General article
Γενικό άρθρο

The necessity of developing a two-stage qualification in ICD-11

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In the International Classification of Diseases, 10th Revision (ICD-10) two opposing principles are combined and mixed: atheoreticity that is necessary for the natural classification and commitment to nosology. Implementation of these principles requires a two-stage qualification. The first stage should be narrative detailed syndromological qualifications with identification of psychotic level of disorders. As for the second stage, the qualification should be nosological, based on complete clinical analysis, which is far from being possible to realize at once. ICD-10, specifically brought to nosological certainty, may remain the natural foundation for nosological qualification. Implementation of the syndromic qualification at the first stage will allow to consider nosological features of each syndrome at the second stage and to expand the list of criteria in different clusters. Such a suggestion opens the prospect for subsequent revisions of the ICD and allows to direct our efforts and those of practitioners to the unified channel, where the statistical goals would not be implemented at the expense of the research ones.

Key words: ICD-10, ICD-11, syndromological approach.

This paper is of interest as a traditional position of the Russian psychiatrists concerning the necessity to amplify fundamentally the ICD-10 design. It is essential that the new ICD-11 would not only become a statistical instrument, but would also promote the development of psychiatry.

Long experience of using ICD-10 in Russia has demonstrated that the universal tendency of "economy of efforts" and "economy of thinking" has led to a rapid exclusion of all other classifications. In practice, the assurances that ICD-10 is a "purely statistical" instrument have proved to be merely declarations. Actually, all manuals and research activities in psychiatry are based on ICD or DSM.

As a result, ICD-10 has taken on the role of a scientific classification, among other things. However, not being designed for that, it has become, at least in Russia, an obstacle to the development of clinical and psychopathological direction in psychiatry as though this direction were an exhausted and com-

pleted method. Therefore, this circumstance should be taken into consideration by the creators of ICD-11 above all things. The point is that the use of ICD-10 changes the diagnostic process drastically: clinical thinking, clinical and psychopathological analysis, and differentiation with alternative diagnostic versions are replaced by a mechanical collation of the available clinical picture with the finite list of criteria.

In psychiatric clinics, which worked at a high clinical level before the introduction of ICD-10, this replacement of clinical thinking by a mechanical collation of the available clinical picture with the list of criteria demonstrates most distinctly the grave prospects of our subject matter in the future.

The elimination of syndromology, the simplification of psychopathology, and the speeding up of the diagnostic procedure can be attained only by switching to a more primitive qualitative level, which would actually transform psychiatry into mythology, as seen by T. Szasz (1961).[1]

Rightly proclaiming the necessity of atheoreticity for natural classification, ICD-10, at the same time, confuses this principle with the adherence to nosology.

While supporting both these principles, we are convinced that their implementation is feasible in a two-stage qualification only. At the first stage, it is necessary to develop a detailed descriptive qualification of the psychopathological syndrome with the indication of the presence of a psychotic or a non-psychotic level of the disorder. At the second stage, it is necessary to develop a nosological qualification on the basis of a clinico-psychopathological analysis following comprehensive studies and observations.

Instead of clearly distinguishing these stages from each other, ICD-10 uses a mixture of them. Natural classes can never become the outcome of such mixing. Moreover, the process of clinical thinking undergoes a vulgarization whose fruits can be seen today already. This means a return of the diagnostic process from syndromes to symptom complexes. In ICD-10, the mechanistic idea of additional symptoms replaces the evaluation of such qualitative features of the clinical picture as, for instance:

Protopathic (vital) transformation of the entire syndrome picture of depression after reaching the psychotic depth by it, regardless of behavioral manifestation;

Various diagnostically valuable intra-syndrome structural features;

Features of the internal structure of symptoms themselves, etc.

This approach drastically reduces and impoverishes the possibility of finding pathognomonic features. The protopathic nature of symptomatology as a whole does not mean additional symptoms; it means a taxonomically more significant sign of rank.

