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COMMENTARY

Horses for courses

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Commentary on: Jablensky A. The disease entity in psychiatry: fact or fiction? *Epidemiology and Psychiatric Sciences* (doi:10.1017/S2045796012000339).

The erudite paper by Jablensky is not only a pleasure to read but is also an important reminder of the insufficiency of our knowledge about disturbances of brain function at the time when the American Psychiatric Association (APA) is about to complete its work on the 5th revision of their Diagnostic and Statistical Manual (DSM 5) and the World Health Organization (WHO) prepares the 11th revision of the International Classification of Diseases (ICD 11) with its chapter on mental disorders. Those involved in the development of proposals for the revision of the classifications would have no problems if they had to classify diseases entities defined on the basis of strong evidence about their pathogenesis, course and outcome: unfortunately however, as Jablensky's paper eloquently shows psychiatry has not yet defined disease entities. In the absence of sufficient evidence, the APA DSM 5 Task Force and the WHO Advisory Group on the classification of mental disorders are trying to produce a classification that will be useful in clinical work, allow billing for service, serve to produce national statistics about mental disorders for public health purposes and serve as a common language for researchers who are trying to ensure that their investigations deal with clearly defined homogenous groups of patients. They have to take into account opinions of psychiatrists and other mental health personnel which are far from being unanimous and reflect practice in different settings and cultures (Sartorius, 2010).

The consequence of the fact that psychiatry is not dealing with nosological entities is the development of different classifications for different purposes and by different groups. General practitioners can have a classification of mental disorders organized in a manner that corresponds to what they see in their patients and what makes them take one or another line of action. The World Association of National Colleges Academies and Academic associations of General Practitioners/family physicians (Wonca) produced such a classification including mental disorders and recommended it to its members (WICC, 2004). Insurance companies can focus on the amount of impairment and the severity of the disability that a particular condition might cause and a number of them have created them. Researchers can set the criteria for inclusion of conditions or syndromes into a category very strictly so as to maximize the probability that the persons whom they study do not differ in their symptoms or other characteristics. Nurses developed classifications that they feel is useful in their work. Specialists in rehabilitation create classifications that make sense from the point of view of rehabilitative practice.

There are two main problems with this state of affairs. The first is that the classifications which have been produced are not of equal quality. Some of them are not comprehensive and some have no operational or other criteria which would facilitate the placement of conditions into categories. Some are not regularly updated; others are very complex which limits their use. The second problem is that the existing classifications are not compatible with each other which makes communication among those who use the classification difficult or impossible.

The first of these two problems could be resolved relatively easily by guidance about the rules of making classifications and by making the acceptance of the classification dependent on their application. The second problem is much more serious. There are two ways of dealing with it. First, one could produce a classification and find a way to force all those who deal with conditions that are being classified to use that classification. This might be possible if there was only one profession that deals with a particular set of health conditions and if all of the members of that profession were to be educated – at least in so far as the use of the classification is concerned – in the same way. This strategy faces difficulties when health workers from different countries (educated in different ways) and of different professions are expected to use

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such a classification. The second solution is to produce a number of versions of the classification – for different professions or for specific purposes – ensuring however that they are translatable into a central classification. This strategy has to overcome the reluctance to accept the constraints of translatability that producers of classifications for use by a particular profession or for a particular purpose usually demonstrate.

Following the latter strategy the WHO produced three versions of the classification of mental and behavioural disorders in the 10th revision of the ICD – one for research purposes, one for practicing psychiatrists and one for use in primary health care settings. The clinical version was well accepted, translated into many languages and used by psychiatrists in their practice. The research version was less well known and less often used although it was well structured and did not differ too much from the DSM. One of the reasons for this was that some of the editors of psychiatric journals refused to take papers in which the subjects were diagnosed using the ICD and preferred those that relied on the DSM. More important in this respect however was the fact that WHO has been far less effective in promoting the use of its classification than the APA. The primary care version was used in a number of settings, often by psychiatrists who found that it served well to classify the vast majority of cases they had seen. All three versions of the classification were translatable into the official version of the ICD which contained a listing of diagnostic groups, each accompanied by a glossary definition.

The labels of conditions that are considered to be in the domain of psychiatry – regardless of whether they refer to nosological entities or to ill-defined syndromes are not only parts of the language of communication among psychiatrists and possibly other health professionals. They have other functions which are important but often given insufficient attention. Labels given to diseases are often becoming labels for persons who have the disease and may change their lives. The stigma attached to some disorders can be particularly grave: thus persons with schizophrenia will soon – in the language of doctors and the general public – become 'schizophrenics' which is likely to ruin their chances for employment, decent housing or the creation of a family. Psychiatrists in Japan – who became aware of the nefarious consequences of using the label – decided to abandon the Japanese name for schizophrenia and to replace it by another term, accompanied by a different description of the disorder (Sato, 2006). An immediate consequence of this change was that the relationship of doctors and their patients changed: psychiatrists reported that the change of the label made it possible to convey the diagnosis to the patient and to agree with them on the process of their treatment.

Names of conditions and their classification also play other major roles. Dr Jablensky's study drew the attention to the important distinction between validity and utility. The latter does not refer only to the practicing psychiatrist and his decision about the most appropriate treatment: there is also utility for public health purposes (e.g. for decisions about the priorities and funding for mental health programmes based on epidemiological studies), utility of the labels used for the image of psychiatry and psychiatrists, utility for the organization of training about mental disorders in schools of health personnel, utility for research purposes and the utility for the management of mentally ill people in primary and other forms of general health care. In all of those instances it would be so much better if we knew that we are dealing with nosological entities but the issue of utility for different purposes remains just as important if they cannot be defined as yet.

The consequence of the uncertainty about the nosological status of conditions which are the domain of psychiatry is that we shall have to live with a variety of classifications each serving the needs of a particular profession or a particular purpose. For the time being our efforts should be directed to both the search for psychiatric diseases entities (which would allow the production of a reference classification) and to maintaining the translatability of the different classifications into each other. Horses for courses, different classifications for different purposes translatable into each other seem to be, for the time being, the least unsatisfactory way to take for psychiatry.

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