УДК: 616.89-008
DOI: https://doi.org/10.17816/nb108994

МКБ-11 (психиатрический раздел): кто лучше диагностирует — тот лучше лечит?

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АННОТАЦИЯ

В статье анализируются причины противостояния многих российских психиатров внедрению новой международной классификации психических и поведенческих расстройств (МКБ-11). Высказывается мнение о том, что увеличение эффективности терапии от МКБ-9 к МКБ-10 в мировой психиатрии связано не столько с переходом на синдромальную (анозологическую) оценку клинических феноменов, сколько по причине широкого применения современных психофармакологических препаратов и внедрения принципов доказательной медицины, которые в отечественной психиатрии также подвергают критике. Утверждается, что два важных аспекта психиатрии — диагностика и терапия — практически друг от друга не зависят, и весь спор о неприятии или приятии новой классификации (МКБ-11) не имеет никакого отношения к эффективности терапии.

Ключевые слова: *МКБ-11, психиатрическая диагностика, психофармакотерапия, доказательная медицина*.

Для цитирования:
Менделевич В.Д. МКБ-11 (психиатрический раздел): кто лучше диагностирует — тот лучше лечит? // Неврологический вестник. 2022. Т. LIV. Вып. 3. С. 5–10. DOI: https://doi.org/10.17816/nb108994.

Рукопись получена: 25.06.2022 **Рукопись одобрена**: 21.07.2022 **Опубликована**: 28.10.2022

DOI: https://doi.org/10.17816/nb108994

ICD-11 (psychiatric section): who diagnoses better treats better?

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ABSTRACT

The article analyzes the reasons for the opposition of a significant number of Russian psychiatrists to the introduction of a new international classification of mental and behavioral disorders (ICD-11). An opinion is expressed that the increase in the effectiveness of therapy from ICD-9 to ICD-10 in world psychiatry is associated not so much with the transition to syndromic (anosological) assessment of clinical phenomena, but because of the widespread use of modern psychopharmacological drugs and the introduction of evidence-based medicine principles, which in domestic psychiatry are also criticized. It is argued that two important aspects of psychiatry — diagnosis and therapy — are practically independent of each other, and the entire dispute about rejection or acceptance of the new classification (ICD-11) has nothing to do with the effectiveness of therapy.

Keywords: *ICD-11, psychiatric diagnostics, psychopharmacotherapy, evidence-based medicine*.

For citation:
Mendelevich VD. ICD-11 (psychiatric section): who diagnoses better — treats better? *Neurology Bulletin*. 2022; LIV(3):5–10. DOI: https://doi.org/10.17816/nb108994.

Received: 25.06.2022 **Accepted**: 21.07.2022 **Published**: 28.10.2022

Although the World Health Organization adopted and approved the new International Classification of Diseases 11th Revision (ICD-11) and its psychiatric section [1], a robust discussion continues in the Russian psychiatric community. Many researchers do not like the diagnostic criteria for some of the mental and behavioral disorders included in the new classification [2]. Some experts are dissatisfied with the abandonment of traditional forms of schizophrenia, i.e., paranoid, catatonic, hebephrenic, and simple, others are dissatisfied with the elimination of Kurt Schneider's first-rank diagnostic symptoms for schizophrenia, still, others do not like confusion with the boundaries of bipolar disorder and the possibility of inclusion of paranoid disorders and hallucinations in its clinical presentation, and some specialists are dissatisfied with the elimination of all forms of personality disorders (schizoid, hysterical, paranoid, etc.) with a focus solely on the severity of behavioral pathology. Many Russian experts do not agree with the transfer of transsexualism from the psychiatric section to a special section [3].

It is fair to say that the classification of things in the world is the main cognitive tendency of humans. Natural classes are best organized around prototypes or typical examples. In a good class, all members should be homogeneous, and all classes should be clearly separated. Unfortunately, most psychiatric diagnoses do not meet this definition.

Most diagnostic categories contain prototype diagnostic categories that have typical clinical characteristics of that category; however, some patients do not correspond exactly to this category. There are also blurred boundaries between diagnostic categories. Blurred boundaries exist not only between diagnostic categories but also between normal and pathological entities. Most mental disorders come within the definition of a syndrome in general medicine. Each psychiatric diagnostic category includes a symptom cluster that is a prototype or a good model for that diagnosis [4].

The main reproach of Russian psychiatrists against the new classification of mental and behavioral disorders is that, according to critics, the clinical psychopathological approach traditional for Russian psychiatry, which is replaced by psychometry, is being lost and forgotten. This will lead to the degradation of psychiatry training and the collapse of the profession. Specifically, with new diagnostic approaches, the efficiency of the treatment of mental and behavioral disorders will decrease.

Moreover, they state that "mental health professionals from the Russian Federation played a significant role in many key stages in the development of the ICD-11. Russian specialists were not only part of the ICD-11 scientific group that administered the ICD-11 field trial process, but thousands of Russian clinicians working in various contexts throughout the Russian Federation participated in the large-scale WHO global field research program" [5–8].

