PSYCHOLOGISTS' PERSPECTIVES ON THE DIAGNOSTIC CLASSIFICATION OF

MENTAL DISORDERS:

RESULTS FROM THE WHO-IUPSYS GLOBAL SURVEY

By

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Submitted to the graduate degree program in Clinical Child Psychology and the Graduate Faculty of the University of Kansas in partial fulfillment of the requirements for the degree of Master of Arts.

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Abstract

Background/Purpose: Revisions are underway for the two major diagnostic classification systems (DCSs) of mental disorders, the *International Classification of Diseases* (*ICD*) and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). For the World Health Organization (WHO), improving clinical utility is a major priority for the *ICD-11*. International clinician surveys are informative in this regard, but such research has not been conducted among psychologists. This study investigates psychologists' views on DCSs in mental health care and how these views differ across countries, regions, and *ICD-10* versus *DSM-IV* users.

Methods: WHO and the International Union of Psychological Science conducted an international online survey examining views of DCSs as part of the *ICD* revision process. Participants were 2,155 psychologists from 23 national psychological associations around the globe. Items addressed practical and conceptual issues related to DCSs and their clinical use.

Results: Majorities of participating psychologists were licensed, seeing patients, made diagnoses, and used a DCS regularly, the slight majority using the *ICD-10* most often. The vast majority viewed the primary purpose of DCSs to be informing treatment decisions and facilitating clinical communication. Flexible diagnostic guidelines were preferred to strict criteria. Most respondents agreed that dimensional classification, severity, and functional impairment should be incorporated into a DCS, but with little agreement as to how or why. Significant percentages reported problems with their DCS including cross-cultural applicability, Western bias, stigmatizing terms, and a need for a national DCS. Clinicians favorably evaluated

the ease of use and goodness of fit of most diagnoses, but identified some as problematic. There were more differences among regions and countries than between *ICD-10* and *DSM-IV* users.

Conclusions: Overall, psychologists' views reflect favorably upon the current *ICD-10* and *DSM-IV* systems and categories, while also identifying areas for improvement. Findings underscore the priority of clinical utility in a DCS, the diverse purposes it must serve, and professional and cultural differences among its international users. Differences associated with countries/regions, DCSs, and psychologists and psychiatrists may be partially explained by country-level differences in health systems, cultural factors, and psychology. Implications for *ICD-11* revisions, field trials, dissemination, and training efforts are discussed.

Keywords: *International Classification of Diseases* (*ICD*), *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), diagnostic classification system, clinical utility, psychologists, cross-cultural applicability

Acknowledgments

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Psychologists' Perspectives on the Diagnostic Classification of Mental Disorders:

Results from the WHO-IUPsyS Global Survey

The two major diagnostic classification systems (DCS) for mental and behavioral disorders—the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*; American Psychiatric Association [APA], 2000) and the *International Classification of Diseases*, Chapter V: Mental and Behavioural Disorders (*ICD-10*; World Health Organization [WHO] 1992a)—are currently under revision. Currently, the *DSM-5* Task Force is nearing the conclusion of its field trials process and developing the penultimate draft of the new manual, with a scheduled publication date of May 2013 (APA, 2012). Meanwhile, the *ICD-11* is undergoing a review and revision of the second (Beta) draft, and WHO is preparing to engage in a broad review and comment process and conduct field testing over the next two years, with an expected completion date of May 2015 (WHO, 2012). As their publication dates have drawn nearer, there has been an increasing level of scientific, professional, and popular interest in these two DCSs, and they have increasingly become foci of critical discussion in the psychological and psychiatric literatures. This discussion has generated controversy and expressions of dissatisfaction in regard to the current systems, as well as different recommendations for how they should be revised.

With regard to the *DSM-5* in particular, the discussion has evolved into a heated public controversy highlighted in numerous popular news media outlets. Among the many points of criticism are fiduciary conflicts of interest among members of *DSM-5* work groups (Aldhous, 2012; Ledford, 2012); concerns regarding new childhood diagnoses, disruptive mood dysregulation disorder (Frances, 2011) and attenuated psychosis syndrome (Frances, 2012); and removal the bereavement exclusion criterion for depression (Frances, 2010; Granek & O'Rourke,

2012; Szalavitz, 2012). These controversies have fueled popular and professional dissatisfaction with the *DSM-5*, as exemplified in a recent petition, organized largely by individuals and organizations in psychology, that expresses several points of protest against the new manual (Ledford, 2011; Waters, 2011). Although many of the points of debate in the popular media are beyond the scope and aim of this thesis, the attention drawn underscores the myriad interests at stake in revising the *DSM-5* or any DCS.

The main premise underlying these discussions is that revision is not necessarily tantamount to improvement. A poorly informed change could entail negative repercussions affecting several sectors of society. For example, altering a single diagnostic criterion for a disorder could lead to (and, in the past, has led to) significant changes in the prevalence of that diagnosis; the number of assessments, treatments, and prescriptions administered; the cost to patients as well as private and public reimbursement agencies; the revenue generated by pharmaceutical companies and healthcare providers; and the characteristics, stigma, and legal status associated with the diagnosed population (Frances, 2009; First & Frances, 2008). On the other hand, however, if these systems are not adequately reformulated in the current revision processes, the mental health field risks further reification of existing diagnostic constructs that are currently lacking in evidence for their biological and nosological validity (Hyman, 2010). In light of the far-reaching social, financial, and clinical implications of the classification and diagnosis of mental disorders, the present question of how best to revise these systems is a matter of great significance not only for those affiliated with the mental health care field, but for the general public as well.

Commensurate with the gravity of the above considerations, APA and WHO have approached their respective revision processes with a degree of careful planning and deliberation. Although the methods and objectives of the *ICD* and *DSM* revision processes differ

in many ways, they are similar in some respects. For both, the revision process began well over ten years prior to publication, and has included establishing a research agenda and identifying key priorities and goals for the new editions (Kupfer, First, & Regier, 2002; Kupfer, Regier, & Kuhl, 2008; International Advisory Group, 2011; Reed, 2010; Reed, Sharan, & Saxena, 2009). Most of these goals aimed to improve the scientific validity and/or clinical utility of the classifications—two complementary yet sometimes competing priorities of psychiatric nosology (Kendall & Jablensky, 2003). Specifically, early in the revision processes, there was a focus on increasing validity and reliability through incorporating recent research on biological etiology and markers from fields such as genetics and neuroscience (e.g., Andrews et al., 2009; Hyman, 2010; Insel et al., 2010; Insel & Wang, 2010). Such a paradigm shift, it was hoped, could advance the science of diagnostic classification from diagnostic reliability (a major accomplishment of the last two generations of the *DSM* and *ICD*) to biological validity, which is sometimes considered the ideal standard of medical pathology and diagnosis. Unfortunately, as the publication dates have drawn nearer it has become increasingly clear that the progress made in these young sciences would be insufficient to effect major change in either DCS (Hyman, 2010; Insel et al., 2010; Reed, 2010; Rutter, 2011). While reliability and validity would remain integral components of mental health diagnosis and classification, any improvements in these dimensions were not likely to come from new findings in the biological sciences.

Subsequently, revisers of the *DSM* and *ICD* have renewed their focus on another central goal of both DCSs, clinical utility—a goal which is directly linked to mental health service delivery and WHO's global public health mission (Reed, 2010). While several definitions of clinical utility have been put forward (e.g., First et al., 2004; Mullins-Sweatt & Widiger, 2009), Reed's (2010) definition is particularly useful for the present study because it is operationalized specifically for research on the clinical utility of the *ICD*. According to this definition,

the clinical utility of a classification construct or category for mental and behavioral

disorders depends on: a) its value in *communicating* (e.g., among practitioners, patients,

families, administrators); b) its *implementation characteristics* in clinical practice,

including its goodness of fit (i.e., accuracy of description), its ease of use, and the time

required to use it (i.e., feasibility); and c) its usefulness in *selecting interventions* and in

making *clinical management* decisions. (p. 461)

Indeed, as many have noted, both DCSs acknowledge the importance of clinical utility within

their pages. The *DSM-IV-TR* states that its "highest priority has been to provide a helpful guide

to clinical practice" (APA, 2000, p. xxiii); similarly, the *ICD-10-CM* was published specifically

for "general clinical, educational and service use" (WHO, 1992b, p. 8). In accordance with these

objectives, many have identified clinically pertinent problems of the current systems and argued

for revisions that would facilitate greater clinical utility (e.g., First, 2005, 2010; First & Westen,

2007; Flanagan & Blashfield, 2010; Mullins-Sweatt & Widiger, 2009; Reed, 2010).

A further consideration, of primary importance for the *ICD* revision process, is WHO's

global public health mission to help relieve the burden of mental illness, particularly in areas

where treatment needs often go unmet. Worldwide, the *ICD* is used for a range of purposes,

including mental health diagnosis, treatment, billing, and reporting of health statistics. Thus, to

the extent that the *ICD-11* can be easily used for these purposes in diverse health professions,

languages, and cultures, this may help to improve the quality and scope of care provided

(International Advisory Group, 2011; Reed, 2009; Saxena & Reed, 2011).

Problems and Solutions

There is no shortage of criticisms of the *DSM-IV* and *ICD-10,* nor is there a limited

number of recommendations for how they might be improved. A full review of this literature is

clearly beyond the scope of this paper. However, for illustrative purposes, a few of the issues addressed by the present study are briefly summarized below.

One common criticism of the *DSM* and the *ICD* is that they are too large and complex to be optimally useful in most clinical settings (Andrews, Anderson, Slade, & Sunderland, 2008; Flanagan & Blashfield, 2010; Watson & Clark, 2006; Zimmerman, Chelminski, McGlinchey, & Young, 2006). This may be especially problematic for those clinicians who are not mental health specialists and do not receive much training in these manuals—yet these are the same clinicians carrying the majority of the global mental health care burden (Wang et al., 2007; WHO, 2011). Both systems contain hundreds of diagnostic categories arranged across multiple hierarchical levels of organization, with each disorder defined by elaborate diagnostic requirements. However, there is evidence suggesting that clinicians do not rigidly adhere to the formal diagnostic procedures and nosologies in which they were trained; rather, they develop and use their own diagnostic methods and cognitive DCSs, which appear to be more parsimonious, flexible, pragmatic, and informed by experience—for better or for worse (First & Westen, 2007; Garb, 2005).

For instance, Flanagan and colleagues' (2007a, 2007b, 2008, 2010) research suggests that most clinicians develop "folk taxonomies" of mental disorders, forming groups based on perceptions of clinical similarity among disorders (e.g., conduct disorder and oppositional defiant disorder). These taxonomies tend to be smaller and simpler than the I*CD-10* and *DSM-IV* taxonomic structures. More recently, two similar investigations (Reed et al., 2012; Roberts et al., 2012) have found that mental health professionals conceptualize relationships among disorders in ways that are remarkably consistent with one another—even across countries, professions, and languages—and less consistent with the *ICD-10* and *DSM-IV*. There is also empirical evidence to suggest that some diagnostic criteria may be simplified in a manner that improves utility

without compromising reliability (Andrews et al., 2008; Zimmerman et al., 2006). Therefore, if it is true that clinicians' folk taxonomies and diagnostic practices are indeed simpler and more clinically useful than the official taxonomies, then for the *DSM-5* and *ICD-11*, a simplification of some kind may be in order.

Other recommendations for improving the overall clinical utility of the *DSM* and *ICD* include the incorporation of various alternative conceptual approaches to defining the nature and degree of mental disorders. For example, the longstanding discussion of dimensional versus categorical classification has intensified in recent years, with many advocating that the *DSM-5* and *ICD-11* incorporate dimensional components into their predominately categorical nosologies (Brown & Barlow, 2005; Cuthbert, 2005; First, 2005; Kupfer, 2005; Maser et al., 2009; Watson & Clark, 2006; Widiger & Samuel, 2005). Still, the question of whether dimensional classification would be more useful than categorical classification remains a matter of debate. Within the context of dimensional assessment, different global aspects of mental illness, such as severity and functional status, have been identified as clinically significant areas of concern that warrant more attention from a DCS (e.g., First & Westen, 2007). Revisions targeting general issues such as these (i.e., dimensional classification, functional impairment, severity) could take place at different levels within a DCS, from disorder-specific modifications to broad changes affecting the entire system.

Finally, clinical utility could be improved by tailoring DCSs to meet the needs and purposes of all those who use or are affected by it. These parties include different providers of mental health care (e.g., psychologists, psychiatrists, primary care physicians, social workers, psychiatric nurses); patients/clients and their families and advocates; and administrative staff. They represent an array of clinical settings, professions, practices, geographic locations, and socio-demographic characteristics (e.g., ethnicity, language, culture, socio-economic status, age).

Meeting clinicians' needs in all such circumstances presents a formidable challenge for any

DCS. WHO has pursued this goal by tailoring versions of the *ICD-10* to the needs of different

clinical users in different settings and professions (WHO, 1992b; WHO, 1996). Moreover, the

ICD-10 is available in 42 languages and in a variety of formats. With the publication of the

ICD-11, WHO aims to produce materials that would make their systems more widely accessible

and satisfactory. Still, questions remain as to how these and many other goals are best achieved,

and they seem most appropriately addressed to the different clinical users of these systems.

Clinicians' Perspectives

Some of the more rigorous research on clinicians' views of DCSs comes from their field

trials. The results of the international *ICD-10* field trials suggested there was promising clinical

utility for the newly revised system, specifically in terms of good reliability, ease of use,

goodness of fit, and positive feedback from clinicians (Sartorius et al., 1993). Studies such as

this offer advantages in size, resources, and methodological design, but are also expensive, rare,

and tailored for the specific purposes of testing and finalizing a new DCS. Moreover, they have

tended to prioritize reliability and validity while under-emphasizing clinicians' opinions on

substantive issues of diagnostic classification.

A more common and feasible method for addressing some of these questions is through

surveys of clinicians. To date, there have been relatively few studies of this type, and they have

often limited by their sample size, methods, or geographical scope. In one of the earliest of these

studies, Maser, Kaelber, and Weise (1991) surveyed 146 people from 42 countries and found that

the *DSM-III* and *DSM-III-R*, in comparison with the *ICD-9*, were more frequently identified as

useful for clinical, research, and educational purposes. Respondents also responded favorably to

the overarching features of the *DSM*. However, this study's methodological limitations likely

resulted in a biased and non-representative sample, which makes the results difficult to interpret.

With the publication of the *ICD-10*, the *ICD* system has emerged as that which is most frequently used in clinical settings throughout the world. In a survey of French psychiatrists, Sechter (1995) found that, although many used the *DSM-III-R* for research purposes, the *ICD-10* was used more frequently for clinical practice and in medical settings. After the publication of the *DSM-IV* and *DSM–IV-TR*, the international shift toward preferring the *ICD* system in mental health care continued to become more evident (Mezzich, 2002; Müssigbrodt et al., 2000). More recently, Zielasek and colleagues (2010) similarly found general satisfaction with most aspects of the *ICD-10* among a sample of German-speaking psychiatrists in three countries.

Only recently have a few clinician surveys moved beyond questions of usage and satisfaction to examine opinions on more substantive issues about diagnostic classification and clinical utility. Mellsop and colleagues (2007b) developed a questionnaire to examine New Zealand psychiatrists' views on the purposes, problems, and design of DCSs, as well as how they could be changed in order to better serve their clinical functions. Adaptations of this questionnaire have subsequently been used to examine psychiatrists' views across different geographical and cultural contexts, including New Zealand, Brazil, and Japan (Mellsop et al., 2007a), the United States (Bell, Sowers, & Thompson, 2008), and Japan, Korea, China, and Taiwan (Suzuki et al., 2010). In all of these studies, clinicians consistently indicated that inter-clinician communication was the most important purpose of a DCS and that they wanted a simple, reliable, and easy-to-use system with fewer disorder categories. However, there was less agreement on how best to tailor a system to meet the needs of different users, and views on cross-cultural applicability varied across different countries and cultural contexts. In the most recent adaptation of this survey, Mellsop, Lutchman, Lillis, and Dutu (2011) examined and compared the views of psychiatrists, primary care physicians, clinical psychologists, and consumers in New Zealand. Although they found some differences between groups (e.g.,

psychologists emphasizing research and health statistics more than psychiatrists), all samples again agreed that inter-clinician communication is the most important purpose.

Recently, WHO and the World Psychiatric Association (WPA) conducted the largest clinician survey to date, involving 4,887 psychiatrists in 44 countries around the globe (Reed, Correia, Esparza, Saxena, & Maj, 2011). Consistent with the findings of previous surveys, Reed et al. (2011) found that the majority of respondents agreed that the most important purposes of a DCS were to facilitate inter-clinician communication and to inform clinical treatment and management decisions. Similarly, respondents preferred flexible (rather than strict) diagnostic guidelines and a simplified system with fewer diagnostic categories. There was disagreement regarding whether/how to incorporate dimensional classification, functional impairment, and severity into the *ICD* and *DSM*. In general, these findings underscored the priority of clinical utility, were favorable for most diagnostic categories, and reflected the current controversies and debates within the mental health field.

With the exception of Mellsop et al. (2011), most of the previous surveys of mental health clinicians' views on DCSs have been conducted with samples comprised entirely or mostly of psychiatrists; few have included psychologists, not to mention the many other health professionals who often provided mental health services (e.g., clinical social workers, general practitioners counselors, psychiatric nurses). This is an important limitation because, worldwide, psychiatrists provide only a small fraction of the mental health services delivered (WHO, 2011), and represent only one of several perspectives in mental health care. In addition to psychiatrists, psychologists represent a significant constituency among those who use these DCSs, and they may offer a valuable perspective on how to improve their clinical utility. Additionally, given that a considerable amount of the protest against the *DSM-5* revisions has come from professional organizations and individuals within psychology (Coalition for DSM-5 Reform,

2012), it seems that many psychologists are dissatisfied with the current revision efforts and interested in sharing their own views to help improve diagnostic classification. In light of these considerations, a large-scale investigation of psychologists' views is an important next step for this emerging literature and for the future of diagnostic classification.

