevention, treatment and rehabilitation of people with mental health problems, was defined by two “Progetti Obiettivo”, one in 1994 and one in 1998. The second “Progetto Obiettivo” also highlighted the importance of coordination among various mental health professionals.

In Italy, the transition from a hospital-based system of care to a community-based mental health care system started with the gradual closing down of psychiatric hospitals. In 1978, 78,538 individuals were living in psychiatric hospitals; there were 7,704 in 1998. By 2000, all psychiatric hospitals had been closed and all patients discharged. There are currently 10 beds in psychiatric wards located in general hospitals per 100,000 population and 46 beds in community residential facilities per 100,000 population, although several differences exist according to different geographic areas (Table 1).

## THE ORGANIZATION OF MENTAL HEALTH CARE

### Department of Mental Health

The Department of Mental Health (DMH) is the health organization responsible for specialist mental health care in the community, as defined by the Progetto Obiettivo "Tutela Salute Mentale 1998-2000". The DMH includes the following facilities: community mental health centres (CMHCs), day care facilities (DCF), general hospital psychiatric units (GHPUs) and residential facilities (RFs).

The DMH plays a central role in planning, organization and management of all medical and social resources related to prevention, treatment and rehabilitative interventions supporting mental health in a defined catchment area (Figure 1). Moreover, the DMH promotes informative and educational interventions for the general population in relation to mental health, in order to challenge stigmatization and discrimination against people with severe mental disorders. In particular, the DMH can lead research projects on the quality and

efficacy of pharmacological and non-pharmacological interventions and promote training courses for mental health professionals.

### Community mental health centres (CMHCs)

Community mental health centres (CMHCs) are the core of the community-based system. They cover all activities pertaining to adult psychiatry in outpatient settings, and they manage therapeutic and rehabilitation activities delivered by daily-care and residential facilities. Community mental health centres are active every day for 24 or 12 hours, depending on the regional organization. They include a multidisciplinary staff comprising psychiatrists, psychologists, social workers, rehabilitation therapists and nurses, who collaborate in order to provide integrated and personalized interventions for patients with severe mental disorders.

According to the PROG-CSM survey,<sup>5</sup> at the national level, the CMHC/resident ratio is about 1 CMHC per 80,460 inhabitants. In terms of staff working in each CMHC, the team usually includes four psychiatrists, two psychologists, two social workers or rehabilitation therapists and eight nurses. The mean is about 24.8 full-time professionals per 100,000 residents. Some differences exist at the national level: the average is 25.9 professionals per 100,000 residents ( $\pm 11.5$ ) in northern Italy, 28.3 ( $\pm 7.4$ ) in central Italy, and 23.7 ( $\pm 6.9$ ) residents in southern Italy.

### Acute inpatient units

Within the DMH system, acute inpatient care is delivered in general hospital psychiatric units (GHPUs). These are

Table 1. Staff and resources for mental health care in Italy<sup>10</sup>

Staff in mental health sector per 100,000	
Psychiatrists	7.83
Nurses	19.28
Social workers	1.93
Psychologists	2.58
Inpatient facilities	
Beds for mental health in general hospitals	10.95
Beds in community residential facilities	46.41
Outpatient facilities	
Outpatient mental health facilities	1.43
Day treatment facilities	1.34