In connection with the obvious opposition to the innovations presented in ICD-11, the earlier proposal to develop a national classification with a focus on Russian traditions and scientific views [9, 10] became relevant again, and it is proposed to consider it again. In addition, studies have shown that ICD-10 had nearly 1.5 times more supporters than ICD-11, and only a few percent of Russian specialists are ready to support the Russian classification [8].

Surprisingly, only 60.8% [8] of specialists indicated the importance of classification for choosing the optimal strategy and approach of treatment, that is, nearly half of the Russian psychiatrists do not believe that diagnostics and therapy are causally related. Perhaps, this is due to the rather skeptical attitude of Russian psychiatrists toward evidence-based medicine, which underlies the choice of effective and safe treatment. On the contrary, this may be due to the widespread phenomenon of diagnostic and therapeutic relativism, which is understood as the doctor's position, according to which making an accurate "nosological" diagnosis according to the ICD (DSM) is not fundamental and significant for making a therapeutic decision ("treatment of the syndrome") [11, 12]. The determination of the level of psychopathological syndrome/phenomenon and the presence of a subjective patient request are significant.

Thus, the discussion about the new ICD as a classification that breaks the traditional nosological foundations is not about the development of reasonable approaches to therapy. Given that the nosological principle of diagnostics, which involves the development of etiopathogenetic approaches to therapy, was rejected by modern psychiatry even when the ICD-10 was adopted in 1994, the current

opposition to the new classification looks like it is divorced from clinical practice. Moreover, under the ICD-9 conditions, which many Russian psychiatrists consider the most reasonable, no etiopathogenetic psychopharmacotherapy exists because this process was never discovered and proven in most mental illnesses (disorders).

If we compare the efficiency of therapy for mental and behavioral disorders between ICD-9 and ICD-10, we can assume that it has increased, however, not so much due to the transition to syndromic (anosological) assessment of clinical phenomena, but due to the introduction and widespread use of modern psychopharmacological drugs (antidepressants, atypical antipsychotics, and others) and principles of evidence-based medicine. Consequently, two important aspects of psychiatry, diagnostics and therapy, are practically independent of each other, and the entire dispute about rejection or acceptance of the new ICD-11 classification has nothing to do with the efficiency of therapy. The exceptions are dementia, bipolar affective disorder, and autism spectrum disorders, in which the analysis of the condition goes beyond the usual psychopathological symptomatology.

Nowadays, the criteria for evaluating the efficiency of treatment of mental and behavioral disorders are being actively revised, suggesting a transition from the concepts of cure and remission to the concepts of clinical recovery, symptomatic and functional remission, and even "personal recovery" [13]. The concept of recovery is gaining more and more supporters, namely, personal and social recovery, specifically in schizophrenia, which is understood as the recovery of the following in the patients:

a) A personally meaningful and satisfying life.

b) A real opportunity to make their decisions regarding life goals and treatment.

c) Hope for the future.

d) Feelings of integrity, well-being, and self-respect [14].

The listed characteristics are practically not related to the establishment of a specific psychiatric diagnosis in accordance with any classification. Thus, we have to state that the one who diagnoses mental and behavioral disorders better does not necessarily treat them better (more effectively) [15]. However, the one who achieves better results in the treatment of patients with mental and behavioral pathologies is undoubtedly a more qualified diagnostician.

Accordingly, it is not a case of nosological diagnostics (which has disappeared long ago), but of the ability to determine accurately the psychopathological syndrome and target of therapy. Mosolov drew attention to such a paradox in his report "Problems of classification of psychotic disorders: a conflict between diagnostics and therapy" [16], noting that the imperfection of systematics of bipolar affective disorder and schizophrenia influences directly the treatment of mental disorders.

The conflict of diagnostics and therapy in ICD-11 extends not only to the psychopharmacotherapeutic process but also to the psychotherapeutic one. In the current realities, an effective clinical psychotherapist or psychologist is not someone who chooses a method based on one's priorities, competencies, and predilection (psychoanalyst, gestalt therapist, CBT[1] therapist, and hypnologist), but someone who can go beyond the method he/she practices, define clearly psychopathological targets, and choose a specific approach from the range of psychotherapy that has confirmed its efficiency based on evidence-based studies [17].

From our point of view, any psychiatric classification at the present stage of science development must be approached with critical attitude. Until evidence of the significance of disorders of specific brain or personality mechanisms for the formation of a particular psychopathology is found, any classification will be auxiliary and cannot determine the etiopathogenetic choice of the strategy and approach of therapy.

ДОПОЛНИТЕЛЬНО

Финансирование. Исследование не имело спонсорской поддержки.
Конфликт интересов. Автор заявляет об отсутствии конфликта интересов.

Funding. This publication was not supported by any external sources of funding.
Conflict of interests. The author declare no conflicts of interests.

[1]CBT, cognitive-behavioral therapy.

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