

EDITORIAL

## In defence of international classification<sup>1</sup>

The chapter on mental disease in the eighth revision of the International Classification of Diseases (ICD-8) was internationally accepted in about 1970. The main reason for the previous reluctance to accept international standards had been the prevailing national discrepancies in diagnostic practice. In Norway and Denmark, where the Kraepelinian nosology was traditional, a need was felt for a third category of functional psychoses ('reactive' or 'psychogenic') in addition to schizophrenia and manic-depressive disorder. More than 42% of first admissions to Norwegian psychiatric hospitals were given this diagnosis in 1965, and in Denmark the comparable figure for first admissions in 1965–6 was 39%. In France intermediate categories of functional psychoses were introduced in the nineteenth century. In Sweden, the USA, the USSR and the UK, however, psychiatrists felt no need for such categories, since they employed either an extremely wide concept of schizophrenia (USA, USSR) or of affective disorder (UK), while in Sweden more than 60% of first admissions in 1962–4 were classified as 'non-psychotic'.

In ICD-8 the World Health Organization proposed a change in diagnostic practice by reserving the 3-digit category 298 for the 'intermediate' (other) psychoses, and by introducing three new subgroups of schizophrenia which, by definition, had a favourable outcome (295.4, 295.5, 295.7). It is therefore of some interest to determine whether there is now a greater uniformity in diagnostic practice. Information on first admissions to psychiatric hospitals by diagnosis is available from several countries: Denmark, Norway, England and Wales, France, Poland, Australia (the province of Victoria), and the USA. The proportion of 'intermediate' psychoses ranged from 8.3% (Australia), 11.8% (USA) to 36.8% in Denmark, where admissions classified as schizophrenia amounted to 7.4%, as compared with 11.5% in England and Wales and 46.6% in the USA. Affective disorder was diagnosed in only 6.3% of cases in Norway, compared with 37.1% in the USA and 42.5% in England and Wales, where 'depressions not elsewhere classified' were included in this category. The proportion of non-psychotic admissions ranged from less than 5% (USA) to more than 50% (Norway). The discrepancy in diagnostic distribution is therefore more or less the same as before the introduction of the ICD-8. In countries with a wide concept of schizophrenia the figures for this diagnosis were unchanged (USA); in Norway, with its very narrow concept of the disorder, there was an even further reduction in admissions classified as schizophrenia. The three new subgroups of schizophrenia were used in only 1.2% of cases.

In England and Wales the proportion of affective disorder, including 'depressions not elsewhere classified', has remained high and did not change in 1970–7. In Norway, furthermore, there has been not only a flight from the two Kraepelinian disease entities, now diagnosed in only 10% of admissions, but also from the use of the term 'psychosis'; for there is now a predominance of non-psychotic admissions. This change might have resulted from a failure to have eliminated the social stigma attached to the notion of psychosis. Psychiatrists prefer a diagnosis which implies a favourable outcome, and non-psychotic depression (300.4) has become the most common diagnosis (Saugstad & Ødegård, 1980, 1983). This preference for depression as the least stigmatizing of mental disorders is also characteristic of England and Wales, where nearly two-thirds of first admissions are classified as non-psychotic depressions or 'depressions not elsewhere classified'. This trend goes back to Aubrey Lewis' influential paper of 1934, establishing the concept of affective disorder which included those depressive psychoses classified as 'reactive or psychogenic' in Norway and Denmark. This category also includes cases which in the USA would have been labelled as schizophrenic or schizoaffective, as is evident from Kantor & Glassman's (1977) re-examination of Lewis' 61 original case reports. The persistent predominance of schizophrenia (46.6%) in the USA

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is taken to indicate that the social stigma attached to the term psychosis, and more particularly to schizophrenia, is apparently less important. The Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-III) appears to have replaced the ICD as the American national classificatory system, and it remains to be seen whether the considerably narrowed concept of schizophrenia will result in fewer admissions with this diagnosis.

