International Classification of Diseases (*ICD*), Mental and Behavioural Disorders Section

Spencer C. Evans and
Michael C. Roberts
University of Kansas, U.S.A.

The World Health Organization's (WHO) *International classification of diseases and related health problems* (*ICD*; World Health Organization, 1992a) is well established as the global standard for the diagnosis, treatment, research, and statistical reporting of all human health conditions, including mental and behavioral disorders. Thus, it represents a powerful clinical, administrative, scientific, and epidemiological tool. The section on mental and behavioral disorders is one chapter (Chapter V or F) within the *ICD,* which, in turn, is one component of the WHO Family of International Classifications. To enhance clinical and scientific utility, Chapter V has been adapted into separate versions tailored for use by mental health clinicians (World Health Organization, 1992b), researchers (World Health Organization, 1993), and primary care providers (World Health Organization, 1996). The full *ICD* classification and several of its adaptations are available online (see World Health Organization, 2012).

Based on current scientific evidence and models of disease, the *ICD* is designed to perform several functions within the framework of the WHO's global public health mission. First, it provides a comprehensive nosology of health conditions, including mental disorders and factors that affect health. Second, and relatedly, it serves as a coding system, assigning to each disease, disorder, or condition a unique code. These codes are used for the international aggregation of health statistics across 117 countries, as well as to facilitate the reimbursement of health-related expenses for approximately 70% of health expenditures around the world (World Health Organization, 2014). Third, *ICD* materials provide clinical descriptions of psychological conditions, as well as diagnostic guidelines and criteria for how they may be reliably diagnosed within clinical and research settings, respectively. None of these functions would be possible at a global scale without this international standard of communication. Thus, by providing a common diagnostic language, the *ICD* enhances the consistency and comparability of health-related information and statistics across countries.

Although these basic functions may seem straightforward, the underlying complexity becomes apparent when one considers the myriad users, purposes, and settings served by the *ICD*. Even within the circumscribed domain of "health service delivery," for example, users include psychiatrists, psychologists, nurses, social workers, primary-care physicians, students and trainees in these disciplines, administrative staff, insurance providers, federal reimbursement programs, and public health agencies. Moreover, consider the diverse cultures and languages represented by the WHO's 194 member states, not to mention the vast differences in how mental disorders are viewed and treated. To better serve these various users and purposes, the WHO has developed several adaptations (discussed below), translations into over 40 languages, and various formats (e.g., online, print publications, CD-ROM). Many of these materials are freely available online, or are available for purchase, with reduced prices for developing nations (WHO, 2014).

At the time of this writing, the 10th edition (*ICD-10;* WHO, 1992a) is the current

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version, but the development of the *ICD-11* is well under way. The *ICD-11* is currently in the field-trials stage, with the final approval expected in 2017. Yet, U.S. health care continues to use the *ICD-9* and is expected to make the transition to *ICD-10* in 2014 (Centers for Medicare and Medicaid Services [CMS], 2014), just as the international health community is preparing for the *ICD-11*. Further, American clinicians, researchers, and training programs sometimes emphasize the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders* (*DSM-5*; American Psychiatric Association, 2013) to the neglect of the *ICD,* such that most mental health diagnoses assigned within the United States are ostensibly made within the *DSM* framework. Nevertheless, the official diagnostic system in the United States is in fact the *ICD*. That is, all *DSM* diagnoses must be translated into *ICD* codes for reimbursement and statistical reporting. In light of all of these complexities and changes, practitioners, researchers, and students in clinical psychology are likely to benefit from a foundational knowledge of the *ICD* system.

Historical Overview

During the latter half of the nineteenth century, European and American health statisticians increasingly recognized the advantages of a common international classification for tracking mortality statistics. While various medical nomenclatures had existed for centuries, the first to gain international acceptance was Jacques Bertillon's *International list of causes of death*, adopted in1893 by the International Statistical Institute. This event marked the inception of the *ICD* (which has borne a few different names throughout the years). The first revision of the *ICD* (*ICD-1*) was published in 1900, with subsequent revisions occurring every 8–10 years until the publication of the *ICD-9* in 1975, after which point revisions became less frequent (Moriyama, Loy, & Robb-Smith, 2011).