Previous studies in this area have two further limitations. First, most have examined clinicians in only one or a few countries or geographical regions. Second, the majority of these studies have been conducted with samples that generally use the same DCS, or researchers have neglected to examine any differences between *DSM* users and *ICD* users. To date, Reed et al. (2011) is the first and only study with sufficient sample size and diversity to investigate either of these issues, and the findings posed interesting implications for psychiatry around the globe and across cultures. Similar research is needed to better understand psychologists' views across regions, countries, and DCSs.

Overview of the Present Study

As the mental health care field anticipates the *DSM-5* and *ICD-11*, there is a need for research examining how altering the general features of those systems could affect their clinical utility. Reed et al. (2011) took an important step in this direction with the first global survey of psychiatrists. This study represents the next major step in this emerging body of research: a global survey of psychologists.

Specifically, the aims of the present study were (a) to examine psychologists' opinions on issues concerning the clinical utility of DCSs, and (b) to determine whether and to what extent these opinions differ across geographical region, country, and users of different DCSs. These data (along with data from other investigations from the *ICD-11* formative research program [Reed et al., 2011, 2012, Roberts et al., 2012]), will be used to help inform revisions to the forthcoming *ICD-11* chapter on mental and behavioural disorders, as one part of the effort to

facilitate greater clinical utility. To this end, an online survey for psychologists was developed and distributed by WHO, the International Union of Psychological Science (IUPsyS), and 23 national psychological associations. The final sample consisted of over 2,155 psychologists from 23 countries, representing a diverse range of social, economic, cultural, and professional backgrounds. Survey items addressed topics such as the usage and purposes of DCSs, as well as practical and conceptual issues of mental disorder classification. The study also examined the prevalence, ease of use and goodness of fit of particular disorders, and explored areas of dissatisfaction with and recommendations for improving the current systems.

Methods

As detailed below, the methods for developing and distributing the survey are similar to those described in the WHO-WPA global survey of psychiatrists (Reed et al., 2011), but with differences relating to the participants, organizations, and time frame. Prior to data collection, all procedures and materials received approval from the WHO Research Ethics Review Committee (ERC) and the University of Kansas Human Subjects Committee – Lawrence (KU HSC-L).

Survey Development

Before developing the survey, three of the investigators (Drs. Pierre Ritchie and Ann Watts, IUPsyS; and Dr. Geoffrey Reed, WHO) composed and sent letters to the presidents of IUPsyS member (national psychological) associations to assess their interest in participating in various international research projects for the *ICD* revision, including the present study. Recipients were asked to indicate their association's level of interest and ability regarding participating in a global survey of psychologists' experiences and attitudes regarding the *ICD-10*, *DSM-IV,* and other DCSs of mental disorders. Associations unable to participate in an English-language survey were asked if they could translate it to the language used by most of their

members. In total, 47 societies expressed interest, and 23 ultimately implemented the survey to completion (see Table 1).

The online survey was developed by the WHO Department of Mental Health and Substance Abuse as a means to allow clinician input to influence revisions to the *ICD* chapter on mental and behavioral disorders. It included content adapted from similar previous surveys of clinicians (Mellsop et al., 2007a, 2007b; Reed et al., 2011; Zielasek et al., 2010) and the *ICD-10* field trials (Sartorius et al., 1993) of the *Clinical Descriptions and Diagnostic Guidelines* (WHO, 1992b). The current survey was tailored specifically for psychologists, including the addition of new questions specifically relevant to psychology practice.

All surveys were programmed and administered through the Qualtrics web-based survey platform, hosted through an account licensed to the University of Kansas. Where appropriate, the survey was programmed to be adaptive to participants' responses, such that some items were presented only if certain responses were selected for previous items (see Appendix footnotes). For example, if respondents indicated that they were not currently seeing patients, they were not presented with the items asking about their clinical experiences with particular diagnostic categories. The survey was also programmed to require participants to provide a response to all items before moving on to the next screen, a method which has been shown to reduce missing data without affecting survey completion rate (Albaum, Wiley, Roster, & Smith, 2011).

The survey was originally developed in English, and 17 out of the 23 societies implemented the English version of the survey only. For the other six countries, survey materials were translated into Spanish, French, German, and Turkish (see Table 1). The Spanish and French translations were provided by WHO. The German and Turkish translations were adapted by the national psychological associations in Germany and Turkey from translations used for the Reed et al. (2011) survey of psychiatrists. To facilitate these translations, WHO

provided explicit instructions that included forward- and back-translation, attention to conceptual equivalence across cultures, semantic equivalence across languages, and the use of multiple translators, with procedures to resolve differences.

Survey Content

Despite the different translations, all participants were presented with the same survey, which consisted of an introduction page followed by four sections (see Appendix). The introduction page presented participants with a brief description of the purposes of the study and the content of the questionnaire, followed by instructions and the opportunity to agree or decline to participate. The remaining sections were collectively designed to address the content areas of sample demographics, professional characteristics, usage of a DCS, global features of a DCS, cultural concerns, and usage and evaluation of particular categories.

Section One contained multiple-choice items on personal demographic characteristics (i.e., age, gender) and information on participants' clinical practices. These included items pertaining to years of professional experience; whether seeing patients/clients was a regular professional activity; if so, how many hours per typical week were spent seeing patients/clients; and usage and knowledge of particular DCSs. In light of the variability of professional psychology across countries, additional items were added to this section to assess participants' licensure status, roles in diagnostic decision-making, and diagnostic practices in the settings in which they work.

Section Two consisted of multiple-choice items assessing participants' opinions on general issues relating to DCSs and their use in clinical practice. For example, these questions inquired about the most important purposes of a DCS; how best to accommodate the needs and purposes of different users; the optimal number of diagnostic categories; whether diagnostic criteria ought to be more rigid or flexible; whether and how to incorporate considerations of

functional status, severity, and dimensional classification; whether it is problematic to apply the DCS across cultures, races, and ethnicities; and whether a diagnosis of depression should be made when the depressive symptoms are a proportionate response to adverse life events such as divorce or the loss of a job or home.

Section Three began by presenting a list of 44 or 45 common diagnostic categories (e.g., major depressive disorder, social phobia) from the *ICD-10* or *DSM-IV*, respectively (whichever system the participant reports using most often). From that list, clinicians were asked to select the diagnostic categories they regularly encountered among their patients or clients as part of their day-to-day practice. Then, for each diagnostic category selected, participants were asked to assess ease of use (i.e., how easily it is used in clinical practice) and goodness of fit (i.e., its accuracy in defining, describing, and diagnosing the disorder) on scales of 0 (low) to 3 (high).

Section Four contained items pertaining to the possible addition, deletion, or re-organization of disorder categories within the DCS, allowing for both yes/no and open-ended responses. Other questions addressed whether there are particular diagnostic categories that are problematic or dissatisfying, whether certain terms in the DCS are stigmatizing in a given cultural context, and whether a DCS ought to be tailored to meet the needs of each specific country. Lastly, an opportunity was given to provide comments about the survey.

Procedures and Participants

Participating IUPsyS member associations received a standard set of instructions for the selection of participants, initial solicitation message, reminder messages, and tracking of participation. To the fullest extent possible, survey distribution materials and instructions were provided in the language of the survey, although some associations helped to modify their translations. The instructions indicated that the primary purpose of the study was to "assess the views and opinions of psychologists around the world regarding the problems with current DCSs

and to provide scientific and clinical input to strengthen, broaden, and improve the revision process." In exchange for their participation, member associations were told they would receive a database containing the results obtained from their sample, which they could freely present or publish as desired, provided that this occur after the publication of the present study and with proper approval and acknowledgement of WHO and IUPsyS.

Eligible participants were identified by their national psychological associations, who were instructed to select participants who met the following inclusion criteria: (a) membership in their national psychological association, (b) professional status as a psychologist in their country, (c) completion of all necessary professional training, (d) authorization or licensure to practice as a psychologist in their country, and (e) current provision of treatment or assessment services for mental and behavioural disorders in their country. National psychological associations were instructed that they should not solicit participation from members who were not psychologists, still in training, or not currently practicing. However, not all associations had the membership data necessary to ensure that all these criteria were met.

Each national association received one of two possible sets of instructions depending on the size of their memberships. Large societies ($\geq$1,000 members) were asked to randomly select 500 individuals from their membership who satisfied the above criteria for participation. Small societies (<1,000 members) were asked to solicit all available members who met these criteria. Once a member association had identified the list of potential participants, those individuals received emails soliciting their voluntary participation in a brief online survey that would help inform WHO's revision process for the *ICD* chapter on Mental and Behavioural Disorders. Two reminder emails were distributed two and six weeks following the initial solicitation. All emails contained an explanation of the purpose of the study, anonymous and voluntary participation, time required, approval and exemption status from the WHO ERC and the KU HSC-L, names of

investigators, and contact information for any questions or comments. Throughout the process of implementing the survey, participating societies were instructed to keep records of the dates and numbers of initial solicitations and reminders sent, as well as the emails returned as undeliverable. Due to technological barriers, one sample (Uganda) implemented a paper-and-pencil version of the survey delivered by mail. Still, they were given the same directions as the associations using the web-based survey. Each association's data collection occurred over a period between December 2010 and February 2012 (median data collection period = 3 months).

Data Analyses

For the purposes of geographical and cross-cultural comparison of results, participating national psychological associations were *a priori* assigned to groups according to their geographical region. Regional demarcations were originally derived from WHO's six official world regions (Africa, Americas, Eastern Mediterranean, Europe, Southeast Asia, and Western Pacific), with slight modifications due to geographical, cultural, and sample considerations. The final six regions used in this study were Africa, Asia, Eastern Mediterranean, Europe, Latin America, and the United States (USA; see Table 1 for constituent countries).

All descriptive results for the regional and overall samples were calculated in two ways: (a) *unweighted* figures, which combine all participants' data from constituent countries into one group for the purposes of analysis; and (b) *weighted* figures, in which analyses draw upon statistics from the country samples, rather than participant-level data. Weighted estimates overcome the problem of disparate sample sizes by giving each national sample "equal weight" in representing the group. However, these figures should be interpreted cautiously when sample sizes are very disproportionate. By comparing weighted and unweighted estimates, it is possible to determine whether the total, unweighted values are disproportionately influenced by countries with large sample sizes, and thereby arrive at a more accurate estimate of regional and

international results. Note that weighted estimates are not calculable for comparisons between *ICD-10* and *DSM-IV* users because different DCSs were used within most national samples.

In addition to descriptive results, Chi-square and ANOVA analyses were conducted on categorical and continuous variables, respectively, in order to identify any overall significant differences (a) between *ICD-10*-users and *DSM-IV*-users, or (b) among all six geographical regions. Due to the large variability in country sample sizes, no statistical analyses were conducted at the country level. To control for an inflated Type I error rate due to numerous comparisons and a large sample, all statistical tests were conducted using the Bonferroni correction; an alpha level of .0005 was used for all analyses, thereby maintaining a study-wise alpha of less than .05. Where significant differences on survey items were found, effect sizes were calculated in the forms of Cramer's *V* for categorical variables and Cohen's *d* for continuous variables. Following Cohen's (1988) recommendations, a Cramer's *V* >.1 is interpreted as a small effect size, >.3 as medium, and >.5 as large; and a Cohen's *d* >.2 is interpreted as a small, >.5 as medium, and >.8 as large.

Results

The final international sample consisted of 2,155 participants (M_{Age} = 44.18, *SD* = 12.06; 70.4% female) comprised of national subsamples (*M* subsample size = 93.70, range = 3 – 343) from 23 countries and six major geographical regions around the globe. Table 1 presents demographic and professional characteristics of the overall sample as well as national and regional subsamples.

Response Rate

The 23 participating psychological associations recorded a total of 6,911 solicitations by email and 40 by mail. For two associations, India and Israel, solicitation data were not recorded, but response data were collected from 54 and 40 participants, respectively. Thus, the true total

number of solicitations, across all countries and modes of participation, was at least 7,045. Among the 6,911 psychologists who received the email solicitation, 2,238 (32.4%) clicked on the survey link, and 2,135 (30.9%) provided consent to participate in the study. Among the paper-and-pencil participants, 20 out of 40 gave consent. Thus, the total sample size, including online and paper-and-pencil survey participants, was 2,155. Omitting data from those two subsamples for which solicitation figures were not tracked ($n = 94$), the overall response rate was 29.7% (weighted = 35.9%), with national subsamples ranging from 8.0% (Ireland) to 76.9% (Estonia).

To determine whether response rates were affected by economic or technological differences among countries, national subsamples were compared by country income level (World Bank, 2012). Interestingly, response rates were much higher among low- and lower-middle-income countries (50.0%; 47.9% weighted) than they were among upper-middle- (26.4%; 33.1% weighted), and high-income countries (29.2%; 33.9% weighted). Given the advantages of an online study, it was also possible to calculate how long it took each participant to complete the survey. However, because it is possible for participants to close out of the survey or leave it open for long periods of time, response time was only calculated for those who spent 5 – 120 minutes on the survey site. The overall mean response time was 22.20 minutes (weighted $M = 23.01$, $SD = 17.6$), with a median of 16.37 minutes (weighted median = 18.32).

Although a total of 2,155 participants provided consent, 2,012 (93.4%) participants then went on to provide responses to one or more subsequent items, and only 1,605 (74.5%) completed the entire survey (i.e., submitted the survey or completed the last item). Such patterns of participant dropout are not unusual in online survey research (Hoerger, 2010). The forced-response programming of the survey minimized missing data for most items, but there was still a

gradual, linear pattern of participant attrition throughout the survey. ANOVAs and Chi-squares were conducted to determine whether differential dropout rates might result in sample bias. Dropout was not significantly associated with country income level, gender, DCS, or with whether or not respondents were seeing patients; but was related to regional differences, X^2 (5, N = 2,155) = 68.89, $p < .0005$, Cramer's V (hereafter referred to as 'V') = .179, age, F (1, 2010) = 13.96, $p < .0005$, Cohen's d = .207, and experience, F (1, 2005) = 13.47, $p < .0005$, Cohen's d = .204. Specifically, completion rates were lower among Eastern Mediterranean (52.7%) and Latin American (70.3%) samples than in European (76.9%), Asian (79.1%), American (81.5%) and African (81.0%) samples. Further, survey completers were slightly older (M_{Age} = 44.68 years, SD = 11.8) and more experienced ($M_{Experience}$ = 15.42 years, SD = 10.9) than non-completers (M_{Age} = 42.19, SD = 12.794;. $M_{Experience}$ = 13.20, SD = 10.996). It should be noted, however, that these differences are all of small magnitude.

Table 1: Sample Characteristics by Country and Region

REGION Country	Participating Psychological Association	Survey Language	*N*	Response Rate (%)	% of Total Sample	*M* Age	*M* Years of Experience	% Female	% Licensed	% Seeing Patients
AFRICA										
Namibia	Psychological Association of Namibia	English	7	21.9	0.3	39.9	8.1	85.7	100.0	85.7
South Africa	Psychological Society of South Africa	English	91	18.8	4.2	48.3	14.1	68.6	96.5	94.2
Uganda	Uganda National Psychological Association	English	20	50.0	0.9	41.1	7.9	40.0	85.0	90.0
Zimbabwe	Zimbabwe Psychological Association	English	3	21.4	0.1	40.5	4.0	0.0	100.0	100.0
Unweighted *M*/total [a]	---	---	**121**	**21.2**	**5.6**	**46.4**	**12.7**	**63.5**	**94.8**	**93.0**
Weighted *M*	---	---	**30.3**	**28.0**	**1.4**	**42.4**	**8.5**	**48.6**	**95.4**	**92.5**
ASIA										
Hong Kong	Hong Kong Psychological Society	English	72	23.9	3.3	41.6	12.3	82.9	98.6	92.9
India	India National Academy of Psychology	English	54	Unknown	2.5	39.3	12.0	70.2	97.9	91.5
Sri Lanka	Sri Lanka Psychological Society	English	13	72.2	0.6	40.5	6.8	63.6	90.9	72.7
Unweighted *M*/total [a]	---	---	**139**	**43.6**	**6.5**	**40.6**	**11.7**	**76.6**	**97.7**	**90.6**
Weighted *M*	---	---	**46.3**	**48.1**	**2.2**	**40.4**	**10.4**	**72.2**	**95.8**	**85.7**
EASTERN MEDITERRANEAN										
Israel	Israel Psychological Association	English	40	Unknown	1.9	53.2	19.9	54.8	96.8	100.0
Lebanon	Lebanese Psychological Association	English & French	10	33.3	0.5	40.3	11.7	90.0	100.0	100.0
Turkey	Turkish Psychological Association	Turkish	174	38.8	8.1	36.7	11.4	75.5	89.8	92.4
Unweighted *M*/total [a]	---	---	**224**	**46.9**	**10.4**	**39.6**	**12.8**	**72.9**	**91.5**	**94.0**
Weighted *M*	---	---	**74.7**	**36.1**	**3.5**	**43.4**	**14.3**	**73.4**	**95.5**	**97.5**
EUROPE										
Denmark	Danish Psychological Association	English	223	50.9	10.3	47.1	14.5	77.5	97.2	98.6
Estonia	Union of Estonian Psychologists	English	10	76.9	0.5	43.6	15.6	77.8	100.0	100.0
Finland	Finnish Psychological Society	English	186	41.3	8.6	43.6	15.1	79.8	98.3	96.6
France	French National Committee of Scientific Psychology	French	343	65.6	15.9	39.9	10.9	76.7	95.5	95.5
Germany	Federation of German Psychologists' Associations	German	170	34.8	7.9	50.6	19.2	53.9	94.6	89.8
Ireland	Psychological Society of Ireland	English	40	8.0	1.9	45.7	16.3	78.4	94.6	94.6
Norway	Norwegian Psychological Association	English	239	48.6	11.1	42.5	11.5	67.7	99.6	97.0
Sweden	Swedish Psychological Society	English	100	20.0	4.6	44.3	10.8	67.7	100.0	97.8
Switzerland	Swiss Psychological Association	English	37	14.3	1.7	47.9	18.2	61.8	100.0	97.0
United Kingdom	British Psychological Society	English	50	11.4	2.3	44.0	13.7	70.2	100.0	95.7
Unweighted *M*/total [a]	---	---	**1398**	**15.6**	**64.8**	**44.2**	**13.7**	**71.6**	**97.4**	**95.9**
Weighted *M*	---	---	**139.8**	**37.2**	**6.5**	**44.9**	**14.6**	**71.1**	**98.0**	**96.2**
LATIN AMERICA										
Argentina	Argentinean Association of Behavioral Science	Spanish	26	60.5	1.2	41.4	12.3	68.0	100.0	84.0
Mexico	Mexican Psychological Association	Spanish	139	31.2	6.5	44.1	16.8	66.1	93.7	66.9
Unweighted *M*/total [a]	---	---	**165**	**33.8**	**7.7**	**43.7**	**16.1**	**66.4**	**94.7**	**69.7**
Weighted *M*	---	---	**82.5**	**45.9**	**3.8**	**42.8**	**14.5**	**67.1**	**96.9**	**75.5**
USA										
United States	American Psychological Association	English	108	10.9	5.0	54.5	20.9	57.5	100.0	94.3
OVERALL										
Unweighted *M*/total [a]	---	---	**2155**	**31.0**	**100.0**	**44.2**	**14.0**	**70.4**	**96.6**	**93.2**
***M* weighted by country**	---	---	**93.7**	**35.9**	**4.3**	**43.9**	**13.2**	**66.7**	**96.9**	**92.5**
***M* weighted by region**	---	---	**359.2**	**28.7**	**16.7**	**44.8**	**14.6**	**68.1**	**96.0**	**89.6**

[a] In these rows, sample size (*N*) and % of total sample are total values, and all other figures are unweighted means.

