Indian experiences with International Classification of Mental and Behaviour Disorders-10: Pathway for ICD-11

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ABSTRACT

Background: International Classification of Mental and Behavioural Disorders (ICD)-10 has been serving its purpose in the spheres of diagnosing psychiatric patients, research, and education since long. With ICD-11 is on the horizon, this is the right time to assess issues in the application of these guidelines in routine clinical practice.

Aim: In this study, an effort was made to find out day-to-day difficulties in application of ICD-10.

Materials and Methods: A total of 130 patients attending for the first time the outpatient Department of Psychiatry, CSMMU, Lucknow, were taken as sample for the present study. The “provisional diagnosis,” which was made after the usual assessments on a single day at the clinical setting was recorded. The selected patients were later assessed in detail and a “final diagnosis was recorded for these patients. The diagnoses were matched with ICD-10 and rated on a five-point scale.

Statistics: The direct count and percentage analysis was done.

Results: Results show that 67.69% “provisional diagnosis” were fully matched, while 8% and 5% diagnosis had no match and some match, respectively with the “final diagnosis.” There were also some cases that had significant match (1.5%) and almost match (17.69%).

Conclusion: In a busy clinical setting, the focus of the clinicians is more on management and accurate diagnosis based on ICD-10 may be ignored.

Key words: Classification, international classification of mental and behavioural disorders-10, psychiatric disorder

INTRODUCTION

Nosology (from Greek word nosos-disease) refers to systemization of knowledge for identification and classification of disease.

In psychiatry, the aim of the classification is to identify groups of patients who share similar clinical symptoms so that adequate diagnosis can be made for the treatment of patients. The task of diagnosis is far more complex in Psychiatry than in general medicine because “even the typical form of a given mental disorder is often obscured by illness manifestation shaped by personality and sociocultural circumstances.”[1]

Over the centuries, different countries in different regions developed their own classification system and nomenclature. Several classification systems that have been developed in the history threw light on etiology, course of illness, and phenomenology.

At present, there are two prominent classificatory systems, which are widely used in various contexts, eg, research, clinical, primary healthcare.[2]
These are International Classification of Mental and Behaviour Disorders (ICD)-10[3] and Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV.[4]

The main purpose of ICD-10 and DSM-IV is to improve clinical care of individuals suffering from mental disorder. ICD-10 is still probably the most used system of classification worldwide. Several versions of ICD-10 have provided considerable help in the mental health sector.[5] ICD-10 has been found appropriate for diagnosing most of the psychiatric disorders in various treatment settings.[6] World Health Organization (WHO) itself conducted a field trial to assess the applicability of ICD-10 and it was found “generally easy to use, applicable to most of common disorder,”[7] but for some disorders such as personality disorder,[8] somatoform disorder,[9] its reliability is not good.

Contemporary psychiatric diagnosis and classification have evolved in Europe and the US in the last 100 years and reflect the thinking and cultural bias of those cultural areas. Several observers have stressed that “patients in developing countries express themselves more easily in somatic than in psychological terms.”[10] Thus, many such categories based on psychological symptoms are difficult to apply in the countries of the third world.

India is a developing country with a population of over 1,027,015,247.[11] Most of the population reside in rural areas (70%) and is deprived of any type of modern psychiatric services. Currently, there are 0.4 psychiatrists per 100,000 population,[12] reflecting inadequate and underdeveloped status of mental healthcare. Most of the out patient departments (OPD) providing the mental healthcare are overcrowded and the psychiatrists have to adapt accordingly. The psychiatrist has limited time to spend on each patient and this precludes structured clinical interviews or exhaustive assessments. In the usual clinical practice, a “provisional diagnosis” is made after history taking and mental status examination and the patient is treated on the basis of this diagnosis. Psychometric tests, structured interview, or detailed assessment after hospitalization are reserved for doubtful cases only.

The study was carried out to evaluate how much this “provisional diagnosis” based on history taking and mental status examination in a limited time would change on detailed and exhaustive assessments. The authors also wanted to investigate whether certain disorders were more easily overlooked than others.

**Aim**
To find out the difficulty in application of ICD-10, in day-to-day clinical practice.

**MATERIALS AND METHODS**

This study was carried out in the adult OPD of Department of Psychiatry, Chhatrapati Shahuji Maharaj Medical University (CSMMU), Lucknow, from June 25 to July 29, 2008. The medical university hospital is a tertiary center and the Department of Psychiatry is a part of this hospital.

The adult OPD caters to all psychiatry patients both male and female who are 16 years or older. Usually, 100-150 patients attend the OPD each day and about 35-50 of these are new registration, ie, patients visiting the OPD for the first time. The team of attending doctors comprises four junior residents, one chief resident, and one consultant psychiatrist (CP), who is the head of the team.

**Study sample**

The sample of patients was selected from the patients attending the adult OPD at Department of Psychiatry, CSMMU, for the first time. The first five patients to register each day were evaluated after taking their consent. Patients having organic mental disorders, major physical problems, substance abuse, multiple diagnosis, or not having a reliable informant were excluded.

The routine procedure for assessment of new patients at the OPD was followed for the patients. The patients were first assessed by a junior resident (JR), who took the history and completed physical and mental status examination. The JR then presented the case to CP. After a discussion with the JR, the CP further evaluated the patient and a “provisional diagnosis” was made.

As part of the study procedure, the patients were further evaluated in detail by the investigator (MB). The patients were given an appointment for further assessment and history was taken afresh on a semi-structured proforma. A detailed assessment of the patient was carried out, which at times included more than one interview. The case was finally discussed with the CP where the “final diagnosis” was settled. The “provisional diagnosis” was matched with the “final diagnosis” on a five-point scale (ie, No match, Some match, Significant match, Almost match, and Very good match).

**RESULTS AND OBSERVATION**

A total of 150 patients were included in the study. Of these, 130 patients completed the assessment. Table 1 gives the details of patients who were excluded.

A summary of demographic details of the sample is provided in Table 2.

**Table 1: Reason for exclusion**

| Cause                          | No. of patients |
|-------------------------------|-----------------|
| Refused to give consent       | 2               |
| Seizure disorder              | 5               |
| Substance abuse               | 7               |
| Co-morbidity with other disorder | 4             |
| Major physical illness        | 2               |
| Total                         | 20              |
Among the individual diagnosis [Table 4], “Depression” had poor concordance with the final diagnosis. The “depressive symptoms” were therefore overdiagnosed as a disorder. On more thorough assessments, the patients did not fulfill the criteria as laid down in the ICD-10. The possible reason could be lower threshold for diagnosis of “depression” where the distress may be due to other reasons, which are not discovered on the first assessment.

The other diagnosis where 33.33% had “almost match” was dissociative disorder. In order to make a diagnosis on ICD-10, the “evidence for psychological causation in the form of clear association in time with stressful events and problems or disturbed relationship (even if denied by the individual)” should be present. Further, it states that “In the absence of evidence for psychological causation, the diagnosis should remain provisional and enquiry into both physical and psychological aspects should continue.” Here, the difficulty was in clearly delineating a temporal relationship with a psychological causation in a crowded OPD in short duration.

In OPDs, it is believed that due to paucity of time, proper rapport could not be established, and this is the main reason that patients are unable to share their personal matters in crowded surroundings. In most cases, the level of dissociation has been found to be related to reported overwhelming sexual and physical abuse.[11] Chu et al. (1999) reported that child abuse, especially chronic abuse starting at early ages,[12] was related to high levels of dissociative symptoms in clinical samples.[13]

Besides, it has been also found that in the long term, dissociation is associated with decreased psychological functioning and adjustment.[14] Although stressor is the main cause of dissociation, yet the suggestion is that for the purpose of making diagnosis in clinical setting this criteria should be reviewed and diagnosis can be made on the suspicion of the stressor.

Patient with somatoform disorder often attribute their symptoms to organic cause and that is why they seek medical help. They also have a tendency to disbelieve the doctor when they are told that there was no physical cause of the problem. In ICD-10, the reassurance provided by a doctor that the patient had no physical problem has been considered as an essential criterion to make a diagnosis of somatoform disorder. In 25% of cases, it has been noticed that the patient did not fulfill this criterion, as they had
never been reassured by the physician although they fulfilled other criteria.

The discordance in the final diagnoses in “Adjustment Disorder” was recorded as the onset of symptoms occurred 3 months after the stressful situation. Thus, a temporal correlation between the problem and stressor was not established.

Nearly 33% patients with dysthymia were found moderately depressed at the time of further assessment, revealing a greater possibility of having clear cut episode of depression in dysthymia. The ICD-10 states that the depressive symptoms are “never or very rarely severe enough to fulfill the criteria for recurrent depressive disorder mild or moderate severity.” Therefore, a precise diagnosis of dysthymia could not be made. Considering the possibility of depression in dysthymia, a category of Double Depression may be worth considering in the future.

The criteria for diagnosis of Recurrent Depression in ICD-10 required that “the criteria for Recurrent Depressive Disorder should be fulfilled, and the current episode should fulfill the criteria for depressive episode – mild or moderate severity” for definite diagnosis. It was observed in 33% of the cases that the patient came to OPD in the beginning of depression, eg, 3-4 days of disturbed sleep, poor appetite, and loss of interest. From their earlier experience of illness, the patients were able detect the symptom early and seek medical help.

In such cases, doctors’ assessment was that the illness was recurring but diagnosis was not possible on ICD-10 due to the criteria related to duration. Several general population surveys have demonstrated that quite minor differences in the definition of individual syndrome such as major depression may result in large differences in recorded prevalence. Probably, the future version of ICD may take this into consideration and allow a relaxation in duration criteria for relapse episodes.

The approach to diagnosis and management of psychiatric disorder varies worldwide. These local variations are due to the variation in social and cultural norms, availability of resources, training of healthcare workers, and the modality of treatment that are available. Most of the psychiatrists in India are overloaded and have limited time for assessment of an individual patient. The focus of the psychiatrist in such a condition is to choose the best treatment and record accurate diagnosis according to the guidelines may be ignored. The patients may continue to receive treatment on the “provisional diagnosis” they are labeled with, especially if they show improvement on treatment.

CONCLUSION

The present study shows that there is some discordance in the “provisional diagnosis” and “final diagnosis” of a patient under routine clinical settings. Whether this change of diagnosis also affects the patient outcome is a subject for future studies.

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