Early editions of the *ICD* were developed for the primary purpose of classifying causes of death for statistical and public health purposes. However, with the 1948 publication of *ICD-6*, the scope of the *ICD* expanded to include not only causes of death, for the calculation of mortality statistics, but also health conditions, for the calculation of morbidity statistics (e.g., disease prevalence and incidence). *ICD-6* also marked the introduction of Chapter V on psychological disorders, then called "Mental, Psychoneurotic and Personality Disorders" (Moriyama et al., 2011). The first few versions of this chapter resembled the earlier Kraepelinian and psychoanalytic nomenclatures of psychopathology, and traces of these influences can still be seen today (e.g., use of the term *neurotic* in the *ICD-10*).

When the first edition of the *DSM* was published in 1952, it was simply an American variant of the *ICD-6* section on mental and behavioral disorders (American Psychiatric Association, 2000). Since the advent of these two systems, they have followed roughly similar development trajectories, with varying degrees of coordination and efforts toward "harmonization" over time. *ICD-7, ICD-8,* and *DSM-II* represented significant expansions in content, but only incremental improvements by medical or scientific standards. Over time, the paradigm shifted away from earlier theoretical influences and toward an empirical, reliable, descriptive, and atheoretical classification. These advances were reflected in the narrative descriptions of mental disorders in the *ICD-9* (published 1975) and the explicit diagnostic criteria and multiaxial classification of the *DSM-III, DSM-III-R, DSM-IV,* and *DSM-5* (published in 1980, 1987, 1994, and 2013, respectively).

The *ICD-10* classification of mental and behavioral disorders represented the first major effort toward a globally applicable psychiatric nosology. Following an extensive, internationally collaborative revision effort, separate field trials were conducted for the clinical and research adaptations (Sartorius et al., 1993; Sartorius, Ustün, Korten, Cooper,

& van Drimmelen, 1995), each involving over 11,000 assessments conducted by more than 700 professionals in over 30 countries. The final products were viewed favorably by both clinicians and researchers, and the international usage of the *ICD-10* has since expanded greatly.

Organization and Content of the *ICD-10* Mental and Behavioural Disorders Section

At the time of this writing, the *ICD-11* is expected to be approved by the World Health Assembly in 2017, and proposed revisions are accessible online (WHO, 2014). Nevertheless, this entry provides a general overview of the *ICD-10* in the hope that it will be useful for those who continue to use the *ICD-10*, as well as for the general features retained in the *ICD-11*. For terminological clarity, the name *ICD-10* is used only to refer to the entire classification system (WHO, 1992a); the manuals adapted for mental health service delivery and research are respectively referred to as the *ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (*CDDG*; WHO, 1992b) and *ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research* (*DCR-10*; WHO, 1993). Each of these three classifications is discussed in turn, below.

ICD-10 and the WHO Family of International Classifications

As noted above, the *ICD* is the central classification system within the WHO Family of International Classifications (WHO FIC), which consists of reference, derived, and related classifications (WHO, 2014). The *ICD* is one of three reference classifications, which are the authoritative sources on classifying disease, functional status, and health interventions. Derived classifications are direct adaptations of one or more of the three reference classifications, adapted for specific purposes. For example, the *CDDG* and *DCR-10* both derive from the *ICD-10*. Finally, related classifications are more loosely associated with the entire set of reference classifications, and may be tailored to the needs of particular health services and professions (e.g., primary care, nursing).

Of all the classifications within the WHO FIC, the *ICD* is the oldest, most significant, and most widely used. Though a single classification system, the *ICD-10* publication actually consists of three separate, complementary volumes: (a) the *Tabular List* (WHO, 1992a), which contains the actual *ICD-10* classification; (b) the *Instruction Manual*; and (c) the *Index*. The *ICD-10* classification is divided into 22 chapters—enumerated with Roman numerals I through XXII—each representing a particular category of human diseases, disorders, or health-related conditions. Chapter V (F) contains all of the mental and behavioral disorders.

As with other chapters in the *ICD-10*, Chapter V is subdivided into "blocks" of disorders (see Table 1). However, Chapter V is particularly unique in that it does not just contain diagnoses and codes, as do the rest of the chapters in the *ICD-10*. Rather, given the nature of the diagnoses and the complexity of diagnostic decision making within professional psychology and psychiatry, Chapter V also contains a brief description of each particular disorder. These include characteristic symptoms, common associated features, and other useful information for diagnostic purposes. These descriptions are similar, but not identical, to those contained in the *CDDG* (discussed below).