Professional Characteristics and Practices

Clinical experience. A major priority of this study was to obtain data from mental health professionals working with clients/patients in clinical settings. Accordingly, several items addressed participants' professional characteristics and clinical activities. Globally, 93.1% (92.5% weighted) and large majorities of each country sample (range = 66.9 – 100.0%) were currently seeing patients. Moreover, an even greater majority, 96.6% of participants (96.9% weighted), were currently licensed or authorized to provide assessment or treatment services to persons with mental disorders, whether independently (86.7%; 84.1% weighted) or under supervision (9.9%; 12.9% weighted). Significant differences were found across regions, X^2 (5, N = 1,998) = 147.63, $p < .0005$, $V = .272$, such that 69.7 % (75.5% weighted) of respondents in Latin American countries reported seeing patients, compared to 90.6 – 95.9% (85.7 – 96.2% weighted) of respondents among all other regional samples. To gauge participants' level of clinical exposure and experience, the survey asked how many years of experience participants had and, for those who were currently practicing, how much time they spent seeing patients each week. Overall, respondents had an average of 13.97 years of experience (weighted $M = 13.22$, range = 0 – 60, $SD = 10.93$). With regard to weekly clinical activities, 75.2% (66.3% weighted) of practitioners reported that they spend between 10 and 40 hours per week seeing patients, with a plurality (40.0%; 35.3% weighted) spending 10 – 19 hours per week.

Diagnostic practices. Because psychologists' roles and backgrounds can vary greatly within global mental health care (Stevens & Wedding, 2004), respondents were asked to indicate which professionals typically make diagnoses in the setting where they practice most, and what role psychologists play with regard to diagnostic decision-making. Among the entire sample, respondents reported that in the settings where they worked most, psychologists (75.0%; 79.2% weighted) typically made diagnoses, followed by psychiatrists (60.4%; 56.8% weighted), other

physicians (20.0%; 17.7% weighted), "other" (6.8%; 6.9% weighted) and nurses (3.8%; 2.7% weighted). This rank ordering remained consistent across each regional subgroup, but there were significant regional differences in the degree to which respondents indicated that psychologists [X^2 (5, N = 1,817) = 79.08, p < .0005, V = .209], psychiatrists [X^2 (5, N = 1,817) = 96.26, p < .0005, V = .230], and other physicians [X^2 (5, N = 1,817) = 23.35, p < .0005, V = .113] typically made diagnoses in their work settings. In the USA and Latin America, for example, respondents indicated that psychologists very frequently made diagnoses (USA = 99.0%; Latin America unweighted = 93.1%, weighted = 92.1%), while psychiatrists (USA = 34.0%; Latin America unweighted = 38.6%, weighted = 43.7%) were less commonly reported as being diagnosticians in the settings in which respondents worked. By contrast, respondents in Europe and Asia reported that, in the setting where they worked, psychologists (Europe unweighted = 70.2%, weighted = 73.2%; Asia unweighted = 86.7%, weighted = 80.1%) and psychiatrists (Europe unweighted = 66.3%, weighted = 66.8%; Asia unweighted = 59.3%, weighted = 69.5%) both frequently made diagnoses. Further details of the differences among regions and countries can be seen in Table 2. No significant regional differences were found relating to nurses or other professionals, and *ICD-10* users were not significantly different from *DSM-IV* users.

Regarding psychologists' diagnostic roles, a modest majority (57.4%; 61.4% weighted) reported that they "make diagnoses independently," compared to 32.1% (31.7% weighted) who "contribute to diagnostic formulations made by other health professionals." Only 6.4% (3.5% weighted) had no role, and 4.1% (3.4% weighted) selected "other." Although the majorities in all regions reported independently making diagnoses, there were significant differences across regions, X^2 (5, N = 1,817) = 132.30, p < .0005, V = .156. As shown in Table 2, the practice of contributing to diagnostic formulations made by other professionals was found to be more common among respondents from European (36.9%; 41.1% weighted) and Eastern

Mediterranean (37.5%, 31.5% weighted) nations than among those from the USA (3.0%), Africa,

(18.9%; 19.8% weighted) Latin America (17.8%; 20.0% weighted), and Asia (22.1%; 33.9%

weighted). No significant differences were found relating to DCS.

Table 2: Respondents' Diagnostic Practices by Region and Country

		Who makes diagnoses in the setting where you work? (%)				Respondents' diagnostic role (%)			% Always / often use DCS	DCS used most often (%)	
	Item N	Psychol-ogists	Psychia-trists	Other physicians	Nurses	Diagnose independently	Contribute to diagnostic formulations	No active role		ICD-10	DSM-IV
AFRICA											
Namibia	6	83.3	66.7	16.7	0.0	83.3	16.7	0.0	16.7	0.0	83.3
South Africa	80	93.8	28.8	11.3	5.0	81.3	12.5	3.8	72.5	45.6	49.4
Uganda	18	40.0	50.0	15.0	5.0	50.0	50.0	0.0	72.2	7.7	69.2
Zimbabwe	2	100.0	0.0	0.0	0.0	100.0	0.0	0.0	100.0	100.0	100.0
Unweighted total	**106**	**84.9**	**34.9**	**12.3**	**4.7**	**76.4**	**18.9**	**2.8**	**69.8**	**37.0**	**55.0**
Weighted M	**26.5**	**79.3**	**36.4**	**10.7**	**2.5**	**78.6**	**19.8**	**0.9**	**65.3**	**38.3**	**75.5**
ASIA											
Hong Kong	64	87.5	45.3	20.3	1.6	79.7	17.2	3.1	79.7	3.1	96.9
India	41	90.2	75.6	14.6	0.0	73.2	22.0	0.0	78.0	75.0	12.5
Sri Lanka	8	62.5	87.5	50.0	0.0	25.0	62.5	0.0	12.5	37.5	62.5
Unweighted total	**113**	**86.7**	**59.3**	**20.4**	**0.9**	**73.5**	**22.1**	**1.8**	**74.3**	**31.3**	**64.3**
Weighted M	**37.7**	**80.1**	**69.5**	**28.3**	**0.5**	**59.3**	**33.9**	**1.0**	**56.7**	**38.5**	**57.3**
EASTERN MEDITERRANEAN											
Israel	25	96.0	40.0	8.0	0.0	76.0	20.0	4.0	24.0	9.2	85.0
Lebanon	9	88.9	55.6	0.0	0.0	66.7	33.3	0.0	77.8	11.1	77.8
Turkey	126	64.3	67.5	9.5	0.8	46.8	41.3	9.5	54.0	7.4	87.6
Unweighted total	**160**	**70.6**	**62.5**	**8.8**	**0.6**	**52.5**	**37.5**	**8.1**	**50.6**	**9.2**	**85.0**
Weighted M	**53.3**	**83.1**	**54.3**	**5.8**	**0.3**	**63.2**	**31.5**	**4.5**	**51.9**	**12.0**	**79.8**
EUROPE											
Denmark	207	57.5	73.4	7.2	5.3	37.2	51.2	4.3	71.0	94.0	3.5
Estonia	9	55.6	88.9	33.3	0.0	0.0	100.0	0.0	55.6	100.0	0.0
Finland	172	11.0	79.7	28.5	1.7	3.5	72.1	18.0	19.8	76.3	21.1
France	285	68.1	67.0	36.8	3.9	34.0	44.2	15.1	22.8	19.2	69.5
Germany	147	98.6	21.8	12.2	0.7	93.9	4.8	0.7	93.2	93.2	5.4
Ireland	33	84.8	48.5	6.1	3.0	48.5	42.4	6.1	69.7	6.1	90.9
Norway	220	99.1	75.9	19.1	6.4	87.7	8.6	1.4	86.4	98.2	1.4
Sweden	89	87.6	69.7	31.5	13.5	56.2	31.5	6.7	71.9	34.1	61.4
Switzerland	32	100.0	59.4	9.4	0.0	96.9	3.1	0.0	78.1	71.0	19.4
UK	43	69.8	83.7	16.3	11.6	41.9	53.5	0.0	34.9	36.6	61.0
Unweighted total	**1237**	**70.2**	**66.3**	**22.0**	**4.7**	**50.6**	**36.9**	**7.7**	**57.0**	**68.4**	**27.6**
Weighted M	**123.7**	**73.2**	**66.8**	**20.0**	**4.6**	**50.0**	**41.1**	**5.2**	**60.3**	**62.9**	**33.3**
LATIN AMERICA											
Argentina	21	90.5	52.4	19.0	0.0	57.1	23.8	4.8	61.9	0.0	85.7
Mexico	80	93.8	35.0	27.5	1.3	76.3	16.3	2.5	51.3	10.8	81.1
Unweighted total	**101**	**93.1**	**38.6**	**25.7**	**1.0**	**72.3**	**17.8**	**3.0**	**53.5**	**8.4**	**82.1**
Weighted M	**50.5**	**92.1**	**43.7**	**23.3**	**0.6**	**66.7**	**20.0**	**3.6**	**56.6**	**5.4**	**83.4**
USA											
USA	100	99.0	34.0	15.0	3.0	96.0	3.0	0.0	86.0	1.0	93.9
OVERALL											
Unweighted total	**1817**	**75.0**	**60.4**	**20.0**	**3.8**	**57.4**	**32.1**	**6.4**	**59.7**	**51.4**	**43.8**
Weighted M	**116**	**79.9**	**56.0**	**17.7**	**2.4**	**62.2**	**30.6**	**3.6**	**60.2**	**37.7**	**59.6**

Note. Table does not display percentages of respondents who selected "other" in response to "Who makes diagnoses…?", or who selected "ICD-9" or "other" as the DCS used most often. Item *N* refers to the number of participants who responded to the majority of these items.

Usage of diagnostic classification systems. Respondents were asked, "As part of your day-to-day clinical work, how much of the time do you use a formal DCS, such as the *ICD-10*, the *DSM-IV*, the *ICD-9* or *ICD-9-CM*, or a national classification?" Responses from the overall sample followed a clear trend, such that the majority reported using a DCS with high frequency: 35.7% (34.7% weighted) reported using a DCS "always or almost always, 24.0% (25.7% weighted) used one "often," 18.1% (22.2% weighted) "sometimes," 16.1% (14.4% weighted) "rarely," and 6.1% (3.0 % weighted) "never". Distinct variations were found among respondents from different regions, X^2 (20, N = 1,817) = 114.96, p < .0005, V = .126, and between *ICD-10* and *DSM-IV* users, X^2 (3, N = 1,611) = 53.58, p < .0005, V = .182. Whereas a large majority of the respondents from the USA (86.0%) reported "always" or "often" using a DCS, this majority was much smaller among those from the Eastern Mediterranean (50.6%; 51.9% weighted), Latin America (53.5%; 56.5% weighted), and Europe (57.0%; 60.3% weighted). Further, among respondents who used any DCS, those who used the *ICD-10* tended to use it more frequently (71.8% always/often) than those who used the *DSM-IV* (56.5% always/often).

With regard to particular DCSs, 51.4% (36.8% weighted) of all respondents indicated that they most often use the *ICD-10*, followed by the *DSM-IV* (43.8%; 56.8% weighted), "other" (4.1%; 5.7% weighted), and *ICD-9* (0.7%). There was a great deal of regional variability related to participants' usage of the *ICD-10* or *DSM-IV*, X^2 (5, N = 1,611) = 445.49, p < .0005, V = .526. Majorities of respondents in European nations (68.4%; 62.9% weighted) indicated that they use the *ICD-10* most often. By contrast, in the USA (93.9%) and Latin America (82.1%; 83.4% weighted), large majorities indicated that they use the *DSM-IV*, and smaller majorities followed this trend leaning toward the *DSM-IV* in all other regions. Because this investigation was conducted as part of the *ICD* revision process, respondents' level of familiarity with the *ICD-10* was of interest. Among clinicians who use a DCS other than the *ICD-10,* 36.2% (44.3%

weighted) were at least Somewhat familiar with the *ICD-10*. No significant regional differences were found on this item.

General Features of Diagnostic Classification Systems

> **Most important purpose.** Participants were asked, "From your perspective, which is the single most important purpose of a diagnostic classification system?" As presented in Figure 1, the three most popular responses were clinical purposes—(a) treatment and management, (b) inter-clinician communication, and (c) communication with patients—which together comprised a large majority of the sample's response (87.6%; 89.1% weighted). Significant differences were found across regions, X^2 (25, $N = 1,883) = 106.87$, $p < .0005$, $V = .107$, the most notable difference being that respondents from Latin America most often selected inter-clinician communication (48.3%; 48.2% weighted) as the most important purpose, while only 16.8% (14.9% weighted) of the sample selected treatment and management decisions. No significant differences were between *ICD-10* and *DSM-IV* users.
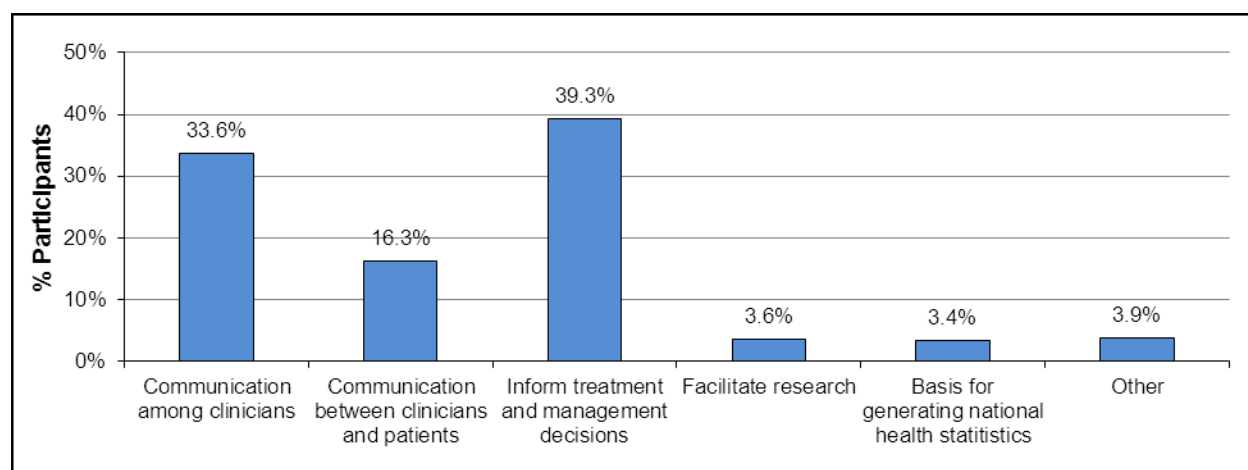

Figure 1. Respondents' views on "what is the single, most important purpose of diagnostic classification system." Percentages are equally weighted by country. Unweighted percentages were relatively similar (from left to right: 38.7%, 15.5%, 33.4%, 3.3%, 4.6%, and 4.5%).

Optimal number of diagnostic categories. Respondents were asked, "In clinical settings, how many diagnostic categories should a classification system contain to be most useful for mental health professionals?" The vast majority (85.1%; 86.9% weighted) indicated that a DCS would be most useful if it contained between 10 and 100 categories. Specifically, 34.8% (38.3% weighted) selected 10-31 categories, and 50.3% (48.6% weighted) selected 31-100 categories as the optimal number. Only 10.6% (9.0% weighted) selected 101-200, and 4.4% (4.1% weighted) selected more than 200 as the preferred number of categories. No significant variations were found across regions or DCS.

Strict criteria vs. flexible guidance. In a DCS, diagnostic categories can be defined according to strict, specified diagnostic criteria or more flexible diagnostic guidelines. When asked which format would allow for "maximum utility in clinical settings," the large majority, 78.3% (74.8% weighted), preferred "diagnostic guidance that is flexible enough to allow for cultural variation and clinical judgment" over "clear and strict (specified) diagnostic criteria for all disorders" (21.7%; 25.2% weighted). Moreover, this result was not significantly different across regions or users of different DCSs (see Figure 2).
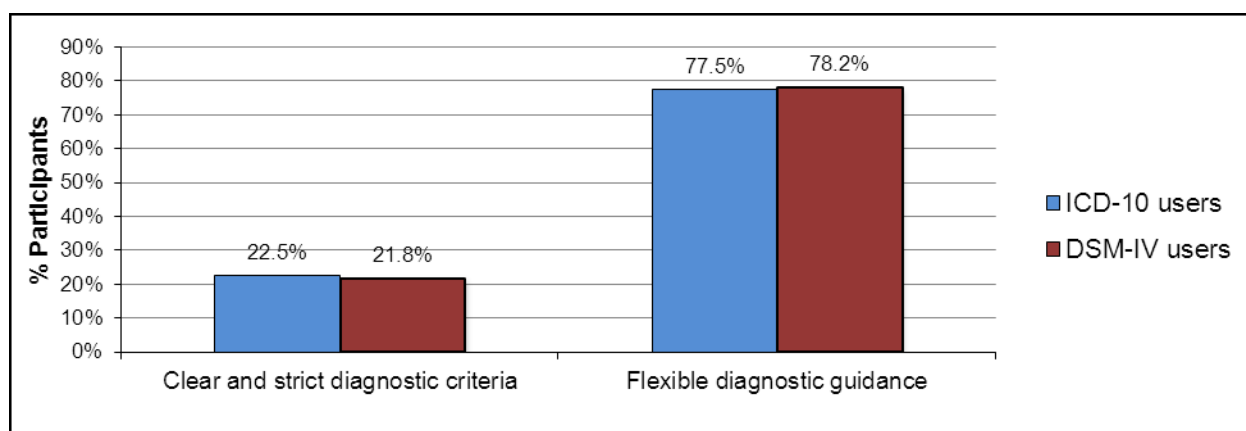

Figure 2. For maximum clinical utility, clinicians preferred "diagnostic guidance that is flexible enough to allow for cultural variation and clinical judgment" over "clear and strict (specified) diagnostic criteria for all disorders."

