Introduction
A Guide to This Book

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Psychiatric classification is like growing old – a subject often avoided but recognized as inevitable. Whether you use a standard classification such as ICD-11 or a personal one such as 'people-I-feel-confident-in-treating' or 'people-I-prefer to avoid', it is impossible to avoid some sort of order in a subject which can present in a myriad of ways. Carl Linnaeus, not exactly a modest man, often liked to quote his prime achievement, 'God created the world, Linnaeus organized it'. His *Systema Naturae*, published in 1735, introduced the 'definitive' classification of all living organisms, organized into species, genera, classes, and orders. This classification certainly revolutionized biology and the Linnaean system continues to remain supreme, and in psychiatry we would like to aspire to a similar pinnacle of achievement if we were able to create a classification of equal standing. But please pause a minute. The Linnaean system is not definitive. Whole groups of organisms are now being refined by DNA technology and a new classification is likely to be on its way to replace or enhance it. All classifications are ephemeral.

This is a salutary lesson for all clinicians. No classification is sacrosanct, and even as we attempt to make a pale imitation of *Systema Naturae* in psychiatry[1] in creating the 11th revision of the International Classification of Diseases, we know it is bound to fail. Some critics, including a significant proportion of users of psychiatric services who have not had good experiences, wish to abandon psychiatric diagnosis in its entirety,[2] but even a modicum of thought leads to the realization that without any form of diagnosis we would turn back 400 years and allow our patients to rely only on compassion, soft words, and knowledge of the four humours in offering management.

Robert Kendell, who wrote with razor-sharp precision about psychiatric classification, once wrote, 'All our diagnostic terms are simply concepts, and the only fundamental question we can ask about them is whether they are useful concepts, and useful to whom?'[3] We must have this central element, now cast in the words 'clinical utility', repeatedly invoked in ICD-11, at the forefront of our thinking.

So we would like the reader to ask the question after reading each of the following chapters, 'Is this going to be helpful in my clinical practice?' If indeed the book does appear to be making sense by increasing understanding and promoting better practice, it will indeed represent an advance. We know already that ICD-10 did not succeed entirely in this respect. To give one example, in a Danish study of the national use of ICD-10 diagnoses, 16 diagnoses accounted for over half of all the diagnoses made for mental and behavioural disorders. These constituted only 4.2% of the 380 diagnoses available. The three most frequently registered diagnoses were paranoid schizophrenia, alcohol dependence, and adjustment disorder, used respectively in 10.2%, 8.3%, and 5.9% of the cases. At the other

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extreme, 109 diagnoses (28.7% of all available diagnoses) were used fewer than 100 times each.[4] Put bluntly, they were either useless or, more generously, not quite fit for purpose.

This distribution would not matter if we had a high degree of certainty about our diagnostic system. A list of all the fauna in the world would show a similar distribution. But psychiatric diagnoses are not in this category. A good psychiatric diagnosis is one that conveys immediate understanding, one that is 'a clinically recognizable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions'.[5] It is also paramount that any classification should be used worldwide, that it is understandable and able to be implemented in all countries, not least in those with limited resources. So, the intention is for ICD-11 to be used not only by doctors but also by other mental health professionals, other health professionals working in areas involving mental distress, and even lay health care workers.

It is also worth examining the second part of Kendell's aphorism, 'useful to whom?' If you are a counsellor in primary care or private practice seeing referrals whom you expect to treat entirely in your service, you do not need an external classification. You could make one up for yourself and signify accordingly (e.g., Type 1 problem), so when you come to see others with similar problems you can compare notes. A simple formulation at the end of the interview will normally suffice.