Within the *ICD-10* nosology, each diagnostic entity corresponds to a unique alphanumeric code. Table 1 displays the codes for each block within Chapter V. These codes are constructed according to a systematic grammar that conveys their placement within the larger *ICD-10* framework, as well as information about clinical presentation. Consider a common diagnosis, F32.01. The "F" indicates that this diagnosis is among the mental or behavioral disorders; "3" denotes the mood (affective) disorders

Table 1 Organization of the *ICD-10* Section on Mental and Behavioural Disorders (Chapter V).

Diagnostic codes	*Disorder block*
F00 – F09	Organic, including symptomatic, mental disorders
F10 – F19	Mental and behavioral disorders due to psychoactive substance use
F20 – F29	Schizophrenia, schizotypal and delusional disorders
F30 – F39	Mood (affective) disorders
F40 – F48	Neurotic, stress – related and somatoform disorders
F50 – F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60 – F69	Disorders of adult personality and behavior
F70 – F79	Mental retardation
F80 – F89	Disorders of psychological development
F90 – F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

Source: WHO 1992b.

block (F30 – F39); "2" indicates this as a depressive episode (F32); and the final two characters convey that it is a mild depressive episode (F32.0) with somatic symptoms (F32.01). An additional benefit of this coding scheme is that it allows health statistics to be calculated at varying degrees of specificity. For example, using the same dataset, an epidemiologist could examine the incidence of alcohol dependence syndrome with current use (F10.24 – F10.26), current abstinence (F10.20 – F10.23), current treatment/supervision (F10.21 – F10.23), or any mental/behavioral disorders due to the use of alcohol (F10) or any psychoactive substance (F10 – F19).

The Clinical Descriptions and Diagnostic Guidelines

As a derived classification, the *ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (*CDDG*, colloquially known as the *Blue Book*; WHO, 1992b) contains even more information beyond basic labels, codes, and definitions provided in the *ICD-10*. This detailed adaptation of Chapter V (F) is "intended for general clinical, educational and service use" (WHO, 1992b, p. 1).

The *CDDG* contains two central components for each diagnostic entity: (a) clinical descriptions, which detail primary symptoms and common associated features; and (b) diagnostic guidelines, which indicate the number and type of symptoms that would typically be sufficient for a confident diagnosis. Importantly, these

> guidelines are worded so that a degree of flexibility is retained for diagnostic decisions in clinical work, particularly in the situation where provisional diagnosis may have to be made before the clinical picture is entirely clear or information is complete. (WHO, 1992b, p. 1)

This ambiguity affords the diagnostician the use of clinical judgment and flexibility in cases where distress and impairment indicate the need for a diagnosis, but the clinical presentation does not clearly or completely correspond to a single diagnostic category.

Underlying the descriptions and guidelines for each particular disorder is the central question of how to define a mental/behavioral disorder. The *CDDG* uses the term "disorder" (and *avoids* terms such as "disease" and "illness") to "imply the existence of a clinically recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included … " (WHO, 1992b, p. 5).

At this point, a diagnostic example may be illustrative. Conduct disorders (F91), are characterized as "a repetitive and persistent pattern of dissocial, aggressive, and defiant conduct …" which "… should amount to major violations of age-appropriate social expectations, and is therefore more severe than ordinary mischief" (WHO, 1992b, p. 266). Diagnostic guidelines articulate these principles more concretely and prescriptively, while still maintaining a degree of flexibility:

> Judgments concerning the presence of conduct disorder should take into account the child's developmental level. Temper tantrums, for example, are a normal part of a 3-year-old's development and their mere presence would not be grounds for diagnosis … Examples of the behaviours on which the diagnosis is based include the following: excessive levels of fighting or bullying; cruelty to animals or other people; severe destructiveness to property; firesetting; stealing; repeated lying; truancy from school and running away from home … (WHO, 1992b, pp. 266–267)

Additional guidelines are provided with respect to frequency, exclusion criteria, duration, and differential diagnosis. Again, these are general recommendations rather than strict requirements.