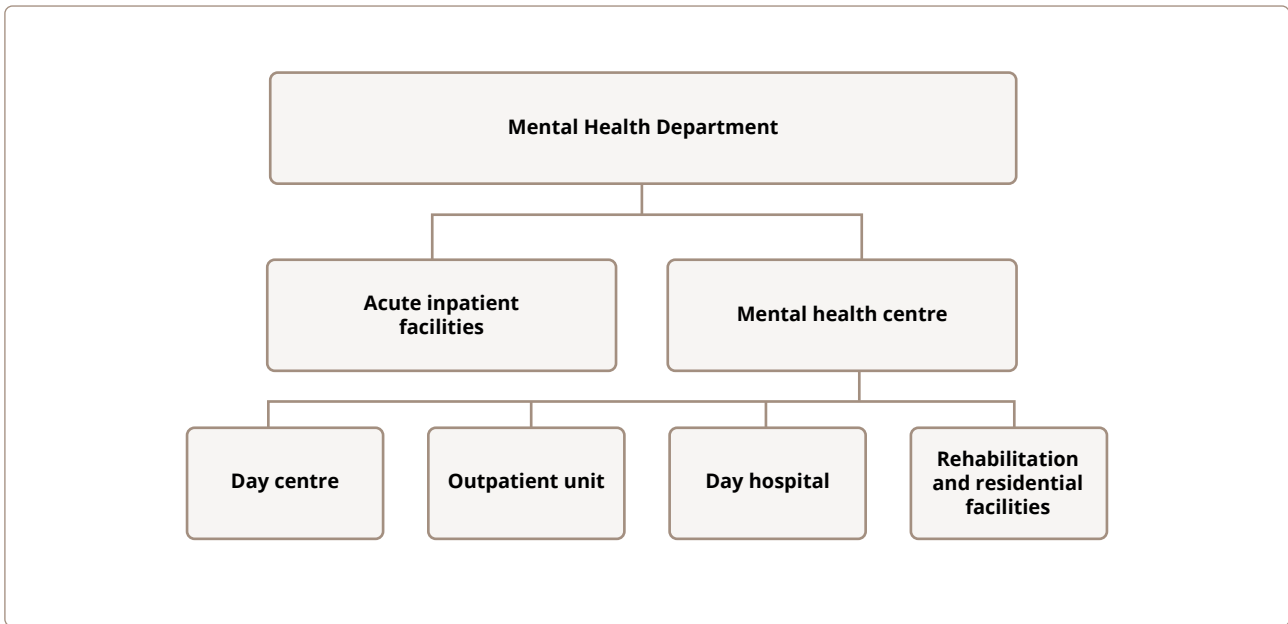


Figure 1. Organization of mental health care in Italy

inpatient facilities with a maximum of 15 beds and are closely linked with the CMHCs in order to ensure continuity of care. Admissions to a GHPU can be on a voluntary or a compulsory basis. For compulsory admissions, it is necessary for three criteria to be met, as follows: the patient has a severe mental disorder; he/she does not accept proposed treatments; the proposed treatments cannot be provided elsewhere.

### Day centres

Short- and medium-term rehabilitation programmes are usually implemented in day centres.

These are generally open 8 hours per day from Monday to Saturday and can accommodate 20 patients per day. In particular, mental health professionals working in day centres promote expressive activities and conduct training and empowerment workshops through small group activities in order to improve individuals' relational abilities. Day centres are usually accessed by sub-acute patients.

### Community residential facilities

Community residential facilities are non-hospital, community-based facilities that provide overnight care for patients with severe mental disorders. People living in these residential facilities have relatively stable mental health conditions and require rehabilitation

interventions. These residential facilities are classified as high-, medium- or low-intensity of care reflecting the level of patient autonomy. The main difference is the number of beds: high-intensity facilities include up to 14 beds; medium-intensity facilities include up to eight beds; and low-intensity facilities have three beds. Moreover, according to the intensity of the rehabilitation interventions provided to patients, residential facilities can be classified in terms of high-, medium- or low-intensity of therapeutic interventions.

In Italy, both public and private non-profit and for-profit facilities are available. The main focus of these facilities is rehabilitation, with the development of personalized intervention plans for each patient. However, it has been found that the length of stay in such residential facilities often exceeds two years. Available data may suggest that these facilities, rather than focusing on rehabilitation, provide inpatient care and long-stay residential services.<sup>6</sup>

### Service use data relating to mental health care in Italian regions

In Italy, there remains extreme variability in the provision of mental health care in different regions. In particular, the prevalence of treated mental disorders, which can be considered as a proxy indicator of the coverage capacity of community psychiatric services, ranges from 205 individuals per 10,000 population in Emilia



Romagna (northern Italy) to 108 in Basilicata (southern Italy).<sup>7</sup> Similar differences can be found for the incidence of treated mental disorders, although a north to south gradient has not been found; in fact, the incidence of mental disorders is higher in Liguria and Friuli (both regions of northern Italy) and lower in Lombardy (northern Italy), Tuscany, Umbria and Marche (all from central Italy) and Basilicata (southern Italy). The rate of compulsory admissions is 1.73/10,000 population, ranging from 5.68 in Marche (central Italy) to 0.43 in Friuli and 0.22 in Bolzano (northern Italy).