A two-stage succession corresponds to the natural holistic perception of the concrete patient: we at once perceive clearly and directly the individual psychopathological syndrome picture. A strictly phenomenological description prohibiting a premature conceptualization ensures the greatest adequacy and reliability. This approach always implies many times fewer errors than the requirement to make a nosological diagnosis immediately. It is only on the basis of the clinical analysis of anamnesis data, medical documentation, and multiple clinical and laboratory studies that the clinician should select one or another nosological diagnosis, which not always can be made at once, because it requires the evaluation of response to therapy and new environment and manifests itself in the subsequent course of disease.[2–12]

A detailed psychiatric diagnosis includes: (1) a differentiated psychopathological syndrome characteristic; (2) the indication of the presence of a psychotic level of a mental disorder ("psychotic" – "non-psychotic"); (3) the type of the course of disease with the indication of the presence of psychotic states in the past; (4) the presence of a tendency for progression; (5) the presence of a defect; its character and intensity; (6) the type of characteropathy (personality disorder) and the presence of its decompensation; (7) a nosological diagnosis.

Thus, the first stage requires a detailed descriptive qualification of the psychopathological syndrome on the basis of an optional open-ended list of descriptions of the basic known syndromes successively arranged in the spectrums of mental disorders, namely, borderline, affective, hallucinatory-delusional, catatono-hebephrenic, and consciousness disorders.

Each time each syndrome should be given a pairwise description, i.e. a generic description of its psychotic and non-psychotic levels.

The distinguishing of the psychotic level from the non-psychotic one is purely descriptive, with no relation to the psychosis–neurosis dichotomy. This distinguishing does not manifest itself "simply" – according to the ICD-10 preamble – by the presence of a delusion, hallucinations, and characteristic behavioral manifestations. It manifests itself in two opposite forms of qualitatively peculiar states – either in the presence of persistent new formations, such as delusion and hallucinations, or in the presence of a protopathic (vital) transformation of the field of experiences, i.e. of a drastic total inert simplification of the structural properties of syndrome pictures of any spectrum. The latter reflects a fundamentally greater depth of these changes – prolonged and resistant to every possible external exposure.

The notion "psychotic level" can also be attributed to the syndromes of borderline mental states, which can take on the role of masks of various psychotic disturbances. Therefore, these syndromes require especially accurate descriptions of their distinctive clinico-psychopathological features. It refers, for instance, to the asthenic syndrome and the vital asthenic syndrome, the somatoform (hypochondriac) syndrome and the vital senesto-hypochondriac syndrome, the syndrome of non-psychotic depression and the syndrome of psychotic depression (melancholy, anguish), the syndrome of non-psychotic anxiety and the syndrome of psychotic anxiety, etc. Here the level of a phenomenological description reveals a qualitative difference between psychotic and non-psychotic syndromes. This phenomenologically identifiable psychopathological feature is much more reliable than behavioral manifestations (Kurt Goldstein, Klaus Conrad).[13,14]

ICD-10 has ignored multiple comprehensive substantiations of the taxonomic independence of psychotic anxiety states.

The first stage of classification proposed in this paper retains the multidimensional role of syndromology, which has regressed to semiology in a number of the ICD-10 clusters. At the same time, differential diagnostic features are not at all confined to some individual symptoms. They represent the structural dynamic features of syndrome pictures, for instance, the peculiarities of the "vital field of experiences" rather than the "vital sensations and feelings".

The generic pairwise descriptions of compensated and decompensated disorders should also be given to such pathologic deviations as "personality disorders", "intellectual impairment", and "intellectual retardation".

At the second stage, a nosological qualification should be implemented. Here, ICD, purposefully brought to nosological certainty, can remain the foundation of the new classification.

It is important to simplify the quantification of depressive disorders in ICD-10. The presentation of one of the authors of this paper at the WPA Congress in Prague in 2007 was dedicated to the justification of this issue (table 1).[15,16] To this effect, it is necessary to return to a qualitative distinction between psychotic and non-psychotic depressions rigorously described in classical psychopathology. The quantification is only correct in a qualitatively homogenous stratum. Table 1 not only demonstrates clearly a greater naturalness and simplicity of the proposed change, but also illustrates the fact that a significantly greater number of patients refers to the high-risk zone.