While F91 can be coded as a singular disorder for some purposes, it does not represent a specific diagnosis. Diagnoses are typically subdivided into further specificity, which is provided by a fourth (or fifth) character in the code. For F91, these include: (a) F91.0 Conduct disorder confined to the family context; (b) F91.1 Unsocialized conduct disorder; (c) F91.2 Socialized conduct disorder; (d) F91.3 Oppositional defiant disorder; (e) F91.8 Other conduct disorders; and (f) F91.9 Conduct disorder, unspecified. The last two of these categories highlight a unique feature of the *ICD-10* system. For many diagnostic categories there is an "unspecified" (F–.9) and an "other" (F–.8) option. Generally, the four-character "unspecified" diagnosis refers to cases that meet criteria for the three-character diagnosis, but have not been specified or do not meet criteria for a particular three-character subtype. "Other" diagnoses afford the diagnostician more clinical judgment and flexibility in making diagnoses that generally fit within a higher-order category, but do not clearly meet all the diagnostic guidelines (WHO, 1992b).

The Diagnostic Criteria for Research

Just as the *CDDG* were created for clinical purposes, the *ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research* (*DCR-10* or the "Green Book"; WHO, 1993) were developed specifically for research on psychological disorders. Accordingly, the *DCR-10* offers the following caveat:

> Although completely compatible with both *CDDG* and Chapter V(F) of *ICD-10*, the *DCR-10* have a different style and lay-out. It is not designed to be used alone, and researchers should therefore make themselves familiar with the *CDDG*. *DCR-10* does not contain the descriptions of the clinical concepts upon which the research criteria are based, or any comments on commonly associated features which, although not essential for diagnosis, may well be relevant for both clinicians and researchers. (WHO, 1993, p. 1).

The most striking difference between the *CDDG* and *DCR-10* is indeed the difference between criteria and guidelines. "Like other published diagnostic criteria, the criteria of the *DCR-10* are deliberately restrictive: their use allows the selection of groups of individuals whose symptoms and other characteristics resemble each other in clearly stated ways" (WHO, 1993, p. 1). This highly specified method of operationalizing diagnostic entities is useful for many (though not all) kinds of clinical research, particularly when the focus of investigation involves "pure" diagnostic entities, as is often the case in early stages of clinical trials of psychopharmacological or psychological interventions. A related feature of these criteria, unique to the *DCR-10*, is that there is "no requirement for extensive rules on mutual exclusions and co-morbidity in a set of diagnostic criteria, since different research

projects have varied requirements for these, depending on their objectives" (WHO, 1993, p. 2).

Of course, as many researchers have cautioned (and as noted in the *DCR-10*), the use of strict diagnostic guidelines for research purposes can produce the (sometimes) unfortunate result of homogeneous clinical samples. This limits the generalizability of research findings to larger, "real-world" populations, which often include a greater diversity of symptom presentation, severity, comorbidities, and service utilization. In other words, the familiar tension between internal and external validity in clinical research is reflected by differences between the *DCR-10* and *CDDG,* respectively.

To continue with the example of conduct disorders, *DCR-10* begins with a list of 24 possible symptoms of conduct problems. Drawing upon these symptoms, specific conduct disorder diagnoses can be made according to their criteria. For example, a diagnosis of F91.2 Socialized conduct disorder requires: (a) the general criterion for conduct disorder (F91) must be met; (b) presence of three of more symptoms from the criterion list above, of which at least three must be from items 9–24; (c) at least one of the symptoms from items 9–24 must have been present for at least six months; (d) conduct disturbance includes settings outside the home or family context; and (e) peer relationships within normal limits (WHO, 1993). Note that these criteria bear a *substantive* resemblance to the *CDDG* guidelines, and a *structural* resemblance to *DSM-5* criteria.

Other *ICD* and FIC Materials

To aid in the application of the *DCR-10* to international psychiatric and epidemiological research investigations, the WHO developed the Composite International Diagnostic Interview (CIDI; Robins et al., 1988) to correspond with the *ICD* and *DSM*. This instrument has since been updated several times and into multiple adaptations, including computerized interviews. The CIDI will continue to serve as a useful measurement tool with the publication of the *ICD-11*.