Severity. When respondents were asked what would be the best way to incorporate the concept of severity in the diagnostic system, there was very little consensus beyond the general agreement that it should be included somehow (88.1%; 89.8% weighted). That is, as Figure 3 illustrates, these respondents were nearly evenly split into three different opinions as to how best to incorporate considerations of severity: (a) subtypes based on severity and/or symptom count (29.7%; 32.4% weighted); (b) subtypes based on degree of functional impairment (29.5%; 31.9% weighted); or (c) on a separate, "cross-cutting" axis used for all diagnoses (28.9; 25.5% weighted; see Figure 3). Although there were some statistically significant differences by region, X^2 (15, $N = 1,808$) = 58.10, $p < .0005$, $V = .104$, no clear trends emerged. Rather, all regional groups selected the same three responses most frequently, and in no case did a majority (i.e., > 50%) select any one response. No significant differences were found for DCS.

Functional impairment. Similar to the above item on severity, respondents were asked whether and how considerations of functional status should be conceptualized in a DCS. As shown in Figure 3, 76.9% (81.6% weighted) of participants provided responses indicating that it should be included somehow—most commonly (48.2 %; 46.8% weighted), that "functional status should be a diagnostic criterion for some disorders" when necessary. Following this response, 28.7% (34.9% weighted) responded, "functional impairment should be a diagnostic criterion for most disorders," and the rest (23.1%; 18.4% weighted) indicated that "functional status should not be included in diagnostic criteria." No significant regional or DCS-related differences were found.
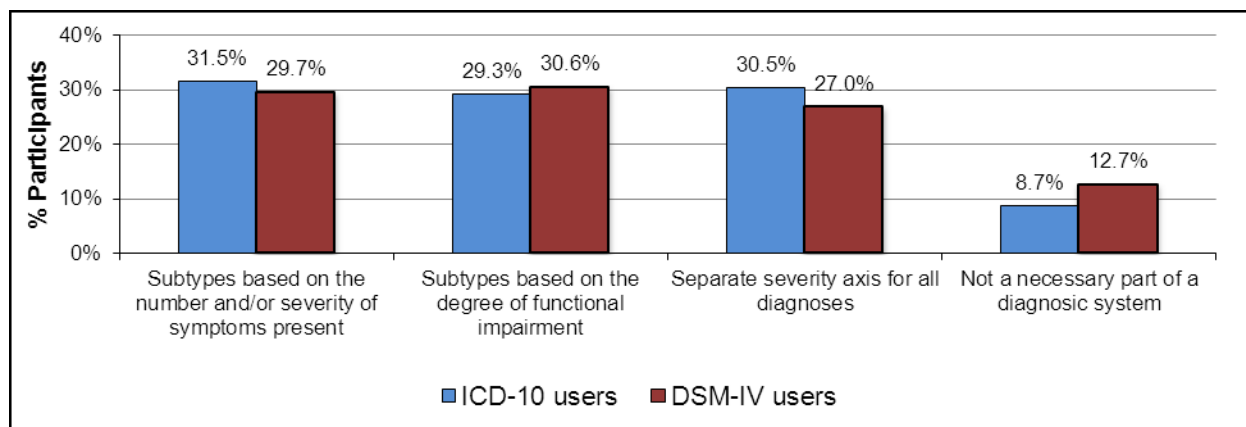
Figure 3. Clinicians' views on "the best way for a diagnostic system to address the concept of severity."
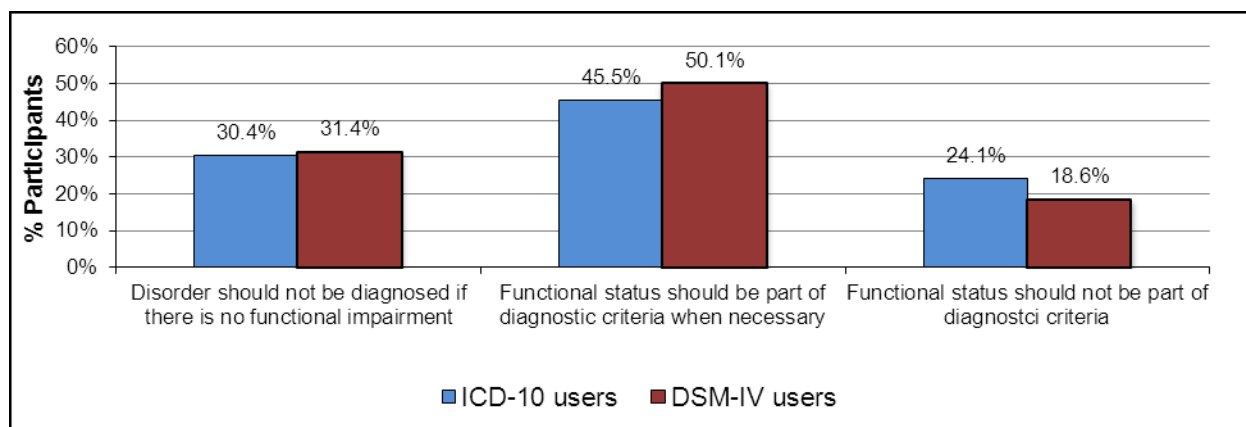

Figure 4. Clinicians' opinions on "the best way for a diagnostic system to conceptualize the relationship between diagnosis and functional status."
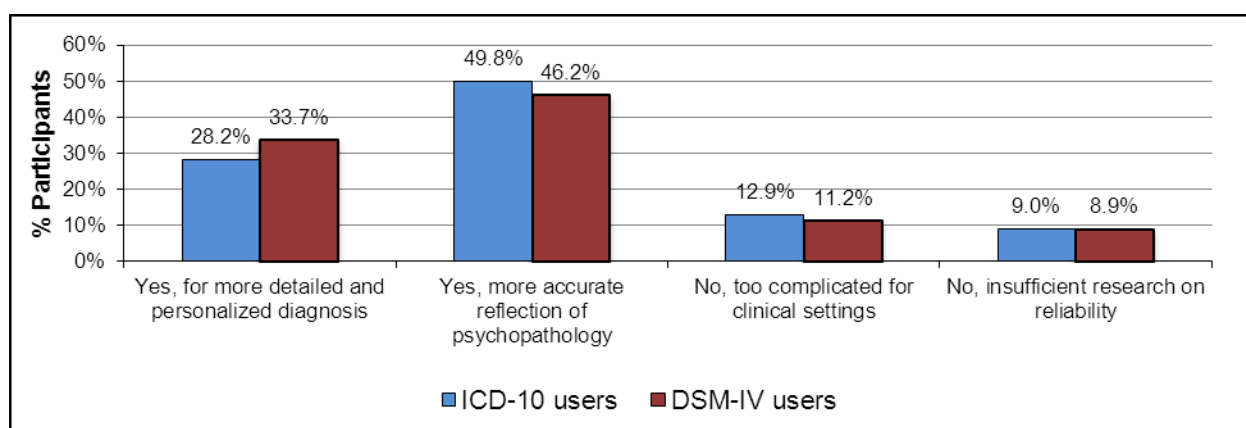

Figure 5. Clinicians' views on whether to incorporate a dimensional component into a diagnostic classification system and why.

Dimensional component. As Figure 5 illustrates, when asked whether a DCS should include a dimensional component, the majority of participants (78.9%; 83.2% weighted) responded in favor of dimensional classification: 47.7% (49.1% weighted) because it would provide a more accurate representation of psychopathology, and 31.2% (34.1% weighted) because it would offer more detailed and personalized assessment. Among those who did not desire a dimensional classification, their rationale was nearly evenly split between it being too complicated for clinical settings (11.9%; 9.6%) and insufficient research evidence to support its reliability (9.1%; 7.2% weighted). Significant differences were found among regions, X^2 (115, N = 1,716) = 55.79, $p < .0005$, $V = .104$, but the differences were not related to whether or not respondents endorsed dimensional classification, but rather to the justification they selected to support their answer. No significant differences were found relating to DCS.

Depression and proportionality to adverse life events. Of particular relevance for the *ICD* revision process is the question of whether a diagnosis of depression should be "assigned if the symptoms are a proportionate response to adverse life events." Among the overall sample, and consistently across different regions and DCSs, respondents were almost perfectly divided on this questions: 51.2% (52.0% weighted) selected "Yes, if the full depressive syndrome is present, the diagnosis of depression should be made regardless of whether there are life events that can potentially explain it;" 48.8% (48.0% weighted) disagreed, responding "No, a proportionate response to an adverse life event should not be considered a mental disorder."

Cultural Concerns

Cross-cultural applicability. Respondents who reported that they were currently seeing patients and that they used a diagnostic system at least "rarely" were asked: "Please rate the extent to which you agree with the following statement based on your day to day clinical experience: 'The diagnostic system I use is difficult to apply across cultures, or when the

patient/service user is of a different cultural or ethnic background from my own.'" Among all participants, 5.4% (6.1% weighted) completely agreed, 25.4% (29.1% weighted) mostly agreed, 51.9% (50.2% weighted) agreed somewhat, and 17.3% (15.9% weighted) did not agree with the above statement. As Figure 6 demonstrates, there were significant differences among regions, X^2 (15, $N = 1,513$) = 43.68, $p < .0005$, $V = .098$, such that respondents from the Eastern Mediterranean (35.0%; 38.5% weighted), Latin America (33.7%; 32.1% weighted), Europe (32.4%; 30.8% weighted), and Africa (29.0%l 43.2% weighted) more often indicated that they mostly or completely agreed that their DCS was cross-culturally problematic, compared to those from the USA (18.4%) and Asia (20.0%; 33.4% weighted). No significant differences were found for DCS.

U.S. and European Bias. Respondents were also asked to indicate their level of "agreement with the following statement based on your day to day clinical experience: 'The diagnostic system I use is problematic because it is over-embedded in U.S. and European culturally-derived concepts and values.'" Results followed a similar trend as for the previous item: 6.2% (7.2% weighted) selected "completely agree," 23.5% (29.1% weighted) "mostly agree," 48.7% (42.3% weighted) "Agree somewhat," and 21.6% (21.4% weighted "Do not agree". Figure 6 also illustrates significant regional differences for this item, X^2 (15 $N = 1,512$) = 45.91, $p < .0005$, $V = .101$. Specifically, respondents from Africa, the Eastern Mediterranean, and Latin America (38.0 – 44.6%; 46.0 – 47.7% weighted) more often "mostly" or "completely" agreed that U.S./European bias was a problem, compared to relatively fewer in Asia, the USA, and Europe (21.8 – 27.8% unweighted; 21.8 – 37.4% weighted). No significant differences were found relating to DCS.
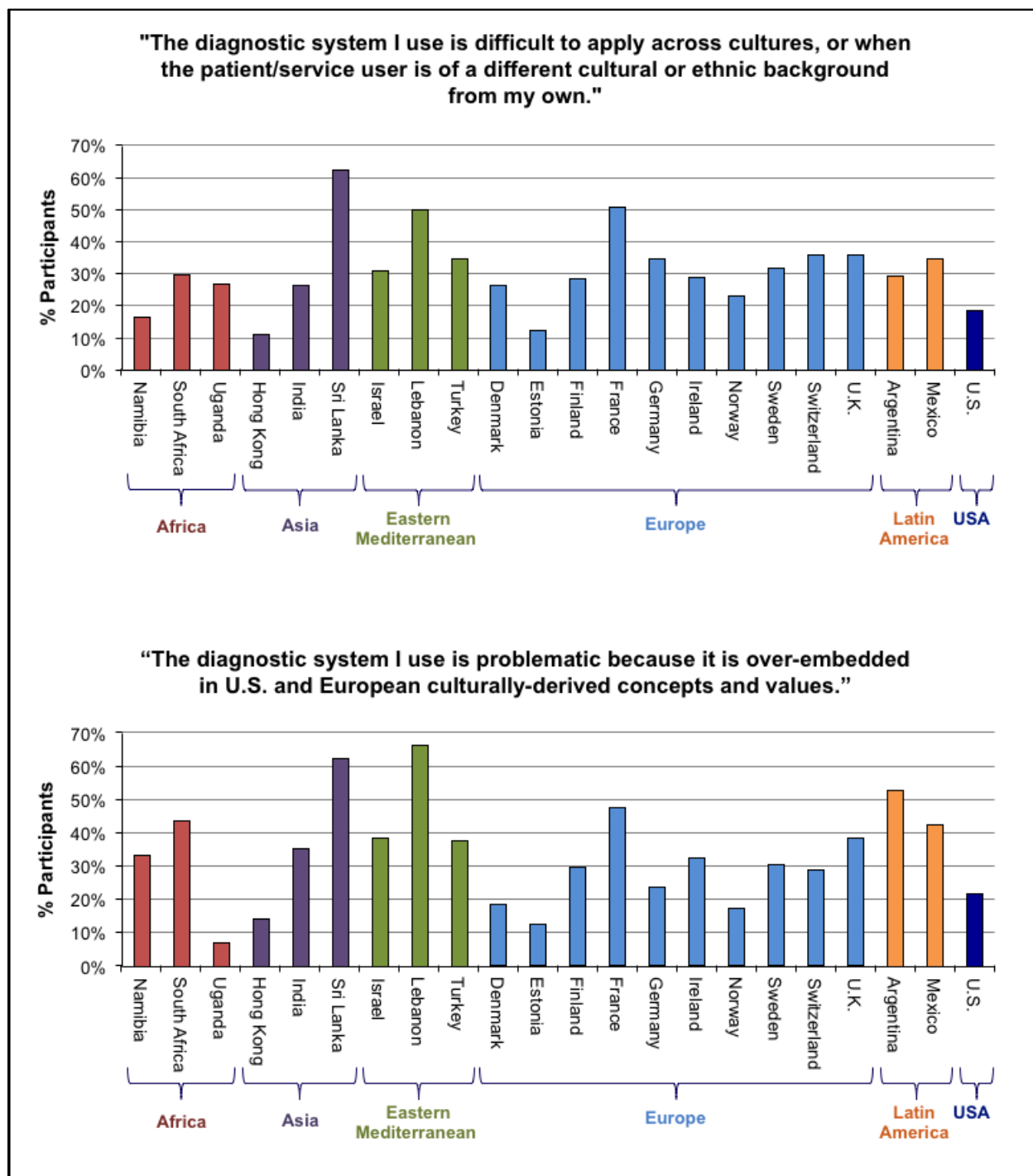
Figure 6. Percentages of respondents in each national subsample who indicated that they "mostly agree" or "completely agree" with the above statements about diagnostic classification systems' cross-cultural problems and U.S./European bias. Data from the Zimbabwean sample are not presented due to very low response on these items (*N* < 3).

Stigmatizing terminology. When asked whether "any of the terms used in current diagnostic systems are stigmatizing in your language or cultural context," over one-third of the entire sample (36.5%; 37.1% weighted) responded "yes". As presented in Figure 7, this finding varied significantly across regional groups, X^2 (5, $N = 1,551) = 38.92$, $p < .0005$, $V = .158$. Interestingly, the highest percentages of agreement came from respondents in Europe (41.7%; 38.7% weighted) followed by the USA (32.2%) and Eastern Mediterranean (28.9%; 43.9% weighted); whereas the rest of the samples indicated rates of agreement between 22.9% and 25.0% (24.9 – 38.7% weighted). No significant differences were found by DCS.