On the whole, neither the new concept of functional psychosis nor the three new subgroups of schizophrenia with a favourable outcome have been widely adopted. The discrepancy in diagnostic distribution is striking and has remained more or less unchanged since 1970. These fundamental differences in the diagnostic distributions reported from countries with similar nosological concepts cannot be explained satisfactorily as a variation in psychiatric morbidity; they must result from differences in diagnostic practice. The general reluctance to adhere to international diagnostic standards was seemingly overcome when the ICD-8 was universally accepted, but the statistics indicate the persistence of national differences and the last ten years have witnessed the development of a multitude of new national and local diagnostic and classificatory systems which create additional problems. For example, the Research Diagnostic Criteria have been used in the USA, and CATEGO and the Index of Definition (ID) have been used in Britain (Wing *et al.* 1974). Several of these systems were constructed to serve as guides for less experienced psychiatrists to arrive at a reliable diagnosis. Specific operational criteria have been introduced as well as multi-axial systems. In these so-called atheoretical systems, however, the fundamentals of psychopathology are frequently disregarded and there is a dissolution of classical disease entities and syndromes (Berner & Küfferle, 1982). Because of this atheoretical approach, the underlying concepts differ from one classificatory system to another. This is evident from the alarming lack of consensus in diagnosis between the British and American systems, as verified by Dean *et al.* (1983): in only 16.7% of cases of anxiety and in 56% of depressions was there agreement on diagnostic labelling. Further, the proportion of schizophrenics has been found to vary from 3% to 38% within the same sample, depending upon the diagnostic 'system' chosen (Brockington *et al.* 1978). According to Kendell (1982), the various operational criteria have actually decreased international agreement. The average K-value of the concordance between each pair of nine operational definitions of schizophrenia varied from 0.41 to as little as 0.14, values lower than the corresponding figures for the reliability of psychiatric diagnosis in the 1960s, before the operational definitions were introduced'.

The replacement in the USA of the ICD by a local classification (DSM-III) is a serious move, as it could further aggravate the reluctance to accept international diagnostic standards. We need to preserve the ICD as the official international classificatory system in psychiatry. More information is obviously needed about the ICD, its concepts as well as its practical usage, for it has already been shown how more information can lead to a significant reduction in certain unspecific categories (Zigmond & Sims, 1983). The use of the ICD does not interfere with the development of local, more detailed systems of classification for research and other purposes, but without an internationally accepted psychiatric classification we are back in the state described by Renaudin (1856, p. 341): 'we now see anarchy in the field of classification threatening to split our ranks and robbing us of the victories of our predecessors'.

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## REFERENCES

- Berner, P. & Küfferle, K. (1982). British phenomenological and psychopathological concepts: a comparative review. *British Journal of Psychiatry* **140**, 558–565.
- Brockington, I. F., Kendell, R. E. & Leff, J. P. (1978). Definitions of schizophrenia: concordance and prediction of outcome. *Psychological Medicine* **8**, 387–398.
- Dean, C., Surtee, P. G. & Sashidharan, S. P. (1983). Comparison of research diagnostic systems in an Edinburgh community sample. *British Journal of Psychiatry* **142**, 247–256.
- Kantor, S. J. & Glassman, A. H. (1977). Delusional depressions: natural history and response to treatment. *British Journal of Psychiatry* **131**, 351–360.
- Kendell, R. E. (1982). The choice of diagnostic criteria for biological research. *Archives of General Psychiatry* **39**, 1334–1339.
- Lewis, A. J. (1934). Melancholia: clinical survey of depressed states. *Journal of Mental Science* **80**, 277–378.
- Renaudin, P. (1856). Recherches statistiques relative à l'aliénation mentale. *Annales Médico-Psychologiques* **339–360**.
- Saugstad, L. & Ødegård, Ø. (1980). Ingen internasjonal tilnærming etter 10 år med den internasjonale diagnoseliste ICD-8. *Nordisk Psykiatrisk Tidsskrift* **34**, 455–464.
- Saugstad, L. & Ødegård, Ø. (1983). Persistent discrepancy in international diagnostic practice since 1970. *Acta Psychiatrica Scandinavica* **68**, 501–510.
- Wing, J. K., Cooper, J. E. & Sartorius, N. (1974). *Measurement and Classification of Psychiatric Symptoms*. Cambridge University Press: Cambridge.
- Zigmond, A. S. & Sims, A. C. P. (1983). The effect of the use of the International Classification of Diseases (9th revision) upon hospital in-patient diagnosis. *British Journal of Psychiatry* **142**, 409–413.