Additional classification materials derived from the *ICD* and the WHO FIC may be of interest to psychological scientists and practitioners. These include the *ICD-10 Chapter V Primary Care Version* (WHO, 1996), which may be described as an abbreviated version of the *CDDG* intended for use among health-care providers who are not mental-health specialists. Additionally, many national adaptations of the *ICD* have been developed to suit the unique needs and purposes for which the *ICD* is utilized within particular countries. For example, within the United States, the National Center for Health Statistics, a branch of the Centers for Disease Control and Prevention (CDC), developed and maintains a *clinical modification* of the ninth edition (*ICD-9-CM*) for current use within United States health care. The *ICD-10-CM* has also been developed, but has not yet been implemented (Centers for Disease Control and Prevention: National Center for Health Statistics, 2014).

Comparison of the *ICD* and *DSM*

Readers unfamiliar with the *ICD* may find it instructive to conceptualize the *ICD-10* classifications of mental and behavioral disorders (i.e., Chapter V, *CDDG*, and *DCR-10*) as rough parallels to *DSM*. The two are generally similar in content and function, but with many significant differences. To begin, several differences are associated with the professional, national, and organizational backgrounds behind each manual. The *ICD* is published and maintained by WHO, a global, multidisciplinary, public health organization. By contrast, the *DSM* is published by APA, an American national professional association of psychiatrists. Reflecting these organizational differences, the *ICD* was developed with the explicit intention of optimizing utility as an *international* classification, whereas the *DSM* was developed primarily based upon North American clinical experience and research, and therefore may have limited usage in non-Western

cultures or developing nations. Similarly, in accordance with the public health mission of WHO, *ICD-10* has been made available in over 40 languages, at reduced cost to developing nations, and in various formats, including CD-ROM, text publications, and free online resources (WHO, 2014). By contrast, *DSM* is a for-profit publication, a primary source of revenue for APA, and has fewer adaptations and translations.

In terms of structure and content, both manuals generally contain similar diagnostic constructs, often using identical or very similar terminology. Indeed, in order to obtain public or private reimbursement, every *DSM* diagnosis made in the U.S. health-care system, as well as several other countries, must first be translated into *ICD-10* codes via electronic or manual "crosswalks." But while every diagnosis in the *DSM* may have a parallel in the *ICD*, these codes do not necessarily convey equivalent information. Differences exist on various levels, from terminology, to diagnostic criteria/guidelines, to rules about comorbid diagnoses. To continue with the foregoing example, *DSM-5* identifies conduct disorder and ODD as two separate diagnostic categories, whereas the *ICD-10* includes ODD as one of four different conduct disorder diagnoses.[1] Thus, a *DSM-5* diagnosis of ODD has a similar counterpart in *ICD-10*, but *DSM-5* conduct disorder could translate to one of many different types of *ICD-10* conduct disorders (e.g., socialized, unsocialized, confined to the family context).

Perhaps the most significant difference between the two systems is that the clinical applications of the *ICD-10* contain flexible diagnostic guidelines, whereas the *DSM-5* contains strict diagnostic criteria with thresholds of necessary and sufficient conditions for diagnoses. That is, unlike the *ICD*, *DSM* uses the same diagnostic methods for both clinical and research purposes.

[1]At the time of this writing, *ICD-11* proposals formulate conduct disorder and ODD as separate diagnostic categories, with conduct disorder no longer subdivided into socialized, unsocialized, ODD, and confined to the family context.

Finally, compared with the 362-page *ICD-10 CDDG*, the 947-page *DSM-5* contains a greater breadth and depth of information associated with each disorder, including associated features, developmental course, and differential diagnosis. In this manner, it is effectively both a diagnostic classification system and an authoritative "textbook" on mental disorders. By contrast, in order to attain optimal clinical utility, the *CDDG* was developed to contain only the information necessary to guide the clinician to the correct diagnosis. Thus, the *CDDG* is not an exhaustive compendium of current knowledge in psychiatry, but rather, "simply a set of symptoms and comments that have been agreed, by a large number of advisors and consultants in many different countries, to be a reasonable basis for defining the limits of categories in the classification of mental disorders" (WHO, 1992b, p. 2).