Need for a national classification system. Overall, 18.3% (28.0% weighted) responded "yes" to the question, "Do you see a need in your country for a national classification of mental disorders (i.e., a country-specific classification that is not just a translation of *ICD-10*)?" As Figure 7 illustrates, there was a great deal of variability among subsamples on this item; significant differences were found for region, X^2 (5, $N = 1,575) = 229.05$, $p < .0005$, $V = .381$, and DCS, X^2 (1, $N = 1,321) = 71.68$, $p < .0005$, $V = .233$. A slight majority of respondents from Latin America (51.3%; 53.0% weighted) indicated that there was a need for a national DCS, as did many respondents from Africa (42.9%; 63.4% weighted), the Eastern Mediterranean (42.7%; 35.2% weighted), and, to a lesser extent, Asia (24.8%; 30.5% weighted). By contrast, European (9.7%; 7.6% weighted) and American (10.5%) respondents less often indicated such a need. Furthermore, out of all the respondents who reported that they used the *DSM-IV* most frequently, 26.5% indicated a need for a national classification in their country, compared to only 9.0% of *ICD-10* users who selected this response.
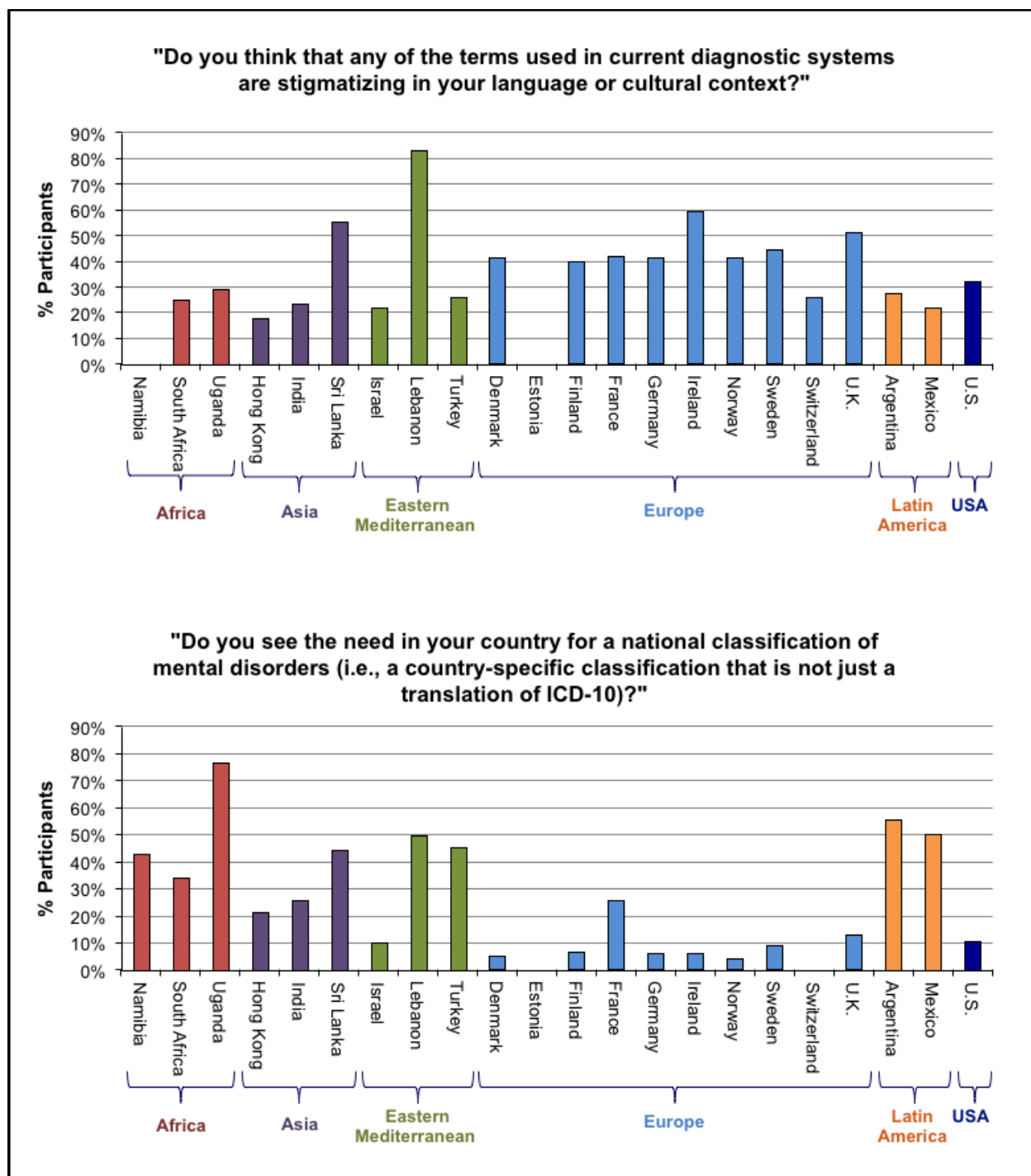
"Do you think that any of the terms used in current diagnostic systems are stigmatizing in your language or cultural context?"

"Do you see the need in your country for a national classification of mental disorders (i.e., a country-specific classification that is not just a translation of ICD-10)?"

Figure 7. Percentages of respondents in each national subsample who responded "yes" to the above statements about stigma and the need for a national classification system. Data from the Zimbabwean sample are not presented due to very low response on these items (*N* < 3).

Meeting the needs of different users and stakeholders. Because DCSs are used by a variety of professionals and nonprofessionals for diverse purposes, one concern for the current *ICD* revision process is how best to accommodate those users. Accordingly, respondents were asked whether primary care providers should have a modified/simpler version or the same DCS as mental health professionals. Overall, a slight majority (53.9%; 58.4% weighted) favored a modified version for primary care. Although *ICD-10* and *DSM-IV* users were not significantly different on this item, there were significant variations across regions, X^2 (5, $N = 1,810) = 32.44$, $p < .0005$, $V = .134$, as seen in Figure 7. Greater proportions of respondents from the Eastern Mediterranean (72.4%; 65.2% weighted), Asia (64.4%; 75.6% weighted), and Africa (54.1%; 70.6% weighted) favored a simpler primary care version than did those from the USA (45.5%), Europe (51.2%; 49.3% weighted), and Latin America (53.3%; 49.7% weighted).

Overall, 84.8% (87.8% weighted) of respondents indicated that they "completely" or "mostly" agree with the following statement: "A diagnostic classification system should serve as a useful reference not only for psychiatrists but for all mental health professionals (e.g., psychologists, social workers, psychiatric nurses)." Out of the remainder, 11.0% (9.0% weighted) selected "agree somewhat" and 4.2% (3.2% weighted) "do not agree." "In response to a similar item, 70.6% (74.7% weighted) of the entire sample indicated that they "completely" or "mostly" agreed that "A diagnostic classification system should be understandable to service users, patient advocates, administrators, and other relevant people as well as to health professionals." Fewer respondents selected "agree somewhat" (23.0%; 19.7% weighted) and "do not agree." After "completely" and "mostly" agree responses were collapsed on these two items, no significant differences were found for region or DCS.

Usage and Evaluation of *ICD-10* and *DSM-IV* Diagnostic Categories

Usage of diagnostic categories. Respondents who reported that they regularly see

patients and use either the *ICD-10* (*N* = 797) or the *DSM-IV* (*N* = 629) were asked a series of

questions about specific diagnostic categories. First, they were asked to select from either a list

of 44 *ICD-10* diagnostic categories or a list of 45 *DSM-IV* diagnostic categories (depending on

which DCS they used) which ones "you use once a week or more in your day-to-day clinical

practice (that is, you see a patient or client with that diagnosis at least once a week), whether or

not you personally assign the diagnosis." Second, participants were asked to evaluate those

particular categories they selected. Because the conditional administration of these three items

(frequency of use, ease of use, and goodness of fit) was not reliably implemented in the paper-

and-pencil version of this survey, responses from participants in the Ugandan sample who

attempted to complete these items (*N* = 2) were excluded from these analyses.
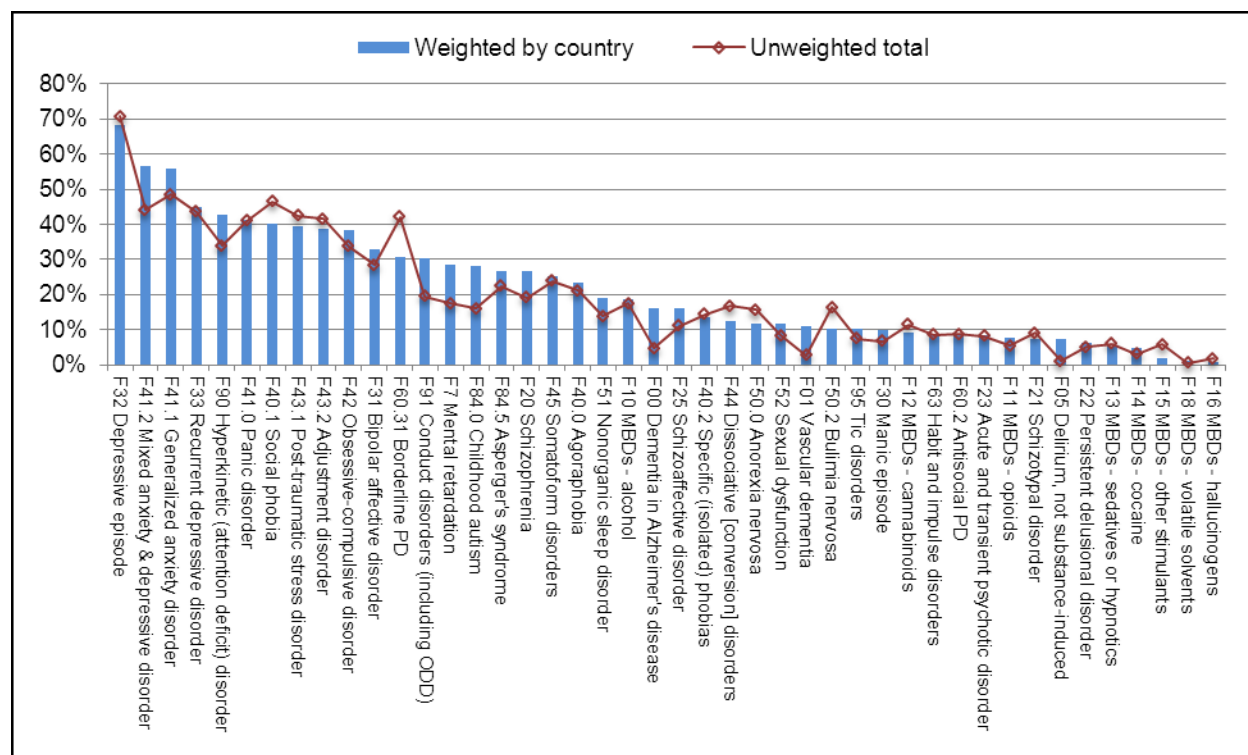

Figure 8. Percentages of clinicians who reported seeing persons with select *ICD-10* diagnostic categories at least once a week.
Bars represent mean percentages across all national subsamples, with each country weighted equally. Lines represent the
unweighted total percentages of the entire sample. MBDs = mental and behavioural disorders.
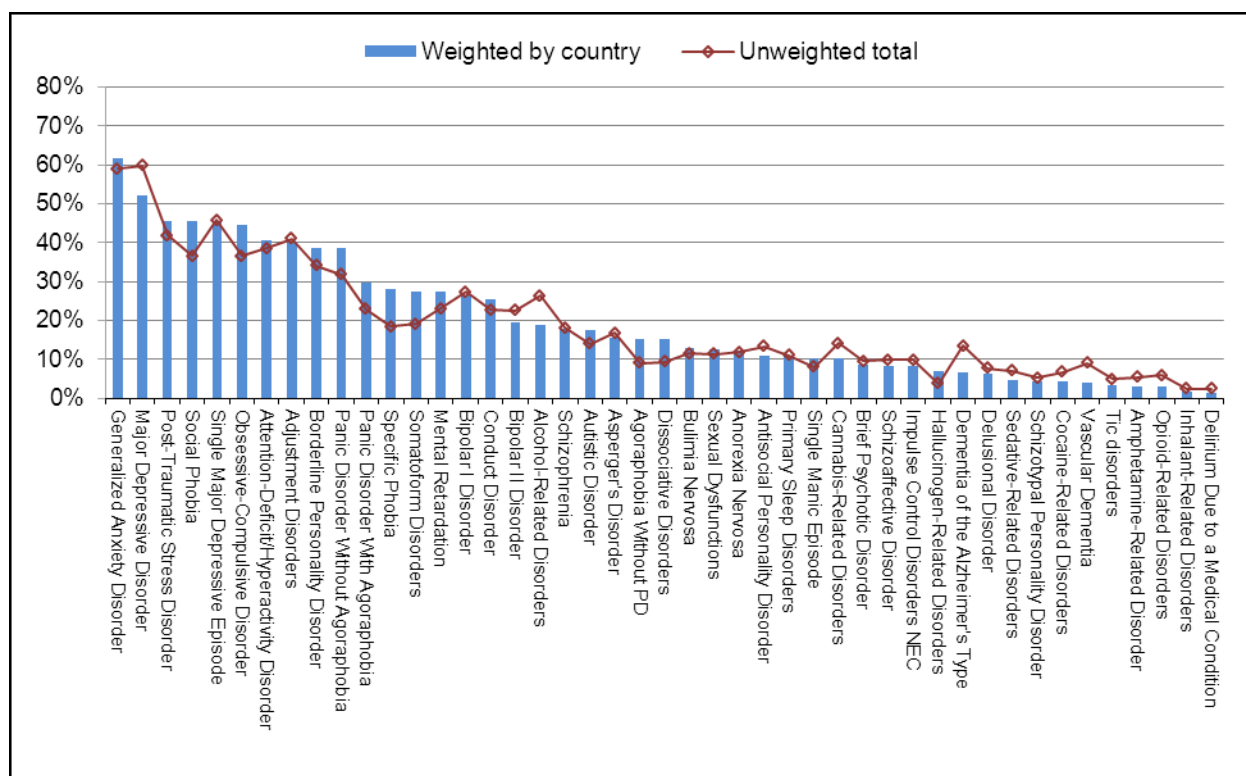
Figure 9. Percentages of clinicians who reported seeing persons with select *DSM-IV* diagnostic categories at least once a week. Bars represent mean percentages across all national subsamples, with each country weighted equally. Lines represent the unweighted total percentages of the entire sample.

Figures 8 and 9 present the percentages of clinicians who reported that they regularly use

particular diagnostic categories from the *ICD-10* and *DSM-IV*, respectively. Patterns of

frequency were generally similar between *ICD-10* and *DSM-IV* users and categories. Mood and

anxiety disorders were by far the most commonly seen categories, and stress-related and

childhood disorders were also seen fairly regularly. Less frequently seen were substance-related

disorders, psychotic disorders, and eating disorders. Interestingly, individual clinicians saw an

average of only 8.85 categories (*SD* = 5.69; weighted *M* = 9.77) on a regular basis, with no

significant difference between *ICD-10* users and *DSM-IV* users. However, as Figure 10

illustrates, the number of categories seen regularly varies by country and region. Regional usage

ranged from a mean of 6.91 (*SD* = 4.17; weighted *M* = 6.59) diagnostic categories in Latin

America to 10.58 (*SD* = 5.63; weighted *M* = 10.58) in the USA. But the variability was most

notable at the country level, ranging from means of 6.07 (*SD* = 4.92) categories in Argentina and

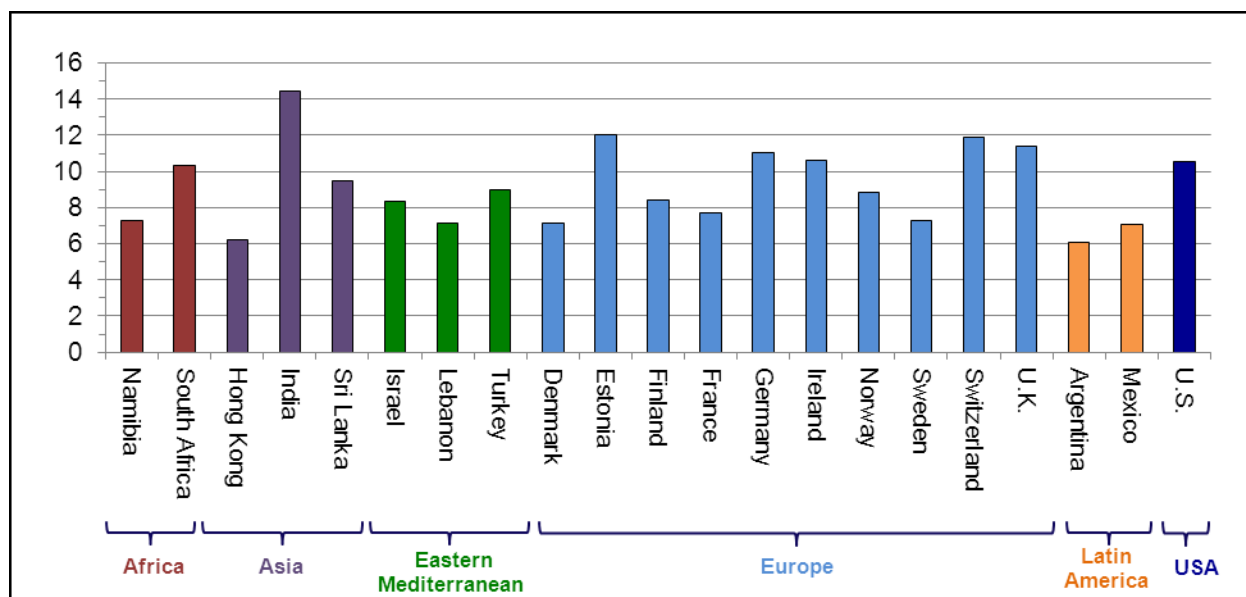6.19 (*SD* = 4.12) in Hong Kong to 14.41 (*SD* = 6.57) in India.

Figure 10. Average number of diagnostic categories (*ICD-10* or *DSM-IV*) that clinicians see at least once a week, by country. Ugandan and Zimbabwean samples are not presented due to very small sample sizes on this item (*N* < 3).

Ease of use and goodness of fit of diagnostic categories. Next, participants were

presented with the following item:

> Please evaluate the ICD-10 [or DSM-IV] diagnostic categories you previously selected
>
> by making a rating of each category on two dimensions: 1) ease of use of the ICD-10
>
> [DSM-IV] diagnostic criteria for that category or group of disorders; and 2) goodness of
>
> fit or accuracy of the ICD-10 [DSM-IV] definition, description, and diagnostic criteria in
>
> describing the patients or clients you see in clinical practice.

Note that respondents were asked to rate only those categories that they had already reported

they encountered regularly in clinical practice. This method was selected in order to ensure that

clinicians' evaluations were informed by clinical experience with patients with those particular

diagnoses. Ease of use and goodness of fit ratings were originally made on the following 4-point

likert scale: 0 = Not at all (easy to use or accurate); 1 = Somewhat; 2 = Quite; and 3 = Extremely.

In order to facilitate comparisons between the results on these two items and across all categories, the original 0-3 likert scale variables were transformed into continuous variables on a scale of 0-1. Thus, the above descriptions of ratings 0, 1, 2, and 3 on the original scale can be interpreted at 0.00, 0.33, 0.67, and 1.00, respectively, on the transformed scale.