But when you must refer a patient to other practitioners or give a report for an external agency, you cannot rely on this approach alone. You have to use some form of communication that is relatively economical, accurate, and comprehensive. The authors of ICD-11 would like to think the revised classification will suit this demand. The World Health Organization also made it clear at the beginning of the ICD-11 classification process that its outcome should be of value in all cultures and in all countries, particularly those which have the highest burden of mental illness and the least resources.[6]

This book was created as a consequence of feedback from a two-day meeting on the 25th and 26th of May 2021 hosted by the Royal College of Psychiatrists. The 11th revision of the International Classification of Diseases has long been awaited and its publication in 2022 is thirty years after the publication of the ICD-10, a much longer period than any previous revision. The new classification is coming out at a critical time in psychiatric practice. Diagnosis in psychiatry is coming under attack on many fronts, not least from within the profession. This is partly a consequence of mistakes that have been made in the past with a superfluity of diagnoses from the introduction of DSM-III onwards. Every new diagnosis now has to be subjected to very close scrutiny and can only be introduced after a serious examination of evidence.

This is where we stumble. What is evidence for a new disorder that does not yet exist? It is almost always absent or patchy at best, and the common criticism is that the evidence gap is filled by experts who are biased in promoting their own points of view. This criticism can never be fully countered. The best we can offer is a balanced description of the advantages of the new classification over the old and a reasoned defence of the new kids on the block, with the acknowledgement that in time they will be knocked off the block in their turn.

At this stage, it is impossible to gauge whether ICD-11 will be regarded as superior to its predecessors. The maxim of Kendell's clinical utility has been adopted by the WHO in its preparation for ICD-11. This is a sensible policy, as both DSM and ICD classifications have been criticized for excessive of diagnoses ever since the success of DSM-III in 1980. It is through clinical utility that the new system will be judged.

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It could be said that these changes make diagnosis fuzzier, less certain, and less crisp than formerly. But the response can be, 'Yes, maybe, but we think the changes better reflect clinical reality. Classification should be in tune with practice and if you are forced to use it because there is no alternative, something is wrong.' Anthony Storr, a psychiatrist whose writing often cut through the unnecessary verbiage of nosology, argued for a broader diagnostic approach: 'I want to show that the dividing lines between sanity and mental illness have been drawn in the wrong place. The sane are madder than we think, the mad saner' (quoted in obituary). Walled-off psychiatric diagnoses do not work.

Because we are committed to open debate, we have also invited the bête-noire of DSM-5, Allen Frances, to give his own verdict on ICD-11, especially the changes from ICD-10. We were not expecting an easy ride from Allen, and he has not pulled any punches in his criticism. Because he marshals his arguments well, they may carry conviction in some quarters. But that is for the reader to decide, and we hope that by giving alternative viewpoints each clinician can test them out in practice rather than accepting the new system as rote. The ICD-11 work groups have been examining their subjects for close on ten years; they are not, as so many believe, in hock to drug companies and corrupted by money, and no funds have been paid to them for their work. The World Health Organization has carried out this exercise on a shoestring, and throughout it has been guided by Geoffrey Reed, who has been the key to the whole enterprise.

There are many who are very keen to read the equivalent of the ICD-10 Diagnostic Guidelines published in 1993. These have moved through several names and acronyms but are now going to being published as *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural or Neurodevelopmental Disorders (CDDR)*.[7] These are now available from the WHO. They are not to be used for statistical recording of diagnosis but in being developed specifically for the ICD-11 Mental, Behavioural and Neurodevelopmental Disorders chapter, provide much more detailed information needed by both mental health and other health professionals to understand more fully this classification in their work with patients.

The exact text of the ICD-11 is not always replicated in this book, but it is available online – *ICD-11 who/int* then click on *ICD-11 Browser* to type in the disorder you wish to access. By giving a background to the classification rather than mere replication of the definitions, we hope that we can achieve a more sophisticated understanding of the different diagnoses.

But we are quite aware that not everything was covered at our meeting in May 2021 or in the text here. There was no presentation on eating disorders, but this has been partly compensated by Professor Ulrike Schmidt in her account of the new diagnosis of Binge-Eating Disorder. There is also no primary care version currently available, but the best available review and update is to be found in Chris Dowrick's primary care chapter at the end of the book.

Nobody at this point can say whether ICD-11 will represent a significant advance over its predecessors. This will only evolve with use over time, but our contributors have made a pretty good fist in getting the reasoning behind the changes clear for all to see.

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