Current Status and Future Directions of the *ICD*

If the *ICD* is indeed a "global" standard, this universality is not reflected by its usage among mental-health professionals in the United States. Internationally, however, the picture is very different. A recent survey of 4,887 psychiatrists in 44 countries found that, among those who regularly used a diagnostic classification system (79% of the total sample), 70% primarily used the *ICD-10* and 23% used the *DSM-IV*. But among the U.S. psychiatrists in that sample, only 1% used the *ICD-10* (Reed, Correia, Esparza, Saxena, & Maj, 2011). The primary explanation for this finding is that, within American psychology and psychiatry, science and practice have developed largely in the tradition of *DSM*. Thus, American clinical psychologists are often unfamiliar with the *ICD*, and its functionality within U.S. mental health care is currently limited to that of a coding, billing, and statistical mechanism (Reed, 2010).

The dominance of *DSM* in U.S. mental health care is therefore not solely attributable to academic, clinical, and research tradition, but

also due to larger, systemic barriers within the health care system.

Beyond the United States, the international mental-health community has increasingly used the *ICD* over the last several decades. This trend appears to be less clear within psychology than in psychiatry, perhaps due to the variability in the status, prevalence, and roles of psychologists around the world. While psychology's history is entrenched in U.S. and Western traditions, the science and practice of psychology are rapidly becoming global endeavors. Additionally, with the publication of each subsequent edition, *DSM* and *ICD* have moved toward greater harmonization, while also retaining some differences. Both systems are useful tools for myriad purposes related to the diagnosis and treatment of mental illness.

ICD-11 Development

The *ICD-10*, which has been the focal point of much of this entry, is to be supplanted by the *ICD-11* within the next few years. Unfortunately, the timing of this publication is premature to allow for a concrete discussion of the content and structure of *ICD-11*, as the proposed revisions are still subject to change. However, the development process behind the *ICD-11* merits examination in its own right.

The ongoing *ICD* revision efforts have been extensive, both for the overall system, and particularly for the section on mental and behavioral disorders. This process has involved global, multidisciplinary, and multilingual collaboration, with representation from the many professions, organizations, and WHO member countries that use the *ICD*. Early in the revision process, WHO articulated its priorities, methods, and conceptual framework for developing the next classification of mental and behavioral disorders (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011; Reed, 2010). Among their priorities, the highest has been to help reduce the global disease burden by improving the clinical utility of the *ICD* in mental health care. In order to achieve this goal, WHO has formed expert work groups, conducted systematic literature reviews, and executed several formative research studies including global surveys of practicing psychologists and psychiatrists, as well as two investigations of how clinicians view relationships among disorders. The goal of these early research projects has been to allow the views, experiences, and practices of clinicians to help guide decisions in revising the *ICD*, so as to facilitate improved clinical utility (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011; Reed, 2010).

Currently, WHO is finalizing the second (beta) draft of the *ICD-11* categories, which are available for viewing online (WHO, 2014). This is the beginning of a public review and comment period, during which interested professionals and other individuals may make comments and proposals to be taken into consideration by the *ICD-11* work groups. Additionally, mental health professionals may volunteer to participate in two different kinds of field trials. First, online field trials will use clinical vignettes to test the utility of revisions made to the *ICD-11* diagnostic guidelines. Second, later versions of the proposed *ICD-11* materials will be tested through international field trials involving "real-world" mental health professionals, patients, and facilities. According to the current timeline, this process will conclude when the *ICD-11* is presented to the World Health Assembly in 2017 (WHO, 2014). From that point forward, the task before the WHO will be to disseminate, implement, and maintain this next generation of diagnostic classification materials among the global mental health community.

Numerous issues remain unresolved for the enterprise of diagnostic classification, including questions related to dimensional classification, developmental variability, comorbidity, functional status, personality, and particular disorders and symptoms. However, while psychology's "gold standard" of biopsychosocial validity continues to elude

present efforts at diagnostic classification, it is hoped that the *ICD-11* will achieve significant improvements in clinical utility. As noted in *CDDG*, "a classification is a way of seeing the world at a point in time" (WHO, 1992b, p. vii). With future editions of the *ICD*, WHO aims to improve not only the accuracy and clarity of that picture but also the degree to which international clinicians can make sense of it and apply it effectively in clinical practice.

SEE ALSO: Approaches to Diagnostic Validity; Classification of Disorders versus Individuals; Clinical Utility; Cross-Cultural Issues in Assessment; Definition of Mental Disorder; Dimensional versus Categorical Models of Psychopathology; *DSM-IV*; *DSM-5*; Medical Model of Mental Disorders

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