Ratings of ease of use and goodness of fit are presented in Figure 11 for *ICD-10* categories and in Figure 12 for *DSM-IV* categories. The overall mean ratings were relatively favorable for diagnostic categories in both the *ICD-10* (M = .641, SD = .076 for ease of use; M = .600, SD = .072 for goodness of fit) and the *DSM-IV* (M = .657, SD = .076; M = .597, SD = .075), with no significant differences between the two DCSs. Interestingly, mean ease of use ratings were nearly always greater than goodness of fit ratings, and participants' individual ease of use and goodness of fit ratings were highly, though not perfectly, correlated (for *ICD-10* categories, M Pearson's r = .662, SD = .105; for *DSM-IV* categories, M Pearson's r = .680, SD = .101). Table 3 lists *ICD-10* and *DSM-IV* categories with particularly low mean ratings for ease of use and goodness of fit, defined as falling at least one half standard deviation below the mean.

Table 3: ICD-10 and *DSM-IV* Diagnostic Categories with Low Ease of Use and/or Goodness of Fit.

ICD-10 Categories	EOU	GOF	DSM-IV Categories	EOU	GOF
Adjustment disorder	.603	**.550**	Asperger's Disorder	**.557**	**.477**
Antisocial personality disorder	.609	**.547**	Autistic Disorder	**.608**	**.541**
Asperger's syndrome	**.495**	**.451**	Bipolar II Disorder	**.577**	**.534**
Bipolar affective disorder	**.596**	.570	Borderline Personality Disorder	.629	**.535**
Borderline personality disorder	**.556**	**.514**	Brief Psychotic Disorder	**.602**	**.550**
Delirium, not substance-induced	**.583**	.583	Delusional Disorder	**.615**	.615
Dissociative [conversion] disorders	**.497**	**.447**	Dissociative Disorders	**.483**	**.454**
Habit and impulse disorders	**.591**	**.554**	Impulse Control Disorders	**.500**	**.483**
Hyperkinetic (attention deficit) disorder	**.556**	**.500**	Primary Sleep Disorders	**.576**	**.510**
MBDs due to the use of hallucinogens	**.595**	**.524**	Schizoaffective Disorder	**.544**	**.489**
MBDs due to the use of volatile solvents	**.583**	.583	Schizotypal Personality Disorder	**.538**	**.441**
Mixed anxiety and depressive disorder	**.599**	**.560**	Sexual Dysfunctions	**.603**	**.559**
Schizoaffective disorder	**.508**	**.508**	Somatoform Disorders	**.564**	**.474**
Schizotypal disorder	**.510**	**.525**	Tic disorders	**.593**	**.531**
Somatoform disorders	**.523**	**.510**	Vascular Dementia	**.603**	.564
Vascular dementia	.650	**.533**			

Note. EOU = ease of use; GOF = goodness of fit; MBDs = mental and behavioural disorders. Categories are considered to have a low ease of use or goodness of fit if the mean rating fell at least one-half standard deviation below the mean for all categories. Boldface type denotes these low ratings. All mean ratings are unweighted.
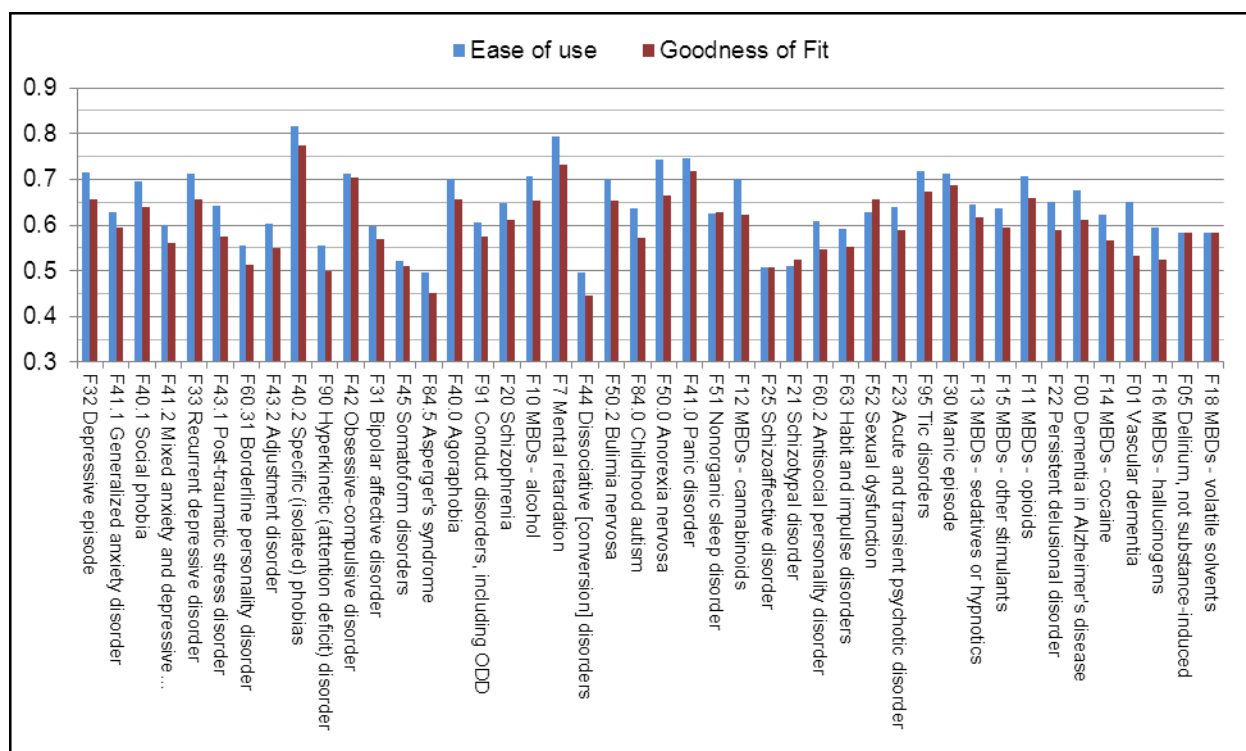
Figure 11. Clinicians' unweighted mean ratings for the ease of use and goodness of fit of the *ICD-10* diagnostic categories they see regularly. Categories are in order from most to least frequently seen, such that those toward the left of the graph were seen more often and therefore received more ratings than those near the right. This warrants cautious interpretation, particularly toward the data points toward the right side of the graph. MBDs = mental and behavioural disorders.
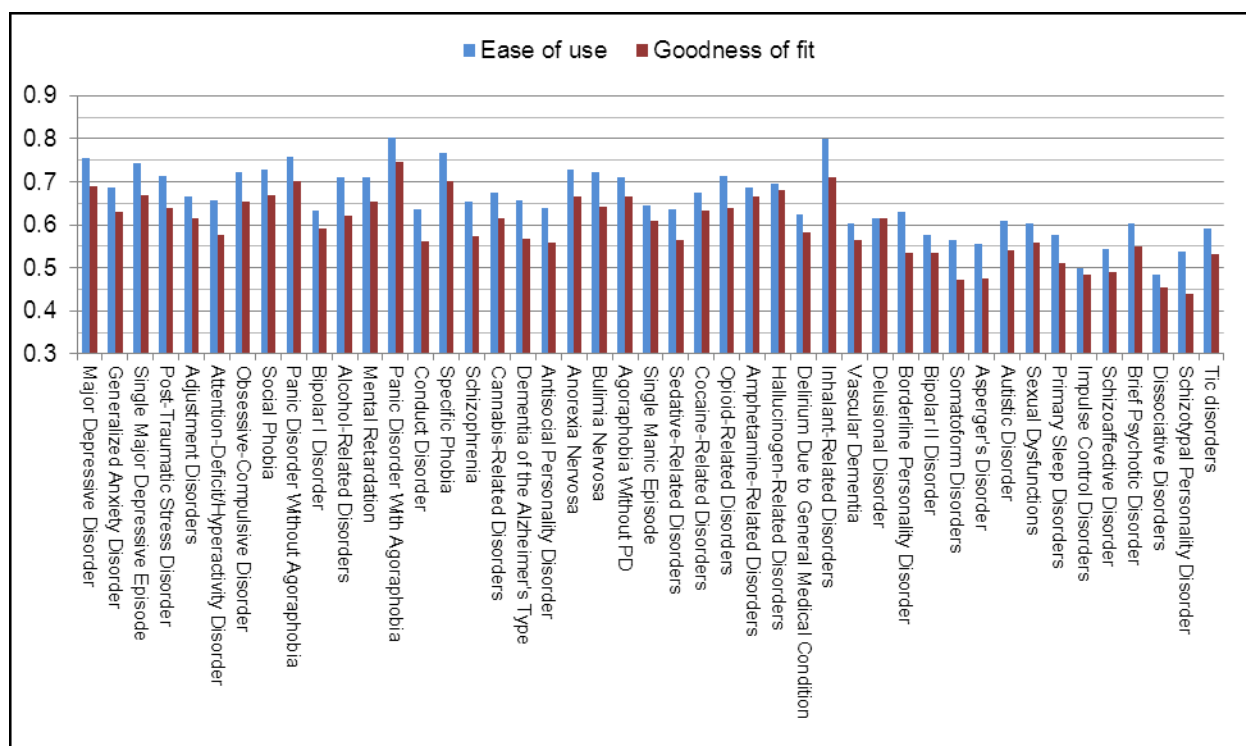

Figure 12. Clinicians' unweighted mean ratings for the ease of use and goodness of fit of the *DSM-IV* diagnostic categories they see regularly. Categories are in order from most to least frequently seen, such that those toward the left of the graph were seen more often and therefore received more ratings than those near the right. This warrants cautious interpretation, particularly toward the data points toward the right side of the graph.

Problematic diagnostic categories. Approximately half (49.4%; 53.1% weighted) of all respondents indicated that there are "diagnostic categories with which you are especially dissatisfied, or that you believe are especially problematic in terms of their goodness of fit in clinical settings." There was significant variability across regions, X^2 (4, N = 1,594) = 25.07, $p <$ .0005, V = .125, such that rates of dissatisfaction were 33.3% (37.9 weighted) in Latin America, 40.6% (55.6% weighted) in Africa, 42.9% (63.7% weighted) in Eastern Mediterranean, 46.3% (48.5% weighted) in Asia, 52.1% (51.5% weighted) in Africa, and 60.2% (60.2% weighted) in the USA. No significant differences were found for DCS.

Adding, moving, and removing diagnostic categories. Lastly, in two items, participants were asked whether there any specific diagnostic categories that you feel should be: (a) "removed or moved to another section?" or (b) "added to the classification system for mental disorders?" The majority of respondents in both cases responded "No." Interestingly, a greater percentage felt that disorders should be added (32.7%; 35.8% weighted) than moved/removed (22.3%; 22.9% weighted). *ICD-10* users more often reported that disorders should be added (38.6%) compared to *DSM-IV* users (28.0%), X^2 (1, N = 1,280) = 16.16, $p <$ .05, V = .112. No other significant differences were found for region or DCS.

Discussion

The primary aims of this study were to examine practicing psychologists' views on conceptual and practical issues concerning the clinical utility of DCSs, so as to inform the ongoing development of the *ICD-11*. In this effort, particular attention was paid to whether there were any significant differences among clinicians from different nations, global regions, or between *ICD-10* and *DSM-IV* users. Indeed, the size, diversity, and characteristics of the obtained samples were sufficient to allow for an examination of these questions. With over 93% of the sample currently seeing patients and an average of nearly 14 years of clinical experience,

participants collectively represented a great deal of clinical experience with patients with mental health conditions. Furthermore, despite differences in national sample sizes and regional representation, relatively large numbers of participants were obtained from each of the global regions examined, allowing for preliminary examinations of regional and DCS-related differences.

Among some of the more consistent findings were that clinicians generally emphasized the priority of clinical utility as the principal purpose of and primary consideration when revising a DCS. Respondents agreed that a DCS should somehow incorporate dimensional classification, severity, functional impairment, and flexible diagnostic guidelines, but responses also reflected the current disagreement regarding how to make these kinds of broad, cross-cutting revisions. Results generally suggested favorable views on particular diagnostic categories and cultural concerns, while also indicating specific areas for improvement. Concerning the secondary aim of this investigation, many (but not all) of these findings were associated with significant regional differences; fewer were associated with differences between *ICD-10* and *DSM-IV* users. These main findings and variations among subsamples are discussed below in greater detail.

Professional Practices of Psychologists around the Globe

Although not a primary objective, this study offered interesting findings regarding the professional practices of psychologists with respect to assessment, diagnosis, and usage of a DCS (see Table 2). Given that these results were so variable within regions, they may be more accurately understood at the country rather than regional level. Internationally, individual psychologists appear to play a large and, for the most part, independent role in providing assessments and diagnoses for persons with mental health problems. This, however, was not the case in some countries, particularly in several Western European nations (e.g., Finland, France, Denmark, United Kingdom), where psychologists more often reported that they contributed to

the diagnostic formulations made by other professionals. The findings for these countries may be reflective of their health systems, where mental health care providers are often integrated into the healthcare system and work in medical settings, as opposed to separate independent or group private mental health practices (European Observatory on Health Systems and Policies, 2012).

While the majority of psychologists appear to use a DCS with some regularity in their clinical practice, a significant number of participants do not use a DCS at all, or only do so occasionally. Results suggest that DCS usage is highest (> 75% often/always use a DCS) among psychologists in the United States, Germany, Norway, Hong Kong, Switzerland, India, and Lebanon; and lowest (< 25% often/always use) among those in Finland, France, and Israel. With regard to the usage of particular DCSs, it should be noted that this study was conducted for the purposes of the *ICD-11* revisions, and not to draw comparisons between the *ICD* and *DSM*. Nevertheless, results offer evidence that both systems are in widespread use by psychologists around the world. Broadly speaking, the *ICD-10* appears to be more commonly used by psychologists in most European nations, while the *DSM-IV* is used by the majority of clinicians in most other nations represented in this study. However, there was considerable variability across countries, even among those in the same region. Further, open-ended responses indicated that that it is not uncommon for both systems to be used together.

Many of the above differences in diagnostic practices among countries and regions are likely related to differences in healthcare systems and the definitions, training, and roles of a psychologist within different countries. For example, *ICD* diagnostic codes are a prerequisite for public or private health care reimbursement in some countries (e.g., United States; Reed, 2010), but may be less essential for the provision of care in other countries such as France, where research has consistently found lower rates of DCS usage among clinicians (Reed et al., 2011; Sechter, 1995). Regardless of the particularities of national healthcare policies, *ICD* codes (not

DSM codes) are required by all WHO member nations for the reporting of international health statistics (Reed, 2010). Thus, it is not surprising that, among those who used a DCS, the *ICD-10* was used with greater frequency than the *DSM-IV*. That is, DCS usage may be compulsory among many *ICD* users, but discretionary among many *DSM* users. Relatedly, *DSM-IV* usage has been found to be associated with research and training while *ICD-10* usage is more common among clinicians (Mezzich, 2002).

Several other aspects of international psychology warrant attention prior to any further interpretation of the results (see Stevens and Wedding, 2004). To begin with, the very definition of "psychologist" varies greatly across countries, from exclusively Ph.D.- or Psy.D.-holding, licensed clinicians in the United States to primarily bachelor's- and master's-level psychologists in most other countries, especially developing nations. Moreover, there is sometimes little or no distinction between the roles of counseling and clinical psychologists. Associated with these differences are differences in training (e.g., quality and length of training; knowledge of psychopathology, assessment, and diagnosis; accreditation standards) as well as standards for licensure and conventions of practice (e.g., independent practice or supervision by physicians; relative status, practice, and availability of pharmacotherapy versus psychotherapy). There is also considerable variability in the degree to which psychology has been established, recognized, regulated, and organized as a profession within different countries (Stevens & Wedding, 2004). In light of this heterogeneity among psychologists in the countries represented in the present study, national and regional differences may be reflective of differences in the nature of professional psychology (e.g., training, practice, regulation, roles), healthcare policy, and cultural factors, as well as participants' individual opinions.

It should also be noted that the present findings on psychologists' diagnostic and professional practices differed considerably from those of psychiatrists in the WPA-WHO survey

(Reed et al., 2011). Compared to data on psychiatrists, psychologists reported spending fewer hours in contact with patients; seeing fewer diagnostic categories per week; using DCSs less frequently overall, and with a greater range of variability internationally; and using the *ICD-10* less often and the *DSM-IV* more often. These differences can likely be explained by professional differences in clinical training and practice. First, whereas psychologists often provide psychotherapy, psychiatrists tend to spend more time delivering pharmacotherapy (Mojtabai & Olfson, 2008; Phelps, Eisman, & Kohout, 1998; Pingitore, Scheffler, Sentell, & West, 2002). Thus, for any given patient, psychologists may spend more time—in terms of both the duration and frequency of appointments—engaged in planning and delivering treatments. This would result in fewer clients, and thus, fewer disorders seen on a weekly basis. Second, psychologists in the present sample include a range of practicing professional psychologists, which may include clinical, counseling, health, child, school, or other areas of psychology. Psychologists as a group are therefore likely to perform a range of services with diverse populations and issues, many of which may be non-psychiatric in nature. This, too, limits the number of disorders seen regularly by psychologists and suggests that their clinical experiences may be quite different from those of psychiatrists.

Third, compared to psychiatrists, psychologists may be more likely to engage in professional activities that do not involve direct patient contact (e.g., consultation, billing, report writing, supervision, treatment planning), thereby reducing the proportion of their time that is spent with patients. Fourth, psychologists' relatively low rates of DCS usage, as well as their use of one manual over another, may be due to a combination of factors such as less extensive education and training in *DSM-* and/or *ICD*-based diagnostic practices, particularly in developing countries (Stevens and Wedding, 2004); fewer policies requiring them to report diagnostic codes, or an unawareness of existing policies (Reed, 2010); or philosophical opposition to the practice

of diagnosing and classifying persons in terms of mental disorders, as was noted in several of the open-ended responses in the present study. Of course, the present sample and the Reed et al. (2011) sample are dissimilar in sample size and countries represented, so comparisons between the two should be interpreted with caution. Nevertheless, differences between professional psychology and psychiatry provide a more informed understanding of discrepant results, both in regard to professional practices as well as more substantive findings discussed below.