After implementation of Law 180, the absolute number of compulsory admissions progressively declined, from more than 20,000 in 1978 to less than 9,000 in 2015. Similarly, the proportion of compulsory psychiatric admissions progressively declined from 1978 to 2005, and remained stable thereafter, accounting for less than 5% of all psychiatric admissions.

## DISCUSSION

Approval of Law 180 led to a shift in the provision of care to patients with mental disorders. In particular, this law highlighted the need to treat patients with severe mental disorders the same way as all other patients. Therefore, mental health care moved from a custodialistic to a therapeutic model. In order to accommodate this clinical, ethical, social and ideological change, all asylums were closed.<sup>8</sup> Psychiatric wards were opened within general hospitals, and a community-based model of care was implemented.<sup>6</sup> The need for multidisciplinary équipes to care for patients with severe mental disorders became immediately clear; the care of patients with severe mental disorders is now provided not only by psychiatrists but also by psychologists, psychiatric nurses, social workers, rehabilitation technicians and other mental health professionals working in multidisciplinary teams in order to provide personalized and integrated treatments for each patient.<sup>9</sup>

Nevertheless, according to the WHO ATLAS, the ratio of mental health professionals to the population in Italy is below the optimal standard.<sup>10</sup> In particular, there are 33 workers per 100,000 people, which is below the median of 43.5/100,000 population in Europe and below the median of 52.3/100,000 population in high-income countries. The global median is 9/100,000 population, or less than one mental health worker for 10,000 people. In terms of regional differences, a marked variation

in service provision exists for different areas of the country, especially between northern vs. central and southern Italy. During the last 40 years, progressive consolidation of the community-based mental health care system has been observed. In particular, the Italian experience suggests that the number of psychiatric beds does not represent a key factor in terms of public health indicators such as suicide rates, involuntary admissions and the number of people placed in forensic facilities.<sup>4</sup>

However, some reasons for concern still exist, including low staffing levels, potential use of community residential facilities as long-stay residential services, and lack of community alternatives to acute inpatient admissions.<sup>11,12</sup> Moreover, many authors have highlighted the high heterogeneity in available resources for mental health care in different Italian regions. In fact, in some regions – with low levels of mental health resources – the burden of mental disorders is mainly carried out by patients' families.<sup>13,14</sup> Indeed, the high levels of family burden represent a detrimental consequence of mental disorders and have a significant impact on society at large. In order to reduce the burden reported by family members and by their ill relatives, the need to provide psychoeducational family interventions to patients and their relatives has been repeatedly stated.<sup>15-20</sup> Unfortunately, only 8% of family members report receiving such interventions, although most of them are in close contact with mental health professionals. Obstacles faced during implementation of these interventions in routine care include excessive workload for mental health professionals, the difficulties of including these interventions in routine work, and the need to conduct such interventions outside working hours.<sup>21</sup>

After implementation of the Italian reform, the absolute number of involuntary admissions progressively declined, from more than 20,000 in 1978 to less than 9,000 in 2015. With approval of the reform, criteria for involuntary hospitalizations were made clear, but the use of involuntary admissions still remains one of the most controversial issues in mental health practice in Italy.<sup>22,23</sup>

Another element of concern is represented by the length of stay in community residential facilities. Available data show that patients stay in these facilities for up

to two years, although there are some regional variations.

Finally, one of the most relevant aspects of the Italian law is the focus on the person suffering from mental disorders and the importance of dignifying individuals with treatment in adequate care settings.

## CONCLUSIONS

In conclusion, we believe that the organization of Italian mental health care – albeit one of the oldest models in the whole of Europe – is still modern and up to date. However, the new mission of psychiatry includes prevention and treatment of new forms of mental health problems, as well as management of special patient populations, such as migrants,<sup>24,25</sup> adolescents<sup>26,27</sup> and elderly people. It is time for a rethink of the structure of mental health departments in order to accommodate the needs of these patients.<sup>28-30</sup>

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## Correspondence to:

**Prof. Andrea Fiorillo, MD, PhD**  
andrea.fiorillo@unicampania.it

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