A successive realization of a syndromal qualification at the first stage will allow us to consider, at the second stage, the nosological features of each syndrome and to expand the list of criteria in different clusters by integrating such factors as:

1. Subtle psychopathological features of syndrome pictures and individual phenomena.
2. Intra-syndrome dynamics features, including a response to therapy.
3. Peculiarities of the transformation of syndromes.
4. Clinical analysis outcomes resulting from the inclusion of concrete syndrome pictures into the individual context of the case histories of concrete patients.

A two-stage procedure makes the demarcation between "reliable", "temporary", and "assumptive" diagnostics, as stipulated in the ICD-10 preamble, meaningful. However, that is what ICD-10 confines itself to, without proposing anything more positive ("all the same, it is expedient to make a diagnosis"). ICD will become really atheoretical and will

Table 1. Demonstrating the advantages of the proposed changes in the ICD-10 F.32 and F.33 clusters. The proposed two-stage typology it is simpler and more correct (since quantification is only possible in a qualitatively homogenous stratum). It encompasses a great number of depressive states recognized as psychotic.

Three-levels-of-intensity classification. ICD-10 - F 32 and F 33			Two-stage typology of depressions. Classical clinico-psychopathological concepts	
1	Mild	Without somatic symptoms	Non-psychotic depression and anxiety	1 - Mild
2		With somatic symptoms		2 - Moderate
3	Moderate	Without somatic symptoms		3 - Severe
4		With somatic symptoms	Psychotic depression and anxiety	1 - Mild
5	Severe	Without psychotic symptoms		2 - Moderate
6		With psychotic symptoms		3 - Severe

have the right to be called a natural classification only in case if such temporary diagnosis is not nosological, but comprehensively psychopathological and phenomenological, i.e. fully objectively descriptive and not allowing a premature conceptualization.

To develop ICD-11, it is no less important to use taxonomic data based on the mathematical apparatus of the new branches of mathematics that would allow us to model psychiatric disorders in a fundamentally more adequate way (theory of catastrophes by René Thom; synergetics by Hermann Haken).[17,18]

Our proposal will, in fact, bring back the achievements of classical European psychiatry to ICD-11. It implies a minor complication, which will immediately justify itself by making the classification open-ended and not separating statistical purposes from scientific ones.

Η αναγκαιότητα για την ανάπτυξη μιας πιστοποίησης δύο σταδίων στο ICD-11

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Στο διεθνές σύστημα ταξινόμησης νόσων ICD-10 συνδυάζονται και αναμιγνύονται δύο αντιτιθέμενες αρχές: η αθεωρητική προσέγγιση, που είναι απαραίτητη για τη φυσική ταξινόμηση, και αποτελεί δέσμευση στη νοσολογία. Η εφαρμογή αυτών των αρχών απαιτεί διπλή πιστοποίηση. Το πρώτο στάδιο θα πρέπει να είναι η αφηγηματικά λεπτομερής συνδρομική πιστοποίηση με αναγνώριση του ψυχωτικού επιπέδου των διαταραχών. Όσον αφορά στο δεύτερο στάδιο, η πιστοποίηση πρέπει να είναι νοσολογική, βάσει της πλήρους κλινικής ανάλυσης, η οποία συνήθως δεν είναι εφικτό να πραγματοποιηθεί παράλληλα. Το ICD-10, που με ειδικό τρόπο επέφερε νοσολογική βεβαιότητα, μπορεί να παραμείνει η φυσική θεμελίωση της νοσολογικής πιστοποίησης. Η εφαρμογή της συν-

δρομικής πιστοποίησης σε ένα πρώτο στάδιο θα επιτρέψει να εξετάζονταν νοσολογικά χαρακτηριστικά κάθε συνδρόμου στο δεύτερο στάδιο και να διευρυνθούν οι κατάλογοι των κριτηρίων στις διαφορετικές ομάδες διαταραχών. Μια τέτοια πρόταση ανοίγει την προοπτική για μεταγενέστερες αναθεωρήσεις του ICD και επιτρέπει να κατευθύνουμε τις προσπάθειές μας και τις προσπάθειες των επαγγελματιών σε ένα κοινό κανάλι, στο οποίο οι στατιστικοί στόχοι δεν θα εφαρμόζονταν εις βάρος των ερευνητικών.

Λέξεις ευρετηρίου: ICD-10, ICD-11, συνδρομική προσέγγιση.

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