Views on Diagnostic Classification

Results were surprisingly consistent—across regions and DCS, and in line with previous research—in regard to global aspects of diagnostic classification. Consistency, however, should not be mistaken for consensus. That is, distributions of responses were similar across subsamples, but there were few cases in which a clear majority preferred one view to another. The most notable case of consensus is that, in line with previous research, an overwhelming majority (87.6%) of psychologists indicated that the most important purposes of a DCS were related to clinical care and communication (i.e., treatment/management decisions, inter-clinician communication, and communication with patients), as opposed to all nonclinical and "other" purposes, such as billing. Although this emphasis on clinical utility appears to be common across regions, DCS, and professions, findings on this item suggested a substantive difference between psychologists in the present study, who emphasized "clinical treatment/management decisions" as the top priority, and psychiatrists, who in previous research consistently emphasized "communication among clinicians" as foremost (Bell et al., 2008; Mellsop et al., 2007a, 2007b, 2011; Reed et al., 2011; Suzuki et al., 2010; note, however, that Latin American samples of psychologists in the present study did follow this latter trend). Again, these differences may be accounted for by differences between psychological and psychiatric approaches to treating mental disorders (Mojtabai & Olfson, 2008; Phelps, Eisman, & Kohout,

1998; Pingitore et al., 2002; Wyatt & Livson, 1994). That is, psychologists delivering psychotherapeutic services may be more likely to select and provide services oriented toward a particular clinical syndrome; by contrast, psychiatric treatment may be less concerned with diagnostic categories and more concerned with ameliorating and monitoring particular symptoms and side effects.

Across all regions, DCSs, and consistent with findings among psychiatrists (Bell et al., 2008; Mellsop et al., 2007a, 2007b, 2011; Reed et al., 2011; Suzuki et al., 2010), the vast majority of psychologists preferred a DCS with fewer diagnostic categories (i.e., 10-100 categories), rather than more, and flexible diagnostic guidelines rather than strict criteria. These findings stand in contrast to the *DSM-IV* and *ICD-10*, which both contain several hundred potential diagnoses arranged in complex hierarchical taxonomies, offering empirical support for calls toward nosological simplification (e.g., Flanagan & Blashfield, 2010; Watson & Clark, 2006). In particular, these results run counter to the *DSM-IV*'s method of operationalizing diagnoses through symptom checklists and elaborate diagnostic requirements. Rather, they suggest that a more flexible approach, perhaps similar to that of the *ICD-10*'s guidelines, may be preferable. By contrast, psychologists' opinions were consistently divided on other broad questions about the structure and content of a DCS. Consistent with previous findings among psychiatrists (Reed et al., 2011), majorities of psychologists agreed that functional impairment, severity, and dimensional classification should be included in a DCS, but there was little agreement as to how or why. Any differences between regional and DCS groups were nonsignificant or of a small effect size, suggesting that the differences of opinion on these items are common and widespread, even among clinicians in the same countries and regions.

Psychologists' opinions were also divided on the question of diagnoses and proportionality to adverse life events. However, unlike the conflicting views on functional

impairment, severity, and dimensional classification, results on this item reveal interesting differences between disciplines: nearly two-thirds of psychiatrists supported the practice of making a diagnosis of depression regardless of whether symptoms occur in response to adverse life events (Reed et al., 2011), but only half of psychologists shared this opinion. Again, this difference of opinion may be related to differences in the clinical services provided by psychologists. While psychologists and psychiatrists both recognize the need for mental health services in certain cases of depressed, bereaved individuals, these two professions and systems of care are associated with different populations of individuals (compare Reed et al., 2011 with present study; Pingatore et al., 2002), as well as different theoretical models of mental illness (Wyatt & Livson, 1994). Consistent with a biomedical approach to mental illness and healthcare, the provision of psychiatric care may in some cases be predicated upon the presence of a psychiatric disorder. By contrast, psychologists—including counseling, clinical, and other specialties—may be more able or likely to provide treatment services such as grief counseling or psychotherapy regardless of whether there is a diagnosis.

Classification within Global Mental Health: Needs and Challenges

On questions of cross-cultural applicability, American/European bias, and stigma, significantly large differences were found for region but not for DCS used. Specifically, larger proportions of psychologists in Eastern Mediterranean, Africa, and Latin America reported problems related to cross-cultural applicability and a DCS being over-embedded in American/European customs and values. These results represent empirical support for the notion that the clinicians who have the greatest degree of culture-related difficulties in applying the *DSM-IV* and *ICD-10*—which are, of course, American and European manuals, respectively—are those who live and work outside of the United States and Europe. Interestingly, this trend was somewhat reversed on the question of diagnostic stigma, with Western developed nations

expressing more concern about stigmatizing terminology. However, stigma may carry different connotations depending on the cultural context. That is, the very notion of *diagnostic* stigma presupposes that a sufficient number of persons are actually receiving or living with mental health diagnoses to such an extent that would allow for a stigmatizing attitude to take hold within a culture. According to this understanding, it is reasonable to suggest that stigma may be more salient in developed nations than in developing nations where the problem of treatment availability and access is of primary concern. Additionally, if stigma is conceptualized as a barrier to services, mental health professionals may not be the most accurate reporters because they only encounter a treatment-seeking subset of the larger number of individuals in need of services.

On all of these items, substantial percentages of the overall sample and regional samples indicated their agreement that their current DCS can be problematic in relation to cultural factors. However, given the amount of within-group variability, regional differences only depict a portion of the story. National results are more telling. For example, the relatively high level of cultural problems endorsed by psychologists in Lebanon, Turkey, and Israel suggests that *DSM-IV* framework (the DCS used by over 75% of respondents in those countries) may be more problematic within the cultures of the Eastern Mediterranean than it is in the United States and Europe. Such findings represent significant problems for global mental health care to overcome. Further research is needed to better understand the nature of these problems within particular countries, as well as how to address them in the *ICD-11*.

Another broad question relating to the development *ICD-11* is that of how best to meet the needs of different users and stakeholders across a wide variety of cultural and clinical contexts. Given the findings regarding cultural bias and applicability, it is perhaps not surprising that there appears to be significant interest in a nation-specific DCS for countries in Latin

America, Africa, the Eastern Mediterranean, and, to a lesser extent, Asia. Regarding clinical

adaptations, only a slight majority of the overall sample favored a primary care version, and

regional differences suggest that there may be a greater need for a primary care version in

regions (e.g., Asia, Africa, Eastern Mediterranean) where mental health conditions are more

often treated in primary care settings, as opposed to mental health specialty settings. Given that

the majority of the global mental health care burden is shouldered by primary care providers

(Wang et al., 2007; WHO, 2011), a primary care version of the *ICD-11* would likely offer

significant utility in many clinical settings. Still, one may wonder whether it is reasonable to

expect a DCS to serve so many purposes (e.g., treatment, research, statistics, reimbursements)

for so many individuals (e.g., psychologists, psychiatrists, patients, administrative staff) around

the world, as is the current state of affairs. Results suggest that majorities of psychologists agree:

a DCS should be comprehensible to non-professional stakeholders and useful for clinicians from

a variety of mental health disciplines. It should be emphasized, however, that these data are

psychologists' views as to what physicians, other professionals, and non-professionals prefer.

Such questions may be more accurately understood through a direct investigation among the

populations of interest.

Identifying and Improving upon Problematic Diagnoses

Perhaps some of the more interesting aspects of this study are the findings regarding

psychologists' use and evaluation of particular diagnostic categories. Although the average

number of categories seen regularly was highly variable across countries, psychologists generally

encounter a relatively small number of disorders on a regular basis, particularly when compared

to psychiatrists (Reed et al., 2011). Without accounting for disorder prevalence, psychologists

appear to have more exposure to disorders related to anxiety, mood, stress reactions, and

child/adolescent behavior, and relatively less exposure to substance use, psychotic, eating,

sexual, and personality disorders. In other words, psychologists often saw disorders for which psychosocial treatments can be effective forms of intervention. Disorders that were reportedly seen with less frequency are those for which medication is often the primary treatment component and are thus more likely to be seen by psychiatrists or other physicians. These findings are consistent with previous research on the conditions treated by psychiatrists and psychologists (Olfson & Pincus, 1996; Pingatore et al., 2002; Reed et al., 2011).

Of particular relevance to the *ICD-11* revisions are psychologists' views on the ease of use and goodness of fit of the categories they use most regularly. First, although most diagnostic categories were evaluated relatively favorably, there are several disorders (Table 3) that appear to be less useful and/or accurate for the purposes of clinical assessment and treatment. Many of these "problematic" *ICD-10* and *DSM-IV* categories are the ones that might be expected based on the volume of literature examining their validity, reliability, and utility as they are currently formulated (e.g., Asperger's disorders, borderline personality disorder, bipolar disorders, impulse control disorders, schizoaffective disorders, somatoform disorders); however, these results also draw attention to diagnostic entities (e.g., dissociative disorders) that have seen relatively less critical attention within the literature, but nevertheless appear to be problematic in clinical practice. These "problematic" categories may warrant a greater degree of attention and reformulation during DCS revision processes, or a greater focus on *ICD/DSM* training efforts. Second, those categories that received relatively good ratings (e.g., panic disorders, specific phobias, mental retardation, major depressive diagnoses, and eating disorders) should conversely be acknowledged as diagnoses that are working relatively well in clinical practice, and therefore may not be in need of substantial revisions.

Third, differential findings between *ICD-10* and *DSM-IV* categories may suggest relative strengths and weaknesses in the respective manuals, whereas areas of agreement may suggest

consistent problems with current diagnostic constructs, regardless of DCS. For example, hyperkinetic (attention-deficit/hyperactivity) disorder, antisocial personality disorder, and disorders related to the use of volatile solvents and hallucinogens appear to be problematic as they are formulated in the *ICD-10*, but not in the *DSM-IV*. Conversely, *DSM-IV* diagnoses of Autistic disorder, tic disorders, sexual dysfunctions, brief psychotic disorders, and primary sleep disorders appear to be more clinically problematic than their *ICD-10* counterparts. In the spirit of *ICD-DSM* "harmonisation" (First, 2009; Kupfer, Regier, & Kuhl, 2008), findings such as these offer implications for how DCS revisions may draw upon the strengths and weaknesses of the diagnostic alternatives among the *ICD*, *DSM*, and other systems—if not for the *DSM-5* and *ICD-11*, then possibly for subsequent revisions.

Lastly, is interesting to note that approximately half of all participants indicated that there was one or more disorders with which they were dissatisfied or that they would consider problematic in clinical practice; however, when asked about specific actions to be taken, less than one-quarter of these participants felt that disorders should be moved around or removed altogether, and an even greater number (approximately one-third) felt that disorders should be added. Thus, while a large proportion of psychologists point to disorders that they consider problematic, relatively few agree on how best to remedy those problems, and even fewer agree on which specific disorders are most problematic. Indeed, most disorders received relatively favorable evaluations for ease of use and goodness of fit. So it appears that while individual psychologists may hold mixed opinions toward the *ICD-11* or *DSM-IV* overall, this may be due to a small number of diagnoses viewed as problematic by a small number of clinicians. When one examines the opinions of *many* mental health professionals across a *wide range* of commonly seen diagnostic categories, it seems that clinicians' views on *ICD-11* and *DSM-IV* categories are in fact more favorable than might be suggested through other methodologies.

Certainly, this offers a much more positive picture than the abundance of literature offering criticisms and recommendations for changing the *DSM* and *ICD*.

While these results offer insight into clinicians' views and preferences, they require careful interpretation before leading to any revisions. For example, the prospect of adding disorders or, even failing to move/remove disorders, would necessarily result in a DCS that is larger and more complex (i.e., with more diagnostic categories) than what the vast majority of clinicians consider to be the optimal (10-100 categories). And to incorporate additional components of severity, functional impairment, or dimensionality would likely have the same effect. These changes would therefore be antithetical to previous criticisms that the *DSM-IV* and *ICD-11* are already too large and complex, and therefore need simplification rather than expansion (e.g., Flanagan & Blashfield, 2007b, 2010; Watson & Clark, 2006). Given these mixed findings and recommendations, these results should be interpreted cautiously and collectively. Any revisions made to the *ICD-11* should only be made after a careful consideration of the views and needs of the diverse population of global psychologists.

Limitations

Although the entire sample is quite sizable, this study's primary limitations are related to issues of participant selection and representativeness. First, because participants were solicited through their membership in national psychological associations (possibly the only means through which such a study could feasibly be conducted), they may not be representative of the larger populations within each country. Relatedly, countries without professional organizations could not be represented at all. Second, the majority of participants were from high income and European countries, and participation from other regions and developing nations was comparatively low. Third, due to disparities among sample sizes within regional and DCS groups, findings should not be interpreted as representative of all countries within a given region,

or all users of a particular DCS; rather, the generalizability of these findings may be limited to psychologists in the 23 countries represented. In particular, results for very low-N countries (e.g., Zimbabwe, Namibia) should be interpreted with extreme caution.

However, these differences are reflective of larger disparities in the prevalence of mental health professionals in developed versus developing nations (WHO, 2011) as well as the degree to which professional psychology is defined, regulated, and organized at the national level (Stevens & Wedding, 2004). Thus, the gold standard of "representativeness" is an elusive goal for any purportedly "global" survey to achieve. Nevertheless, by reporting the aggregated results in total and with each country given equal weight, it is possible to examine the extent to which these sample size differences affect the results and to arrive at a more representative estimate. Related to the issue of sample size is that of the data on particular diagnostic categories. Because categories were evaluated only by clinicians who saw them regularly, the results for diagnoses with fewer respondents (e.g., Inhalant-Related Disorders; see Figures 8 and 9) should be interpreted as less reliable than those with more ratings (e.g., Major Depressive disorder).

In light of the variability of professional psychology around the globe (Stevens, & Wedding, 2004), a further limitation is that data were not collected on participants' educational qualifications (e.g., bachelor's, master's, or doctoral degrees), type and quality of training, or professional practices. Such factors should be examined in future research, as they are likely to play a significant role in psychologists' experiences and views regarding classification and diagnosis. Finally, it should be reiterated that these findings are not to be interpreted to as realities of global mental health care. Rather, they represent the experiences and opinions of psychologists in relation to the diverse contexts in which they practice.

Implications and Future Directions

To date, this investigation represents the second largest clinician survey on the diagnostic classification of mental disorders, as well as the first study of its kind to be conducted among a truly global sample of *psychologists*. Given that most similar studies, whether at the national or international level, have been conducted among psychiatrists (e.g., Mellsop et al., 2007a, 2007b, 2011; Suzuki et al., 2010; Zielasek et al., 2010), this survey offers new insights into the views and practices of a previously unexamined professional population within global mental health care. Notably, the online format of the survey allowed for greater participation from professionals in developing regions, such that low and lower-middle income nations exhibited the highest response and completion rates. Indeed, open-ended responses from these participants reflected their gratitude and enthusiasm for participating in this project. In light of the growing ubiquity of Internet access among health professionals even in developing nations, as well as the increasing collaboration among national and international mental health organizations, studies such as this provide examples of how practitioner research can be conducted at the global level quite feasibly and successfully.

In very practical terms, these findings offer several direct implications for the development of the *ICD-11*. First, they are one of several sources of data that are currently being used to inform revisions to the *ICD*, both for specific diagnostic categories as well as for broad, cross-cutting issues of diagnostic classification. For example, these findings suggest that the *ICD-11* should: (a) be designed primarily for the purposes of clinical treatment, management, and communication; (b) contain flexible diagnostic guidelines and, if possible, fewer categories; (c) be useful and comprehensible to mental health clinicians of all backgrounds, patients, administrative staff, advocates, etc.; and (d) address considerations of severity, dimensionality, functional impairment. However, this is not to say that these revisions are democratically

determined; this study was not intended to give psychologists a "vote," *per se*, in shaping the *ICD-11* (in fact, the results contain so many mixed findings and disagreements that such a misguided approach would be fruitless). Rather, this study offers a glimpse into the preferences and opinions of psychologists, which will be used, along with other sources of data (e.g., Reed et al., 2011, 2012; Roberts et al., 2012), to inform the decisions made by well-qualified individuals within the *ICD-11* work, advisory, and coordinating groups.

Second, these results will serve as baseline data to help direct future research on the clinical utility, reliability, and validity of *ICD-11* categories. This bears the most immediate relevance for the *ICD-11* field trials. The present investigation was a part of the *ICD-11 formative* research program, and was conducted on the hypothesis that if the *ICD* can be revised to correspond more closely with clinicians' needs, preferences, and experiences, the result would be improvements not only in clinical utility and care, but also in reliability and validity. These are empirical questions. Soon they will be investigated within the *summative* research program of the *ICD-11* development process. This next phase includes field trials and other studies, which will aim to evaluate and improve the reliability, validity, and utility of the new system.

Third, in addition to implications for changing the *ICD-11* system, these findings offer direction to help facilitate effective *ICD-11* dissemination, adaptation (e.g., national DCSs, primary care version), translation, and training efforts around the globe. Finally, in anticipation of the *DSM-5* and *ICD-11*, the present study offers a better understanding of psychologists' views and practices regarding diagnostic classification and provides direction for further international research among psychologists and clinicians. Indeed, a great deal of research is needed to better understand the unique sociocultural and medical factors (e.g., stigma, treatment access) at play within each country, as well as ways to improve mental health service delivery around the globe. Toward that end, WHO's Department of Mental Health and Substance Use is

currently preparing for the next phase of *ICD-11* research. Building upon the findings of the

present study, these investigations will hopefully help to bring about a diagnostic system which,

compared to its predecessors, is more valid, reliable, and clinically useful within the challenging

context of global mental health care.

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Appendix

The WHO-IUPsyS Online Survey for Psychologists (English Generic Version)

[Introduction Page]

Dear Colleague,

The (NAME) Psychological Association is collaborating with the International Union of Psychological Science (IUPsyS) and the World Health Organization (WHO) in order to provide input into WHO's revision of the International Classification of Diseases and Diseases and Related Health Problems, 10th Revision (ICD-10) currently underway. More specifically, IUPsyS is working with WHO on the revision of the ICD-10 chapter on Mental and Behavioural Disorders.

WHO and IUPsyS are engaging in an international and multilingual process in order to assess the views and opinions of psychologists around the world regarding the problems with current classification systems and how their clinical utility can be improved. WHO has a commitment that the revision process represent multidisciplinary perspectives, including those of psychologists, and IUPsyS is represented on the International Advisory Group charged with assisting WHO with the revision. This is the first time that psychologists have played such an active role in preparing the new classification for mental and behavioural disorders.

WHO expects to publish the ICD-11 in 2014. Throughout the revision process, and with the support of its members, the (NAME) Psychological Association will work with IUPsyS and WHO to provide scientific and clinical input in order to strengthen, broaden, and improve the ICD-11 classification system.

One specific way in which the (NAME) Psychological Association, IUPsyS and WHO are collaborating is through this on-line survey. This is only the first of a series of opportunities for the (NAME) Psychological Association to participate in the revision of the ICD-10, which will involve a systematic program of surveys and field studies. WHO and IUPsyS are taking advantage of technology that did not exist at the time the ICD-10 was developed in order to make this survey available and accessible to psychologists throughout the world.

We are asking you to complete this survey, answering each question as honestly and as accurately as possible. The survey should take approximately 20 minutes to complete. Most of the questions relate to your own views and opinions, based on your day–to-day clinical experience. There are no right or wrong answers.

This survey is designed for psychologists who provide services to patients or clients (e.g., assessment or treatment services) in a variety of settings. Even if you do not currently use a classification system for mental disorders as a normal part of your practice or if you do not typically make the diagnosis yourself, your input regarding the desirable characteristics of a classification system and other general issues will still be important. If you normally use another classification system, such as the American Psychiatric Association's Diagnostic and Statistical Classification of Mental Disorders (DSM-IV), we would still request that you participate in the survey. In fact, the DSM-IV is also currently undergoing revision, and both WHO and the American Psychiatric Association have stated as an explicit goal of their respective revision processes to improve the harmonization of ICD-11 and DSM-5. Your participation will contribute to that process.

Your participation in this survey is strictly voluntary. The information you provide will be used for the purposes of this study only and will be reported only in aggregated form. This survey contains no questions that can potentially identify you or your patients, and your name will not be associated in any way with the research findings. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response.

The content of the questionnaire should cause no more discomfort than you would experience in your everyday life. Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of psychologists' views of ICD and issues related to the classification of mental and behavioural disorders.

We are grateful for your interest and your participation in this study. If you have questions or comments, please send them to Dr. Patricia Esparza, Department of Mental Health and Substance Abuse, World Health Organization at esparzap@who.int.

Thank you very much for your participation and support.

WHO and IUPsyS are working with investigators at the University of Kansas, U.S. to be able to provide this internet survey. WHO, IUPsyS, and the University of Kansas support the practice of protection for human subjects participating in research. The investigators for this study include Dr. Geoffrey M. Reed, WHO, Dr. Pierre Ritchie and Dr. Ann Watts, IUPsyS, and Dr. Michael C. Roberts, University of Kansas. The preceding information is provided for you to decide whether you wish to participate in survey. If you have additional questions about your rights as a research participant, you may call +1 785 864 7429, write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, USA, or email mdenning@ku.edu.

Approved by the Human Subjects Committee University of Kansas, Lawrence Campus (HSCL). Approval expires one year from 30 April 2010. HSCL #18718.

Exempted from review by the World Health Organization Research Ethics Review Committee, 26 March 2010. Protocol ID RPC394.

If you agree to participate in this WHO-sponsored survey, and wish to proceed, please click on the 'Yes' button below. Clicking on the 'Yes' button indicates your willingness to participate in this survey, that you are a psychologist, and that you are qualified or licensed to practice as a psychologist in your country.

If you do not want to participate, please close this browser window to leave the survey website.

I agree to participate in this study:

     a. Yes

     b. No

[Section One]

1. Country of residence

2. Year of birth

3. Gender

4. Years of professional experience (after qualifying or being licensed as a psychologist)

5. Are you licensed or otherwise authorized by your country, state, or province to provide assessment or treatment services to persons with mental and behavioural disorders?

     a. Yes, independently

     b. Yes, under supervision

     c. No

6. Do you currently see patients or clients as part of your regular professional activities?

     a. Yes

     b. No

7. During a typical week, how many hours do you spend seeing patients or clients? [1]

     a. None

     b. Between 1 and 9 hours

     c. Between 10 and 19 hours

     d. Between 20 and 40 hours

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[1] Item displayed only if respondent: (a) is currently seeing patients/clients.

e. More than 40 hours

8. In the settings where you normally practice, who is responsible for making individual diagnoses? [1]

   a. Psychologists

   b. Psychiatrists

   c. Other physicians

   d. Nurses

   e. Other

9. In the one setting where you practice most, what role do you as a psychologist play in making individual diagnoses? [1]

   a. I make diagnoses independently

   b. I contribute to diagnostic formulations made by other health professionals

   c. I have no active role in making diagnoses

   d. Other

10. As part of your **day-to-day clinical work**, how much of the time do you use a formal classification system for mental disorders, such as the ICD-10, the DSM-IV, the ICD-9 or ICD-9-CM, or a national classification? [1]

   a. Almost always/Always

   b. Often

   c. Sometimes

   d. Rarely

   e. Never

11. In your **day-to-day clinical work**, which classification system for mental disorders do you use most? [2]

   a. ICD-10

   b. DSM-IV

   c. ICD-9 or ICD-9-CM

   d. Other diagnostic system (specify)

12. Which of the following best describes how familiar you are with the **ICD-10 classification of mental and behavioural disorders**? [3]

   a. NOT AT ALL or ALMOST NOT AT ALL (e.g., you have not reviewed or studied the ICD-10 in detail and have only a vague idea of its structure and contents)

   b. A LITTLE (e.g., you are familiar with the basic structure and contents of the ICD-10)

   c. SOMEWHAT FAMILIAR (e.g., you have some experience with the ICD-10 in clinical settings and/or a general understanding of its categories, definitions, and descriptions)

   d. QUITE FAMILIAR (e.g., you have substantial experience with the ICD-10 in clinical settings and/or a detailed understanding of its categories, definitions, and descriptions)

[Section Two]

13. From your perspective, which is the **single, most important** purpose of a diagnostic classification system?

   a. To serve as a reliable tool for communication between clinicians

   b. To facilitate communication between clinicians and service users/patients

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[1] Item displayed only if respondent: (a) is currently seeing patients/clients.
[2] Item displayed only if respondent: (a) is currently seeing patients/clients; and (b) uses a diagnostic classification system at least "Rarely".
[3] Item displayed only if respondent: (a) is currently seeing patients/clients; (b) uses a diagnostic classification system at least "Rarely"; and (c) uses a diagnostic system other than the ICD-10.

    c.   To inform decisions about treatment and clinical management

    d.   To facilitate research

    e.   To serve as a basis for generating national health statistics

    f.   Other (please describe):

14. In clinical settings, how many diagnostic categories should a classification system contain to be most useful for mental health professionals?

    a.   10 to 30 diagnostic categories

    b.   31 to 100 diagnostic categories

    c.   101 to 200 diagnostic categories

    d.   More than 200 diagnostic categories

15. Primary care practitioners should have:

    a.   A modified/simpler classification system of mental disorders

    b.   The same classification system as specialist mental health professionals

16. Please rate the extent to which you agree with the following statement: *"A diagnostic classification system should serve as a useful reference not only for psychiatrists but for all mental health professionals (e.g., psychologists, social workers, psychiatric nurses)."*

    a.   Do not agree

    b.   Agree somewhat

    c.   Mostly agree

    d.   Completely agree

17. Please rate the extent to which you agree with the following statement: *"A diagnostic classification system should be understandable to service users, patient advocates, administrators, and other relevant people as well as to health professionals."*

    a.   Do not agree

    b.   Agree somewhat

    c.   Mostly agree

    d.   Completely agree

18. For maximum utility in clinical settings, a diagnostic manual should contain:

    a.   Clear and strict (specified) diagnostic criteria for all disorders

    b.   Diagnostic guidance that is flexible enough to allow for cultural variation and clinical judgment

19. The best way for a diagnostic system to address the concept of **<u>severity</u>** would be:

    a.   To provide subtypes of relevant diagnostic categories (e.g., mild, moderate or severe depressive episode), based on the number and/or severity of symptoms present.

    b.   To provide subtypes of relevant diagnostic categories, based on the degree of functional impairment (e.g., impairment in self-care or occupational functioning).

    c.   To provide a separate axis allowing an overall assessment of severity that could be used for all diagnoses.

    d.   Not to try to include it; severity is an important part of clinical assessment but does not need to be part of the diagnostic classification.

20. What is the best way for a diagnostic system to conceptualize the relationship between diagnosis and **<u>functional status</u>** (e.g., impairment in self-care or occupational functioning)?

    a.   Functional impairment should be a diagnostic criterion for most mental disorders; if there is no functional impairment, then a disorder should not be diagnosed.

    b.   Functional status should be a diagnostic criterion for some mental disorders, when it is necessary to infer the presence of a disorder from its functional consequences.

    c.   Functional status should not be included in diagnostic criteria; functional impairments are more properly viewed as consequences or outcomes of mental disorders.

21. Should a diagnostic system incorporate a **<u>dimensional component</u>**, where some disorders are rated on a scale rather than just as present or absent?

    a.   YES, because this would make the diagnostic assessment more detailed and personalized.

    b.   YES, because this would more accurately reflect the continuous nature of the underlying psychopathology.

    c.   NO, because this would be too complicated for use in most clinical settings.

    d.   NO, because there is insufficient research evidence regarding the reliability of a dimensional approach.

22. Should the diagnosis of depression be assigned when the depressive symptoms are a proportionate response to an adverse life event (e.g., loss of job or home, divorce)?

    a.   NO, a proportionate response to an adverse life event should not be considered a mental disorder.

    b.   YES, if the full depressive syndrome is present, the diagnosis should be made regardless of whether there are life events that can potentially explain it.

23. Please rate the extent to which you agree with the following statement based on your **<u>day to day clinical experience</u>**: *"The diagnostic system I use is difficult to apply across cultures, or when the patient/service user is of a different cultural or ethnic background from my own."* [2]

    a.   Do not agree

    b.   Agree somewhat

    c.   Mostly agree

    d.   Completely agree

24. Please rate the extent to which you agree with the following statement based on your **<u>day to day clinical experience</u>**: *"The diagnostic system I use is problematic because it is over-embedded in U.S. and European culturally-derived concepts and values."* [2]

    a.   Do not agree

    b.   Agree somewhat

    c.   Mostly agree

    d.   Completely agree

[Section Three]

25a. The following questions relate to your use of the ICD-10 diagnostic categories for mental disorders. [4]

Of the ICD-10 diagnostic categories listed below, please indicate which ones you use once a week or more in your day-to-day clinical practice (that is, you see a patient or client with that diagnosis at least once a week), whether or not you personally assign the diagnosis.

1. F00 Dementia in Alzheimer's disease
2. F01 Vascular dementia
3. F05 Delirium, not induced by alcohol and other psychoactive substances
4. F10 Mental and behavioural disorders due to the use of alcohol
5. F11 Mental and behavioural disorders due to the use of opioids
6. F12 Mental and behavioural disorders due to the use of cannabinoids
7. F13 Mental and behavioural disorders due to the use of sedatives or hypnotics
8. F14 Mental and behavioural disorders due to the use of cocaine
9. F15 Mental and behavioural disorders due to the use of other stimulants
10. F16 Mental and behavioural disorders due to the use of hallucinogens
11. F18 Mental and behavioural disorders due to the use of volatile solvents

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[2] Item displayed only if respondent: (a) is currently seeing patients/clients; and (b) uses a diagnostic classification system at least "Rarely".
[4] Item displayed only if respondent: (a) is currently seeing patients/clients; (b) uses a diagnostic classification system at least "Rarely"; and (c) uses the ICD-10.

12. F20 Schizophrenia
13. F21 Schizotypal disorder
14. F22 Persistent delusional disorder
15. F23 Acute and transient psychotic disorder
16. F25 Schizoaffective disorder
17. F30 Manic episode
18. F31 Bipolar affective disorder
19. F32 Depressive episode
20. F33 Recurrent depressive disorder
21. F40.0 Agoraphobia
22. F40.1 Social phobia
23. F40.2 Specific (isolated) phobias
24. F41.0 Panic disorder
25. F41.1 Generalized anxiety disorder
26. F41.2 Mixed anxiety and depressive disorder
27. F42 Obsessive-compulsive disorder
28. F43.1 Post-traumatic stress disorder
29. F43.2 Adjustment disorder
30. F44 Dissociative [conversion] disorders
31. F45 Somatoform disorders
32. F50.0 Anorexia nervosa
33. F50.2 Bulimia nervosa
34. F51 Nonorganic sleep disorder
35. F52 Sexual dysfunction
36. F60.2 Antisocial personality disorder
37. F60.31 Borderline personality disorder
38. F63 Habit and impulse disorders
39. F7 Mental retardation (i.e., intellectual disability)
40. F84.0 Childhood autism
41. F84.5 Asperger's syndrome
42. F90 Hyperkinetic (attention deficit) disorder
43. F91 Conduct disorders, including oppositional defiant disorder
44. F95 Tic disorders
45. Other – Please specify:
46. Other – Please specify:
47. None of the above

25b. Please evaluate the ICD-10 diagnostic categories you previously selected by making a rating of each category on two dimensions: 1) ease of use of the DSM-IV diagnostic criteria for that category or group of disorders; and 2) goodness of fit or accuracy of the DSM-IV definition, description, and diagnostic criteria in describing the patients or clients you see in clinical practice. [5]

Please use the following scales for making your ratings:

EASE OF USE of the ICD-10 diagnostic criteria:

0 = Not at all easy to use in clinical practice

1 = Somewhat easy to use

2 = Quite easy to use

3 = Extremely easy to use

GOODNESS OF FIT in clinical practice (accuracy in describing patients):

0 = Not at all accurate

1 = Somewhat accurate

2 = Quite accurate

3 = Extremely accurate

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[5] Item displayed only if respondent: (a) is currently seeing patients/clients; (b) uses a diagnostic classification system at least "Rarely"; (c) uses the ICD-10; and (d) sees at least one ICD-10 diagnostic category regularly. Additionally, respondents only rated the categories they see regularly.

26a. The following questions relate to your use of the DSM-IV diagnostic categories for mental disorders. [6]

Of the DSM-IV diagnostic categories listed below, please indicate which ones you use **once a week or more** in your day-to-day clinical practice (that is, you see a patient or client with that diagnosis at least once a week), whether or not you personally assign the diagnosis.

1. Mental Retardation (i.e., Intellectual Disability)
2. Autistic Disorder
3. Asperger's Disorder
4. Attention-Deficit/Hyperactivity Disorder
5. Conduct Disorder
6. Tic disorders
7. Delirium Due to General Medical Condition
8. Dementia of the Alzheimer's Type
9. Vascular Dementia
10. Alcohol-Related Disorders
11. Amphetamine (or Amphetamine-Like)-Related Disorders
12. Cannabis–Related Disorders
13. Cocaine–Related Disorders
14. Hallucinogen–Related Disorders
15. Inhalant–Related Disorders
16. Opioid–Related Disorders
17. Sedative, Hypnotic, or Anxyolitic–Related Disorders
18. Schizophrenia
19. Schizoaffective Disorder
20. Delusional Disorder
21. Brief Psychotic Disorder
22. Major Depressive Disorder
23. Single Major Depressive Episode
24. Bipolar I Disorder
25. Single Manic Episode
26. Bipolar II Disorder
27. Panic Disorder Without Agoraphobia
28. Panic Disorder With Agoraphobia
29. Agoraphobia Without History of Panic Disorder
30. Specific Phobia
31. Social Phobia
32. Obsessive–Compulsive Disorder
33. Post-Traumatic Stress Disorder
34. Generalized Anxiety Disorder
35. Somatoform Disorders
36. Dissociative Disorders
37. Sexual Dysfunctions
38. Anorexia Nervosa
39. Bulimia Nervosa
40. Primary Sleep Disorders
41. Impulse Control Disorders Not Elsewhere Classified
42. Adjustment Disorders
43. Schizotypal Personality Disorder
44. Antisocial Personality Disorder
45. Borderline Personality Disorder
46. Other – Please specify:
47. Other – Please specify:
48. None of the above

26b. Please evaluate the DSM-IV diagnostic categories you previously selected by making a rating of each category on two dimensions: 1) **ease of use** of the DSM-IV diagnostic criteria for that category or group of disorders; and 2) **goodness of fit** or accuracy of the DSM-IV definition, description, and diagnostic criteria in describing the patients or clients you see in clinical practice. [7]

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[6] Item displayed only if respondent: (a) is currently seeing patients/clients; (b) uses a diagnostic classification system at least "Rarely"; and (c) uses the DSM-IV.
[7] Item displayed only if respondent: (a) is currently seeing patients/clients; (b) uses a diagnostic classification system at least "Rarely"; (c) uses the DSM-IV; and (d) sees at least one DSM-IV diagnostic category regularly. Additionally, respondents only rated the categories they see regularly.

Please use the following scales for making your ratings:

EASE OF USE of the ICD-10 diagnostic criteria:

0 = Not at all easy to use in clinical practice

1 = Somewhat easy to use

2 = Quite easy to use

3 = Extremely easy to use

GOODNESS OF FIT in clinical practice (accuracy in describing patients):

0 = Not at all accurate

1 = Somewhat accurate

2 = Quite accurate

3 = Extremely accurate

[Section Four]

27. Are there diagnostic categories with which you are **especially dissatisfied**, or that you believe are **especially problematic** in terms of their goodness of fit in clinical settings?

    a.   Yes

    b.   No

    If yes, please explain:

28. Are there any specific diagnoses in that you feel should be **removed or moved** to another section?

    a.   Yes

    b.   No

    If yes, please explain:

29. Are there any specific diagnostic categories that you feel should be **added** to the classification system for mental disorders?

    a.   Yes

    b.   No

    If yes, please explain:

30. Do you think that any of the **terms** used in current diagnostic systems are stigmatizing in your language or cultural context?

    a.   Yes

    b.   No

    If yes, please explain:

31. Do you see the need in your country for a **national classification** of mental disorders (i.e., a country-specific classification that is not just a translation of ICD-10)?

    a.   Yes

    b.   No

    If yes, please explain:

32. Please use this space to provide any comments you have about this survey overall: