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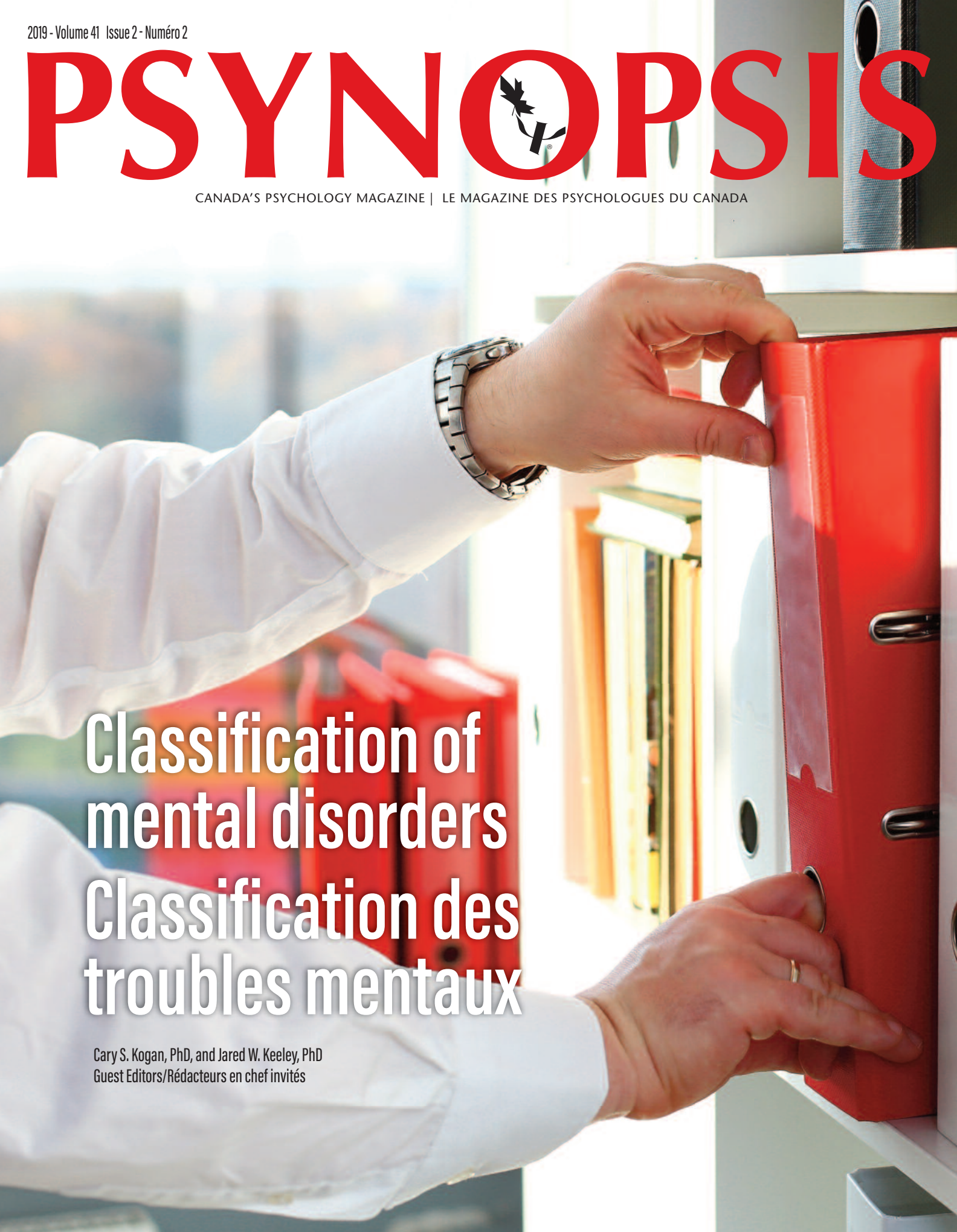

Classification of mental disorders

Classification des troubles mentaux

Cary S. Kogan, PhD, and Jared W. Keeley, PhD
Guest Editors/Rédacteurs en chef invités

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NOTE:

Dear Psynopsis contributors and readers,

We sincerely apologize for our publishing delay, affecting the second and third issues of Psynopsis in 2019. We had some staffing changes in communications, which led to us fall behind. We hope you enjoy this second issue and we thank you for your patience.

Sincerely,
The Psynopsis Editorial Team

Chers collaborateurs et lecteurs de Psynopsis,

Nous nous excusons sincèrement du retard pris dans la publication des deuxième et troisième numéros de Psynopsis en 2019. Nous avons eu des changements de personnel en communications qui ont causé le retard. Nous espérons que vous appréciez ce numéro et nous vous remercions de votre patience.

Cordialement,
L'équipe de rédaction de Psynopsis

Innovations in the classification of mental disorders

Cary S. Kogan, PhD, Professor, School of Psychology, University of Ottawa, and Jared W. Keeley, PhD, Associate Professor, Department of Psychology, Virginia Commonwealth University

Why is the classification and diagnosis of mental disorders important? Some people may take the answer to this question for granted, while others may argue there is no satisfactory answer.

Diagnoses serve various functions. They provide a set of concepts for researchers to investigate and for clinicians to apply. They give stakeholders — clinicians, researchers, teachers, clients, families, politicians, and others — language with which to communicate people's problems. They also provide a starting point for determining treatment or case management by connecting defined constructs to the evidence-base and facilitate bureaucratic procedures, like tracking the number of individuals who need care or mediating payment for services. Nevertheless, there are many perspectives on diagnosis, its role in mental health services, how best to classify disorders systematically, or whether to classify them at all.

One of the first points of contention is whether diagnoses based on nosologies are necessary to fulfill the functions listed above. Clark, Coulombe and Chorney, for example, outline an alternative model, the Choice and Partnership Approach (CAPA). This approach, used by their clinic to treat children, meets the same needs as diagnoses, particularly for clinical care, without relying on traditional classifications of mental disorders to guide their interventions. Although they use a different set of nouns to describe their formulations, CAPA involves a form of diagnosis insofar as it describes client functioning to inform intervention and communicate with children and families. It will be interesting to see if randomized controlled studies comparing CAPA to a traditional 'diagnose and treat' approach support the existing positive client satisfaction data. Similarly, it will be important to establish whether these results generalize to adult patients.

Another important question is whether categorical classification is best. Separate contributions from Vaidyanathan and Collaton discuss alternate dimensional models to current categorical classifications, namely the Hierarchical Taxonomy of Psychopathology (HiTOP) and the National Institute of Mental Health's Research Domain Criteria (RDoC). The authors point out limitations of categorical classifications, including high rates of co-morbidity, arbitrary demarcation of boundaries between normality and pathology, lack of integration of causal mechanisms, and inadequate differentiation of severity. The HiTOP system addresses these concerns through factor analytic techniques that identify transdiagnostic latent variables organized in a hierarchical fashion. The RDoC framework argues for understanding pathology based on discrete brain circuit-behaviour relationships. Vaidyanathan provides a helpful starting point by comparing dimensional classifications to those currently used in clinical practice (i.e., the Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5] and the International Classification of Diseases and Related Health Conditions, 11th edition [ICD-11]), recapitulating the notion that classifications serve clinical versus research purposes differentially. Collaton, on the other hand, raises specific concerns about the RDoC conceptualization of mental illness as prioritizing biomedical constructs over a more inclusive biopsychosocial model. She challenges the premise that mental disorders can be reduced to pathological variations in specific brain-behaviour relationships without integrating socio-cultural factors, which are known to affect behaviour, cognition and emotion.

Although we may well be on the cusp of a classificatory revolution that dispenses with categorical conceptualizations of mental disorders, there are some important caveats. The DSM-5 and the ICD-11 are organized as hierarchical categorical systems in part because they allow mutually exclusive labels for epidemiologic purposes and, in the case of the ICD-11, parity with other health conditions. Furthermore, categorical classifications are better aligned with clinical and policy decisions that are categorical in nature (e.g., to determine eligibility for services). However, it may well be a false dichotomy to pit categorical classifications against dimensional ones — both the DSM-5 and the ICD-11 have incorporated dimensional ratings within categories to better capture the breadth of illness severity. Taillefer, Nolan and Rudnick provide one such example with a cogent illustration of the impact of diagnostic conceptualization on evidence-based treatment selection when the DSM-5 definition of a traumatic event (i.e., Criterion A) is not met but accompanying symptoms warrant clinical attention. Specifically, they

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query the appropriateness of evidence-based treatment for such 'Other Specified Stress- and Trauma-Related Disorders.' Interestingly, the ICD-11 places a greater emphasis on the characteristic constellation of symptoms (re-experiencing, avoidance and persistent perception of heightened threat) following a traumatic event than whether such an event should objectively be counted as a trauma. The latter approach is expected to minimize use of the 'Other Specified' category without compromising integrity of treatment selection.

Another important feature of conducting a psychological diagnosis is the significant role culture can play in the expression and interpretation of symptoms. The DSM-5 includes a cultural formulation section intended to help practitioners begin this conversation with their patients. In contrast, the ICD-11 has purposefully attended to the role of culture throughout its development by including international experts and conducting global field studies. Each diagnostic category in the ICD-11 includes an evidence-based 'Cultural Presentations' section to guide clinicians to make culturally-informed differential diagnoses. Khoury and Ramadan highlight the importance of incorporating culture in the diagnostic process in the specific instance of the Arab region. The authors describe the involvement of researchers, clinicians and patients in the Arab region in adapting the ICD-11 accurately for that context. Their guidance to clinicians is also meaningful in Canada given the increasing number of immigrants and refugees from the Arab region.

Though we may not all agree on why and how to diagnose mental disorders, it is clear that classification of these disorders has undergone an interesting evolution. Denny provides a comprehensive intellectual history of the adoption and use of mental health classifications in Canada as well as an overview of the critical role the Canadian Institute of Health Information (CIHI) plays in working with the provinces to manage health systems data used for research, management and public policy development. And while he notes that the DSM currently dominates clinical use in Canada, treaty agreements with the World Health Organization require health statistics to be reported using ICD codes. As Kogan and Reed point out, whereas previous versions of the DSM aligned with the ICD, the latest version manifests important structural and conceptual differences obviating a simple mapping between the DSM-5 and the ICD-11 diagnostic categories. The authors further describe the multi-stakeholder development and extensive international field testing of the mental health specialist version of the ICD-11, the Clinical Descriptions and Diagnostic Guidelines. They argue that implementing a single classification system published by the world health authority used for all health conditions for both clinical service delivery and gathering health statistics affords significant advantages over using a classification developed for the United States by one professional organization. CIHI is currently evaluating the implementation of the ICD-11 in Canada. The emphasis on incorporating and validating the clinical utility of the ICD-11 is a unique strength of the classification that warrants consideration for its use in clinical practice by Canadian mental health specialists.

Classification systems of psychopathology have evolved significantly since their inception, reflecting the field's increasing understanding of insights from neuroscience, genetics and behavioural science. Each classification system offers a perspective on mental health that is optimized to serve specific purposes. Whereas dimensional classification systems, such as RDoC and HiTOP, elucidate underlying mechanisms of mental illness and are useful tools for research purposes, descriptive phenomenologies such as the DSM-5 and the ICD-11 provide a clinically-useful means of identifying people in need of services and for developing health policy. We encourage clinicians and researchers to learn about the different classification conceptualizations and understand their limits and uses. We believe this will foster a deeper understanding of psychopathology and, importantly, a more comprehensive understanding of how to help reduce the burden of mental illness for our patients.

Dr. Cary Kogan earned his PhD in clinical psychology from McGill University. He is currently Professor of Clinical Psychology in the School of Psychology at the University of Ottawa where he also serves as Director of the Centre for Psychological Services and Research, a community-based mental health training centre. Dr. Kogan teaches at the undergraduate and graduate levels including courses on psychopathology and psychopharmacology. His research interests include classification of psychopathology and translational neuroscience with a special focus on neurodevelopmental disorders. Dr. Kogan is a consultant to the World Health Organization, Department of Mental Health and Substance Abuse, for the revision of the Mental, Behavioural and Neurodevelopmental Disorders chapter of the International Classification of Diseases (ICD). He has contributed to the development, testing, and international implementation of the clinical descriptions and diagnostic guidelines for mental health professionals.

Dr. Jared Keeley earned his PhD in clinical psychology from Auburn University in 2009. He is currently an Associate Professor in the Psychology Department at Virginia Commonwealth University. His primary interest involves the classification of psychopathology, especially concerning mental health professionals' use of the diagnostic system. He has studied cognitive processes involved in clinicians' work, including diagnosis, case conceptualization, and treatment planning. Currently, he is consulting for the World Health Organization on the field trials for the Mental and Behavioural Disorders chapter of the International Classification of Diseases (ICD). He maintains contact with clinical services by engaging in a small private practice and supervising graduate students providing comprehensive assessments and evidence-based therapy. He is also involved in advocating for quality mental health practice in the region, acting as the Continuing Education Director for the Southeastern Psychological Association.

Innovations dans la classification des troubles mentaux

Cary S. Kogan, Ph. D., professeur titulaire, École de psychologie, Université d'Ottawa, et Jared W. Keeley, Ph. D., professeur agrégé, département de psychologie, Virginia Commonwealth University

Quelle importance revêtent la classification et le diagnostic des troubles mentaux? Certaines personnes peuvent tenir pour acquise la réponse à cette question alors que d'autres peuvent soutenir qu'il n'existe pas de réponse satisfaisante.

Les diagnostics remplissent diverses fonctions. Ils fournissent un recueil de concepts que les chercheurs doivent étudier et que les cliniciens doivent appliquer. Ils procurent aux parties intéressées – les cliniciens, les chercheurs, les enseignants, les familles, les politiciens et autres – des éléments de langage pour communiquer des problèmes que peut connaître une personne. Ils donnent également un point de départ pour déterminer un traitement ou pour prendre en charge le cas en reliant les concepts définis aux données probantes. Ils facilitent aussi les procédures bureaucratiques comme exercer une médiation pour le paiement de services ou faire un suivi du nombre de personnes qui ont besoin de soins. Néanmoins, il existe plusieurs points de vue sur le sujet des diagnostics et leurs rôles dans les services de santé mentale et sur la meilleure façon de classer systématiquement les troubles, voire même s'il faut le moindrement les classer.

L'un des premiers éléments de discorde vise à savoir si les diagnostics fondés sur les nosologies sont nécessaires pour assurer les fonctions énumérées précédemment. Clark, Coulombe et Chorney, par exemple, proposent un modèle alternatif, la CAPA, soit l'Approche choix et partenariat (*Choice and Partnership Approach*). Cette approche utilisée pour traiter les enfants dans leur clinique satisfait les mêmes besoins que les diagnostics, en particulier pour les soins cliniques, sans qu'ils aient besoin de recourir aux classifications traditionnelles des troubles mentaux pour guider leurs interventions. Bien qu'ils se servent d'un ensemble différent de mots pour décrire les particularités, la CAPA se sert d'un type de diagnostic dans la mesure où celui-ci décrit le fonctionnement du client afin d'orienter les interventions et facilite la communication avec les enfants et les familles. Il sera intéressant de voir si des études contrôlées aléatoires qui comparent la CAPA à une approche traditionnelle « diagnostic, puis traitement » appuient les données existantes sur la satisfaction positive des clients. De la même façon, il sera important d'établir si ces résultats s'appliquent aux patients adultes.

Une autre question importante est de savoir si la classification catégorique se révèle supérieure. Des rapports de recherche séparés provenant de Vaidyanathan et de Collaton mettent en avant des modèles dimensionnels alternatifs aux classifications catégoriques actuelles, entre autres la taxonomie hiérarchique de la psychopathologie (HiTOP) et le projet RDoC (*Research Domain Criteria*) du NIMH, soit l'institut national de la santé mentale. Les auteurs révèlent les limites des classifications catégoriques, y compris les taux élevés de comorbidité, la démarcation arbitraire des frontières entre la normalité et la pathologie, le manque d'intégration des mécanismes de causalité et la différentiation inadéquate du degré de sévérité. Le système HiTOP prend en compte ces préoccupations au moyen de techniques d'analyse factorielle, lesquelles identifient les variables latentes transdiagnostiques organisées de manière hiérarchique. Le cadre du RDoC, lui, préconise une compréhension de la pathologie fondée sur des relations discrètes entre les circuits cérébraux et les comportements. Vaidyanathan fournit un bon point de départ en comparant les classifications dimensionnelles à celles utilisées actuellement en pratique clinique (c.-à-d. le Manuel statistique et diagnostique des troubles mentaux, 5e édition [DSM-5] et la Classification statistique internationale des maladies et des problèmes de santé connexes, 11e édition [CIM-11]). Vaidyanathan fait un rappel de la notion voulant que les objectifs cliniques et les objectifs de recherche des classifications diffèrent. Collaton, de sa part, soulève des préoccupations particulières concernant la conceptualisation RDoC de la maladie mentale, alors qu'elle s'intéresse en priorité aux constructions biomédicales plutôt qu'au modèle biopsychosocial plus inclusif. Elle remet en question la prémisse voulant que les troubles mentaux puissent être ramenés à des variations pathologiques liées à des relations spécifiques entre les circuits cérébraux et les comportements sans intégrer les facteurs socioculturels, lesquels sont connus pour affecter le comportement, la cognition et l'émotion.

Bien qu'il soit possible que nous nous trouvions à l'aube d'une révolution classificatoire, laquelle se passerait des conceptualisations catégoriques des troubles mentaux, il existe d'importantes lacunes. L'organisation du DSM-5 et de la CIM-11 s'appuie sur des systèmes hiérarchiques catégoriques en partie parce qu'ils permettent des étiquettes mutuellement exclusives pour des fins épidémiologiques et une parité avec d'autres conditions de santé dans le cas de la CIM-11. De plus, les classifications catégoriques sont mieux alignées avec les décisions cliniques et administratives de nature catégorique (par ex., déterminer l'admissibilité à des services). Cependant, le fait d'opposer les classifications catégoriques aux catégorisations dimensionnelles pourrait correspondre à une fausse dichotomie – le DSM-5 et la CIM-11 ont tous les deux incorporé des valeurs dimensionnelles au sein des catégories afin de mieux saisir l'ampleur de la gravité de la maladie. Taillefer, Nolan et Rudnick fournissent un tel exemple avec une illustration convaincante de l'impact de la conceptualisation du diagnostic sur le choix d'un traitement fondé sur des données probantes lorsqu'un événement traumatisant ne cadre pas avec la définition que lui donne le DSM-5 (c.-à-d. le critère A), mais que les symptômes qui l'accompagnent justifient une attention clinique. Plus spécifiquement, ils s'interrogent sur la pertinence d'un traitement fondé sur des données probantes pour ces « Autres troubles spécifiques liés au stress et aux traumatismes ». De façon intéressante, la CIM-11 insiste davantage sur la constellation caractéristique des symptômes (l'impression de revivre, l'évitement et la perception persistante d'une menace accrue) qui surviennent après un événement traumatique, peu importe qu'un tel événement soit considéré objectivement comme un traumatisme. Cette dernière approche minimiserait l'utilisation de la catégorie « Autres troubles spécifiés » sans compromettre l'intégrité du choix du traitement.

Une autre caractéristique importante de la réalisation d'un diagnostic psychologique réside dans le rôle significatif que peut jouer la culture dans l'expression et l'interprétation des symptômes. Le DSM-5 comprend une section sur la formulation culturelle dont l'objectif est d'aider les praticiens à entamer une con-

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versation à ce sujet avec leurs patients. Par opposition, la CIM-11 a délibérément pris soin du rôle de la culture tout au long de son développement en faisant appel à des experts internationaux et en réalisant des études sur le terrain à l'échelle de la planète. Chaque catégorie de diagnostic dans la CIM-11 comprend une section « Présentations culturelles » fondée sur des données probantes visant à orienter les cliniciens afin qu'ils puissent poser des diagnostics différentiels fondés sur la culture. Khoury et Ramadan soulignent l'importance d'incorporer la culture au processus de diagnostic dans le cas particulier de patients du monde arabe. Les auteurs décrivent l'implication des chercheurs, des cliniciens et des patients du monde arabe dans le projet d'adaptation de la CIM-11 pour s'assurer de l'exactitude des renseignements propres à ce contexte. Cette orientation donnée aux cliniciens présente un intérêt pour ceux qui travaillent au Canada en raison du nombre croissant d'immigrants et de réfugiés provenant de cette région du monde.

Bien que de nombreux différends opposent les points de vue sur les raisons pour lesquelles il faut diagnostiquer les troubles mentaux et sur la façon de poser un diagnostic, il est clair que l'évolution de la classification de ces troubles s'est faite de manière intéressante. Denny dresse un historique théorique complet de l'adoption et de l'utilisation des classifications des troubles mentaux au Canada ainsi qu'un portrait de l'important rôle que joue l'Institut canadien d'information sur la santé (ICIS) dans son travail auprès des provinces pour la gestion des données des systèmes de santé et l'utilisation de ces données en recherche, par les systèmes de gestion et pour l'élaboration de politiques publiques. Bien qu'il mentionne que le DSM domine actuellement la pratique clinique au Canada, des obligations découlant des traités avec l'Organisation mondiale de la santé exigent que les statistiques en matière de santé soient déclarées au moyen des codes CIM. Comme le soulignent Kogan et Reed, alors que les versions antérieures du DSM s'alignent sur la CIM, la dernière version présente des différences structurelles et conceptuelles significatives qui empêchent une simple mise en correspondance entre les catégories DSM-5 et CIM-11 de diagnostic. Les auteurs décrivent de façon détaillée le travail d'élaboration et la vaste mise à l'essai à l'échelle internationale, par de nombreuses parties prenantes spécialistes du milieu, de la version de la CIM-11 portant sur les descriptions cliniques et les lignes directrices pour le diagnostic des troubles mentaux. Ils soutiennent que la mise en place du système unique de classification publié par l'autorité mondiale en matière de santé et utilisé pour classer tous les états de santé, autant pour la prestation de services cliniques que pour la collecte de statistiques en matière de santé, présente des avantages significatifs par rapport à l'utilisation du système de classification élaboré par une organisation professionnelle aux États-Unis. L'ICIS procède actuellement à l'évaluation de la mise en place de la CIM-11 au Canada. L'accent mis sur l'intégration et la validation de l'utilité clinique de la CIM-11 correspond à une action unique de la classification qui mérite une considération pour ce qui est de son utilisation par les spécialistes œuvrant dans le domaine de la santé mentale au Canada dans un cadre clinique.

L'importante évolution que les systèmes de classification de la psychopathologie ont connue depuis leur début offre un reflet de l'approfondissement des connaissances reliées aux idées provenant des domaines des neurosciences, de la génétique et de la science du comportement. Chaque système de classification offre un point de vue sur la santé mentale, lequel est optimisé pour servir un objectif précis. Alors que les systèmes de classification dimensionnelle tels le RDoC et le HiTOP font la lumière sur les mécanismes de la maladie mentale et sont des outils utiles pour la recherche, les phénoménologies descriptives telles le DSM-5 et la CIM-11 fournissent un moyen cliniquement utile pour identifier les personnes qui ont besoin de services et élaborer des politiques en matière de santé. Nous encourageons les cliniciens et les chercheurs à en apprendre davantage sur les différentes conceptualisations de la classification, à comprendre leurs limites et à s'informer de leur utilisation. Nous croyons que cela favorisera une meilleure compréhension de la psychopathologie et permettra une compréhension plus complète de la façon d'aider à réduire le fardeau de la maladie mentale chez nos patients.

Dr Cary Kogan a obtenu son doctorat en psychologie clinique de l'Université McGill. À l'heure actuelle, il est professeur de psychologie clinique à l'École de psychologie à l'Université d'Ottawa, où il occupe également le poste de directeur du Centre de recherche et des services psychologiques, un centre de formation en santé mentale axée sur la communauté. Dr Kogan enseigne plusieurs matières, dont des cours en psychopathologie et en psychopharmacologie aux étudiants de premier cycle et aux cycles supérieurs. Ses intérêts de recherche comprennent la classification de la psychopathologie et de la neuroscience translationnelle avec un intérêt particulier pour les troubles neurodéveloppementaux. Dr Kogan travaille également comme consultant auprès de l'Organisation mondiale de la santé, dans le domaine de la santé mentale et des abus des substances psychoactives, pour le projet de révision du chapitre sur les troubles mentaux, comportementaux et neurodéveloppementaux de la Classification internationale des maladies (CIM). Il a contribué à l'élaboration et à la mise à l'essai des descriptions cliniques et des lignes directrices en matière de diagnostic et à leur mise en œuvre à l'échelle internationale.

Dr Jared Keeley a obtenu son doctorat en psychologie clinique de la Auburn University en 2009. Il est actuellement professeur agrégé au département de psychologie à la Virginia Commonwealth University. Il s'intéresse principalement à la classification de la psychopathologie, particulièrement en ce qui concerne l'utilisation du système diagnostique par les professionnels du domaine de la santé mentale. Il a étudié les processus cognitifs liés au travail des cliniciens, y compris le diagnostic, la conceptualisation des cas et la planification des traitements. À l'heure actuelle, il travaille comme consultant pour l'Organisation mondiale de la santé dans le cadre des essais sur le terrain pour le chapitre portant sur les troubles mentaux et de comportement de la Classification internationale des maladies (CIM). Il demeure actif dans le domaine des services cliniques en tenant un petit cabinet privé et en supervisant des étudiants aux cycles supérieurs alors que ces derniers réalisent des évaluations complètes et offrent des thérapies fondées sur des données probantes. Il milite également dans sa région pour des pratiques de qualité en matière de santé mentale alors qu'il occupe le poste de directeur de l'éducation permanente au sein de l'association SPA, soit la Southeastern Psychological Association.

Building a model of clinical care around clients' best hopes for change and desired outcomes:

Where are you now, where do you want to go, and how do we get there?

Sharon E. Clark, PhD, R. Psych., Advance Practice Lead: CAPA, IWK Health Centre; J. Aimée Coulombe, PhD, R. Psych., Clinical Practice Lead, Community Mental Health and Addictions, IWK Health Centre; and Jill MacLaren Chorney, PhD, R. Psych., Advance Practice Lead: Behavior Change, IWK Health Centre

In our service, we are moving away from diagnosis- and treatment-centered care paths (i.e., diagnosis X leads to treatment X) and towards a more client-centered, goal-oriented model based on the Choice and Partnership Approach (CAPA;[1,2] see also[3,4]). CAPA aims to improve the experience of care through shared decision-making, genuine engagement, and placing clients' self-identified needs at the heart of service delivery. It has been implemented in multiple countries in both child and adult services.

Prior to implementing CAPA, wait times for service were long as families waited for a formal diagnostic assessment prior to intervention. Although a diagnosis provided a "label" and a recommended treatment path, families told us they were tired of feeling "labelled," answering the same assessment-based questions at multiple points, and waiting for treatment to start. When provided with a diagnosis, families often had a limited understanding of how these labels translated to making meaningful changes in their lives. We found that when families were assigned to treatment paths based on diagnoses, they often carried expectations that clinicians would "fix" the problems; they frequently missed appointments, and had poor "compliance." We were seeing evidence of disempowerment and disengagement. We wanted to make a change that would lead to greater client engagement and seek to empower families early on; CAPA was an excellent fit for this purpose. Indeed, when clients are actively involved in decisions about their health, there is increased engagement with interventions and maintenance of health behaviour change over time.[5]

CAPA moves away from the necessity of a full diagnostic evaluation and prioritizes the facilitation of change from the first appointment (now called a "Choice appointment"). Rather than investing the majority of the first appointment in collecting enough information about presenting concerns to arrive at a diagnosis, report, and treatment recommendations, we invest time in building a shared understanding of families' goals, what it will take to get there, and how presenting concerns and related barriers stand in the way. Choice clinicians use their knowledge of assessment, diagnosis, and evidence-based treatments throughout the appointment, determining the relevance of presenting concerns to each family member, whose readi-

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ness for any proposed change is a key determinant of treatment success, and discussing likely outcomes of different change pathways so that informed decisions can be made. We do this in the room with families, often with the assistance of a visual tool, such as a whiteboard, to increase transparency and decrease misunderstandings. This process results in the creation of a visual joint formulation that is documented in session; families have their plan in hand when the appointment is done. We have found these formulations capture families' experiences in highly meaningful ways; families routinely take pictures of the whiteboard, bring these formulations to subsequent appointments, and revise and update them at home on their own.

By not relying on diagnostic classification systems to determine what happens next, we achieve greater flexibility and holism in treatment planning, particularly for families with multiple presenting concerns or more complex lives. Formal assessment and diagnosis may be offered in our clinics, but only when treatment planning is unclear; we have found that only a small minority of families require this. As one client recently described, the approach finds ways for treatment to fit the needs of the client, rather than needing the client to fit a specific diagnosis and corresponding treatment. This is consistent with trans-diagnostic approaches, which emphasize greater utility in understanding the "underlying change mechanisms that lead to the attainment of desirable treatment goals."[5] It is also consistent with what we have learned from families about how they want to understand their problems in a more functional way and get right to what they can do to make a difference in their lives. When families do seek a diagnosis, it is almost always to achieve an end that will make a specific impact on their lives (e.g., being able to go to school, having better relationships, meeting needs in non-risky ways). We have found that a collaboratively developed, goal-oriented, and mechanism-explicit model can be a more efficient way to help families meet these desired ends.

We know we still have far to go. However, Experience of Service Questionnaire (ESQ)[7] data, collected at Choice, suggests we are heading in the right direction. Over the past year, parents and youth reported that: the clinicians listened to their concerns (99% and 99%), they felt involved in deciding what would happen next (98% and 92%), and they worked well together in their appointment (91% and 84%). Overall, 95% of parents and 89% of youth felt the Choice appointment was helpful. Qualitatively, families have described feeling encouraged and understood, knowing that a plan was in place and what the next steps would be for them.

We propose that classification systems have served an important purpose; for some areas of practice they will, and should, continue to do so. But not for all. We believe that our service provides an example of an efficient and effective alternative model.

For a complete list of references, please go to www.cpa.ca/psynopsis

Four different ways of understanding mental illness

Uma Vaidyanathan, PhD, Scientific Program Manager, National Institute of Mental Health

Which of the following is NOT a classification system for mental disorders?

a) International Classification of Diseases (ICD)
b) Diagnostic and Statistical Manual of Mental Disorders (DSM)
c) Hierarchical Taxonomy of Psychopathology (HiTOP)
d) Research Domain Criteria (RDoC)
e) All of these are classification systems

Answer:
d) RDoC – it is a framework for research on mental illness.

Given the variety of systems used for numerous purposes by the mental health field around the world, misconceptions regarding RDoC and the systems listed above are common. Indeed, the overlap between them contributes to this confusion; however, there are clear differences.[1]

Two of the systems are the DSM (currently in its fifth edition)[2] and the ICD (currently in its 11th edition).[3] The DSM and the ICD are two major classifications used for clinical and public health purposes, but they have overt differences: the DSM provides semi-quantitative criteria for determining diagnosis and is used in research, while the ICD has roots in public health reporting and emphasizes clinical utility.

The other two have emerged from the RDoC and HiTOP initiatives. These are both much newer than the DSM and ICD, having been created in the past decade or so, but the ideas they instantiate, such as an explicit focus on dimensionality and a study of the links between biology and behaviour, have been around much longer. While RDoC originated at the National Institute of Mental Health (NIMH) in the United States,[4] HiTOP was formulated by a large group of academic and clinical researchers.[5] In fact, as mentioned earlier, RDoC is not even a classification system, but rather a research framework whose results can potentially inform classification systems, like those listed above.

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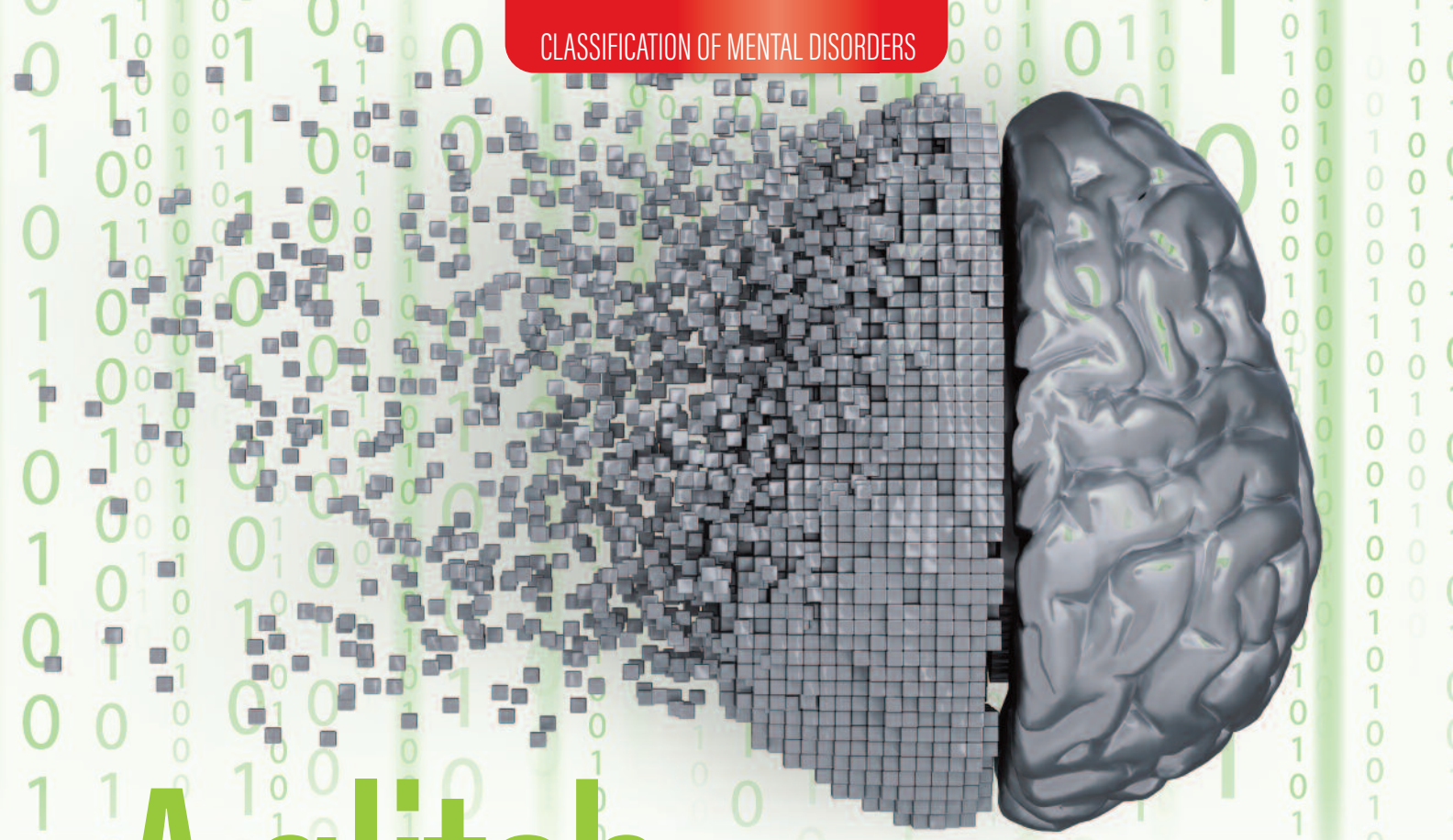
Keeping these differences in origin and purpose in mind, the following table provides a quick comparison of the practical and philosophical bases of these four systems:

	DSM	ICD	HiTOP	RDoC
Originating organization	American Psychiatric Association (APA), USA	World Health Organization (WHO)	Independent academic researchers	National Institute of Mental Health (NIMH), USA
Inception	1952	Mental disorders included in ICD-6 in 1949	2017	2010
Current version	DSM-5	ICD-11 Clinical Descriptions and Diagnostic Guidelines	Modifications made on an ongoing basis	Modifications made on an ongoing basis
Intended purpose	Diagnosis and treatment	Diagnosis, treatment, public health	Research, diagnosis and treatment	Research
Elements used to explain human behaviour	Signs, symptoms, and disorders	Signs, symptoms, and disorders	Signs, symptoms, syndromes, maladaptive personality	Constructs (concepts) based on biology and behaviour – focus on mechanism that drives construct
Approach used to classify disorder	Mostly categorical; specifiers, subtypes, and cross cutting symptoms used to capture nuances	Mostly categorical (diagnostic guidelines)	Dimensional; includes categorical syndromes as well	Constructs are dimensional – but no specification of thresholds for disorder
Range of elements	Focus on maladaptive parts of behaviour alone (mental disorders)	Focus on maladaptive parts of behaviour alone (mental disorders)	Focus on mental illness, though low levels of dimensions can be adaptive	Focus on full range of constructs – adaptive and maladaptive
Elements based on	Self-report and behaviour	Self-report and behaviour	Self-report and behaviour	Biology, self-report, and behaviour

As can be seen in the table above, each system emphasizes different aspects that reflect the organizations behind them. For example, the APA and WHO are focused on public health, diagnosis, and treatment, so their systems are categorical to answer practical clinical and epidemiological questions. In contrast, the researchers behind HiTOP value using well-established statistical models of diagnoses and self-report questionnaires to investigate mental disorders. Finally, the NIMH has many priorities for funding research, so the RDoC initiative promotes using a multifaceted approach to understanding psychopathology and wellness.

Clearly, there is a role for each of these systems given the varying needs they address. It will be exciting to see how they develop and intersect as they continue to evolve.

For a complete list of references, please go to www.cpa.ca/psynopsis



A glitch in the (RDoC) matrix?

Joanna Collaton, MPH, Master's Student, University of Guelph

In recent years, the validity of the Diagnostic and Statistical Manual (DSM) has been questioned. In response, the National Institute of Mental Health (NIMH) has proposed the Research Domain Criteria (RDoC) project as a dimensional approach in psychopathology research that moves away from a biopsychosocial model toward a biomedical model of mental illness, but this framework also has its flaws.

RDoC emphasizes pathophysiology and brain circuitry in an effort to elucidate the etiology of mental disorders with the long-term goal of informing new treatments and cures. A key assumption of the RDoC framework is that mental disorders are brain disorders, characterized by dysfunction of neurocircuitry. In its current state, the RDoC matrix identifies five systems broken into constructs and subconstructs. Each of these systems is then investigated across seven units of analysis, including genes, molecules, cells, circuits, physiology, behaviour, self-report, and paradigms.

Using a dimensional approach to mental illness seems to allow for a better method of scientific inquiry, providing flexibility and precision. In fact, many scientists laud the RDoC project as an opportunity to be freed from oppressive grant requirements, promote replicability, and to bridge the gap between basic science research and clinic applications.[1] However, the clinical utility of a categorical method cannot be understated. As clinicians, we can recognize that the categorization of disorders is necessary for clients for practical reasons, such as access to services and to make insurance claims.

It has been suggested that clinical cut-offs of dimensional constructs such as those articulated in RDoC may help to bridge this gap, but this recommendation is not without controversy as symptoms of psychopathology are not always continuations of normal experiences (e.g., frank hallucinations).[2] Importantly, what will be the basis for establishing clinical cut-offs? Theory generation will be required in determining flexibility in these cut-offs according to differing cultural contexts. For example, certain levels of fear may be more common or accepted in different environments (e.g., groups more likely to be targeted by police) and as such may be adaptive rather than psychopathological. Thoughtfulness surrounding the implications of these decisions is necessary in ensuring the provision of person-centred care.

In line with this, the RDoC matrix does not overtly recognize that social and cultural expectations are key in determining

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Other Specified Trauma- and Stressor-Related Disorder:

Challenges in differential diagnosis and therapeutics

Stephanie Taillefer, MA, Psychologist (Candidate Register), Nova Scotia Health Authority, Operational Stress Injury Clinic; Dougal Nolan, M.Sc., Research and Statistical Officer, Nova Scotia Health Authority, Operational Stress Injury Clinic; and Abraham Rudnick, MD, PhD, Clinical Director, Nova Scotia Health Authority, Operational Stress Injury Clinic and Professor, Department of Psychiatry and School of Occupational Therapy, Dalhousie University

Within the Trauma- and Stressor-Related Disorder section of the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5),[1] there is an option to make an 'Other Specified' diagnosis. Notably, the 11th edition of the International Classification of Diseases (ICD-11)[2] also includes a diagnosis of this variety; other specified disorders specifically associated with stress. According to the DSM-5, this Other Specified Trauma diagnosis is to be used when a clinician determines that presenting symptoms do not meet the necessary criteria for common trauma- and stressor-related disorders, such as Posttraumatic Stress Disorder (PTSD), but do cause an individual clinically significant distress and/or impairment. The DSM-5 cites potential grounds for such a diagnosis, including adjustment-like disorders with either delayed onset or prolonged duration, persistent complex bereavement disorder, or cultural syndromes. Furthermore, when individuals present with PTSD-like symptoms but report no clear Criterion A event (an event in which the patient reports witnessing/exposure to actual/threatened death, serious injury, or sexual violence, learning that a relative/close friend was exposed to a trauma, or indirect exposure that was repeated/extreme during professional duties) to warrant a PTSD diagnosis, clinicians could use the Other Specified Trauma diagnostic label in the absence of other clear diagnostic guidance. Research into the Other Specified category is limited, which raises empirical questions of diagnostic validity, reliability, differential diagnosis, and treatment recommendations.

To illustrate the clinical challenges associated with this diagnosis, take for example a subset of Canadian Armed Forces veterans who present with PTSD symptoms without a clear Criterion A event. In the absence of a Criterion A event, they nonetheless report feeling belittled, bullied, and disrespected by colleagues and/or their superiors whilst in service. Differential diagnosis in these situations is difficult, as the veteran self-reports intrusive symptoms consistent with PTSD, including recurrent, involuntary, intrusive distressing memories and recurrent distressing dreams. The clinician's challenge is to disentangle whether these symptoms truly are intrusive and, therefore, reminiscent of PTSD; or whether they are better captured by depressive ruminations, obsessions, or some other

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Challenges in differential diagnosis and therapeutics

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pattern of repetitive thinking. Accurate differential diagnosis becomes important both to have a consistent nomenclature to discuss these presentations with service providers and to inform therapeutic approaches.

Indeed, much debate exists in the literature regarding the type of incidents that should be considered Criterion A events sufficient to establish a diagnosis of PTSD. Given that prior research suggests stressful life events such as harassment or bullying generate as many PTSD-like symptoms as traumatic events,[3] some have argued that the definition of a Criterion A event should be expanded.[4] If the definition of a Criterion A event were to be expanded, many individuals who currently meet the criteria for an Other Specified Trauma diagnosis could fit into a diagnosis of PTSD. While this would allow for consistent nomenclature, difficulties establishing therapeutic protocols for these individuals would remain.

PTSD has robust treatment guidelines, such as those put forth by the International Society for Traumatic Stress Studies,[5] which include strong recommendations for cognitive processing therapy, cognitive therapy, eye movement desensitization and reprocessing, individual cognitive behavioural therapy with a trauma focus, and prolonged exposure. Such treatment recommendations are not available for the Other Specified Trauma diagnosis. It is possible to modify some of these therapeutic protocols to address the subjective experiences of stress rather than an objectively corroborated Criterion A event, but the therapeutic effectiveness of such modifications needs to be examined in a controlled manner. Additionally, as this is a 'catch-all' diagnostic category, some individuals may be appropriate for trauma-focused interventions (e.g., those with subclinical symptoms), while others may not (e.g., those with no clear Criterion A event), although this too remains an empirical question. As such, with the lack of theoretical and empirical literature from which to draw, treatment recommendations for these individuals rely heavily on a clinician's case conceptualization, which can be influenced by a multitude of factors, including personal bias.[6] It is clear more research on this diagnosis is warranted, including epidemiology (e.g., prevalence, what specifiers clinicians are using, under what circumstances they are making this diagnosis) and the effectiveness of therapeutic treatment options. This research could provide a more universal nomenclature, shared understanding, and evidence-based treatment recommendations for those diagnosed with an Other Specified Trauma- and Stressor-Related Disorder.

For a complete list of references, please go to www.cpa.ca/psynopsis

A glitch in the (RDoC) matrix?

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what we consider to be normal versus abnormal, therefore distinguishing expected human experiences and psychopathology.[3,4] The majority of the units of analysis within the RDoC matrix are biologically-based, without true integration of environmental and developmental factors. We know that these factors are necessary considerations when looking at the development of mental illness.[3] By de-emphasizing environmental factors (e.g., socioeconomic status (SES)), the RDoC framework largely ignores a significant and vulnerable group, who may not benefit from treatments based in translational neuroscience, an intended outcome, if their experiences are not considered in the first place.

Moving forward, the RDoC working group may consider formally integrating environmental and developmental components into the RDoC matrix rather than listing them as separate considerations. As the majority of mental health issues begin during childhood, the importance of developmental experiences is a vital component and psychologists should continue to advocate for better integration and consideration of these factors. One suggestion is to adapt RDoC to align with a developmental psychopathology framework[5] that looks at the interaction between biology, psychology, and environment and weights these factors equally rather than prioritizing pathophysiology.

From a service provision perspective, if the RDoC project ultimately leads to treatments based in translational neuroscience, what will be the associated costs in providing this type of care? If cost-prohibitive, how will we ensure equitable access to these forms of treatment? The implications of inequitable access to care are salient when considering the duty of healthcare professionals to provide empirical mental healthcare for those in need. Emphasis here should be placed on treating children and adolescents, an area currently glossed over, given the prevalence and importance of associated precipitating factors in mental illness that occur within the developmental period (e.g., SES, adverse childhood experiences).[5]

Another important question is whether we must view mental disorders as brain disorders using a biomedical approach to legitimize them as science. Certainly, translational neuroscience is an important endeavour in investigating pathophysiological pathways to illness; however, removing the person from psychopathology may very well lead to biological reductionism and the medicalizing of all emotion.[5,6] When will it be deemed appropriate, for example, to experience negative affectivity? Emotions and feelings have personal nuance that are currently ignored by the RDoC approach.

Given the current insistence on using a biomedical approach,[7] psychologists are in an excellent position to endorse a biopsychosocial model of psychopathology. Advocacy work may be considered to promote the importance of the interactions between biology, psychology, and social contexts rather than isolated constructs in the development of psychopathology in an effort to improve the RDoC framework and ensure wider applicability to clinical contexts.

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The use of psychiatric classification systems in the Arab region

Brigitte Khoury, PhD, Clinical Psychologist and Associate Professor and Director of Clinical Psychology Training Program, American University of Beirut Medical Center, Department of Psychiatry, and Zeina Ramadan, M.Sc., Research Assistant, American University of Beirut Medical Center, Department of Psychiatry

One of the mandates of the World Health Organization (WHO) is to review and update the International Classification of Diseases and Related Health Problems (ICD), now in its 11th version. In 2009, the WHO formed an international advisory group of experts to oversee the latest revision of the mental health chapter and collected feedback from mental health specialists at twelve of its regional field study centers, including one in the Arab region.

Research conducted in the Arab region has used the Diagnostic and Statistical Manual of Mental Disorders (DSM) system (DSM-IV-TR, DSM-IV), the ICD system (ICD-9 or ICD-10), or both[1-6] demonstrating no particular preference for one or the other. Previous efforts have been made to implement more local diagnostic tools in the Arab region, such as an Egyptian diagnostic manual, which was not adopted by other Arab countries due to its lack of specific criteria for diagnoses.[7] Thus, there is a lack of an inclusive diagnostic tool specific to psychiatric disorders in Arab countries using the Arabic language, which hinders culturally relevant diagnoses and research outcomes,[6] as well as communication between professionals[8] and with patients. Similarly, most psychiatric screening instruments were established in countries outside the Arab world, which affects incidence and prevalence rates, as well as patient-centered management and efficient use of resources.[9]

Several examples underscore the difficulty in making symptom descriptors relevant to the Arab culture. One example is the commonly used symptoms of "jounoon" (mental illness or insanity) that can apply to mental retardation, neurotic, or psychotic disorders. Another example is the definition of "inheyar a'sabi" (nervous breakdown) – an extreme reaction to anxiety, depression, dissociation, psychosis, or somatic symptoms.[10] Another example involves Islamic rituals of piety[11] and purification before the Muslim prayer ("wudu.") The preoccupation with contamination and infection (68%) and cleaning, purification, and praying (63%) can be seen as meeting the criteria for a diagnosis of OCD, though these patients do not recognize the maladaptativeness of their rituals,[10] leading to possible bias in the prevalence of OCD in Arab communities.

In the past decades, changing political climates have encouraged Arab inclusion in universalist approaches to mental and behavioural disorders.[12] During the preparation of the ICD-10, 30 years ago, research was conducted in the Arab region to provide validity and reliability from countries including Egypt, Bahrain, United Arab Emirates, Tunisia, and Morocco.[7] Accommodations were also made to better cater to non-Western syndromes, such as the inclusion of Acute and Transient Psychotic Disorders.[7] Nevertheless, many cultural factors were not taken into consideration. The cluster of symptoms known in the literature as "hysteria," commonly found in Arab countries, was not included in ICD-10, forcing clinicians to rely on the less accurate diagnoses of conversion, dissociative, or somatoform disorders.[13]

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Classifying and counting mental disorders in Canada:

A brief overview

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Early efforts to gather information on mental health now seem crude, using terminology jarring to the modern reader. Canadian censuses in the 1830s, 1840s and those of 1851 and 1861 collected information on "idiocy" and "lunacy."[1-3] By 1871, this language was dropped in favour of the enumeration of those of "unsound mind."[4] The 1911 census shifted language again, replacing "unsound mind" with the categories: "crazy or lunatic" and "idiotic or silly."[5]

More sophisticated classification systems were developed in the late 19th century for use with psychiatric hospital patients, but there was little consistency in their use. In 1918, the American Medico-Psychological Association (AMPA; now the American Psychiatric Association) published the *Statistical Manual for the Use of Institutions of the Insane* to ensure a "uniform system of statistics."[6] By 1921, the Canadian census no longer asked questions about mental deficiency. Instead, in 1932 the Dominion Bureau of Statistics began producing the *Annual Report on Mental Institutions*,[7] using the AMPA's *Statistical Manual* to classify patient illness. Beginning in 1950, classification in the annual report[8] switched to the sixth revision of the World Health Organization's *International Classification of Diseases, Injuries and Causes of Death* (ICD;1948). With its newly expanded content, the ICD-6 was the first version to include a classification of mental disorders.[9-10]

In 1952, the American Psychiatric Association published the Diagnostic and Statistical Manual of Mental Disorders (DSM), which provided diagnostic guidance and replaced the earlier *Statistical Manual*. The DSM-II (1968) was subsequently developed to align with the ICD-8.[11,12] This alignment began a relationship between the two classifications that continues to this day. It is not widely appreciated, for example, that the the DSM does not really have its own codes. They are drawn from the ICD. The DSM-5, which bridged the transition from the ICD-9 to the ICD-10 in the United States, includes codes from the U.S. clinical modifications of both (ICD-9-CM and ICD-10-CM).

Though widely used in the U.S., it is not clear what sort of inroads the early iterations of the DSM made into clinical practice in Canada. By the third version of the DSM, we have a better sense of clinical uptake. A survey in the early 1980s by the Canadian Psychiatric Association found that a majority of psychiatrists favoured the DSM-III over other classifications, including the ICD-9[13] (by this point, there were materials to support the use of the ICD's mental health chapter in diagnostic contexts). The Canadian Psychiatric Association itself maintained a position of official neutrality.

Outside of North America, the ICD is widely used in clinical contexts with tools that support its use for psychiatric diagnosis.[14] In the U.S. and Canada, however, the DSM dominates in clinical-diagnostic contexts. In Canada, because

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the codes in the DSM come from the U.S. modifications of the ICD, these codes cannot be used straightforwardly. The DSM may be used to guide diagnosis but psychiatrists, like all fee-for-service physicians, must submit their remuneration claims to their provincial insurance programs using a set of billing codes drawn from the ICD-9.

Data on mental health patients across the country are submitted to the Canadian Institute for Health Information (CIHI).[15] CIHI works with the provinces and territories to manage a broad range of health system databases. In general, diagnoses in hospital data are coded using a Canadian enhancement of the ICD-10 (ICD-10-CA), which facilitates the capture of more specificity to meet Canadian morbidity data needs. Today, the ICD-10-CA coded data are a foundational element for CIHI's decision support methods and tools, publicly and privately reported health system performance measures, and other forms of reporting. The data are also used extensively for research, health system management, and public health surveillance.

Among the databases CIHI manages is the Hospital Mental Health Database (HMHDB),[16] which incorporates data from multiple sources with a focus on hospitalizations in general hospitals or in psychiatric hospitals. In the sources from which the HMHDB data are drawn, diagnoses are coded using the ICD-10-CA, codes from the DSM, or a combination of both. CIHI uses the codes to group each discharge record into broad mental health categories for reporting purposes.[17]

The ICD-11[18] has been in preparation for over a decade. The clinical content has been comprehensively reviewed to ensure it reflects current knowledge and meets the needs of a wide range of uses. Unlike its predecessor, the ICD-11 is designed with tooling that can be integrated into electronic health information systems. Other conceptual innovations make the ICD-11 more interoperable with related classifications and clinical terminologies (such as SNOMED CT).[19] The working groups that developed the content for the Mental, Behavioural or Neurodevelopmental Disorders chapter in the ICD-11 included individuals who also contributed to the development of the DSM-5. However, there are substantive differences between the ICD-11 and the DSM-5, described elsewhere in this publication. These differences will be important considerations for those in clinical practice comparing the two systems.

CIHI is working with stakeholders across Canada to assess the implications of implementing the ICD-11. This work will support decisions about the implementation, timing of implementation, training and technological needs, and how to minimize disruption and ensure continuity of information. It will also address the value of implementing the ICD-11 for data capture across the entire health system, whereas the ICD-10-CA was primarily implemented in hospitals. Mental health clinicians have the opportunity to review the ICD-11 and its tools to support clinical use with a view to determining its value vis-à-vis the DSM.

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The use of psychiatric classification systems in the Arab region

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Another issue is the complexity of the manual and the lack of space for subthreshold disorders. A study with an Egyptian population assessing diagnoses for eating disorders among young teenage girls,[8] found that all cases were identified as "atypical," "unspecified," or "subthreshold" because they did not meet any ICD-10 or DSM-IV diagnoses. As a result, Arab scholars have begun to encourage the use of dimensional measures to allow for increased sensitivity in diagnosing.8,12 Nonetheless, Arab psychiatrists seem to have agreed that the ICD-10 diagnostic guidelines contributed to increased consensus in diagnoses,[7] and there was a high inter-rater reliability in the ICD-10 field trials when diagnosing mental disorders in Eastern Mediterranean and North African (EMRO) countries.[8]

Importantly, the WHO aimed for greater cultural sensitivity, clinical utility, and ease of use of the ICD-11. They implemented a systematic process for its revision — they conducted user surveys, did evaluative field-testing, and held several regional meetings, including one in Beirut, Lebanon in 2011. In this meeting, 30 specialists from 12 Arab countries discussed areas of concern relating to Arab culture.[12] For instance, in Arab countries, distress is typically expressed as somatic symptoms[12] making the assessment or diagnosis of mood disorders, somatoform disorders, or even pain disorders (e.g., fibromyalgia) challenging. Moreover, due to resilience and religious attribution of traumatic events, there is a documented decrease in prevalence of PTSD in Muslim countries, despite the increasing number of traumatic events.[8] In fact, many Arab countries have long faced political instability and violence.[12] Therefore, professionals gathered at the meeting discussed the differing effect of prolonged trauma in group settings,[12] which is not currently recognized in diagnostic manuals. Lastly, sexual dysfunctions have been noticeable among Arab newlyweds due to underexposure and constraining traditional cultural norms, which increases the risk for "over-pathologizing."[12]

These and other related concerns led to a clear recommendation that the ICD-11 consider cultural components of diagnoses by including Arab experts in the process and collecting data from various countries in the region. Both requests were fulfilled.

This is a challenge the WHO took on in the development of the new ICD-11 and that we expect will improve mental health care in the Arab world as a result. When a diagnostic classification becomes a language that can be spoken internationally, it will positively affect populations in the Arab world as well as those immigrating or moving from the Arab world to Western countries (including refugees). Consequently, it is paramount to improve mental health professionals' accurate understanding of their symptoms and diagnoses, and enhance their ability to tailor a treatment plan suitable for this population.

For a complete list of references, please go to www.cpa.ca/psynopsis

The World Health Organization's International Classification of Diseases and Related Health Problems (ICD-11) Clinical Descriptions and Diagnostic Guidelines:

An evidence- and practice-based nosology

Cary S. Kogan, PhD, Professor, School of Psychology, University of Ottawa and Geoffrey M. Reed, PhD, Senior Project Officer, Department of Mental Health and Substance Abuse, World Health Organization, and Professor, Department of Psychiatry, Columbia University Vagelos College of Physicians and Surgeons

Currently, most Canadian psychologists rely on the Diagnostic and Statistical Manual of Mental Disorders[1] (DSM) in their daily clinical practice. Drivers for the dominance of the DSM in Canada include significant advantages that the DSM-III[2] introduced, specifically, an objective descriptive phenomenology of psychopathology with its attendant increases in reliability and opportunities for scientific scrutiny, in addition to the pervasive historical influence of the USA on Canadian training and practice.

In 2013, the American Psychiatric Association published the DSM-5 to mixed reviews. This year, the World Health Organization (WHO) released the 11th revision of its International Classification of Diseases and Related Health Problems (ICD-11), which provides a strong alternative to the DSM-5 for Canadian clinicians.

A core constitutional responsibility of the WHO is to produce standardized international classification systems used by its 194 member states, including Canada, to gather and report health information, monitor disease, allocate resources and organize clinical care. A Canadian ICD adaptation is already used as a framework for health information systems, billing and policies. Several other versions of the ICD-10 exist for different purposes, including the statistical version containing unique codes for specific health conditions and accompanying brief definitions

for mental and behavioural disorders. The *Clinical Descriptions and Diagnostic Guidelines* (CDDG)[3] version contains sufficiently detailed information for application by mental health specialists in clinical settings. The ICD-10 has been used in daily clinical practice by a majority of mental health professionals worldwide.[4,5]

The WHO Department of Mental Health and Substance Abuse was responsible for coordinating the development of the ICD-11 CDDG, which will be released later this year after a decade of revision efforts by international experts, extensive field testing and multiple stakeholder input. In developing the ICD-11 CDDG, the WHO established governance structures to ensure open and transparent processes that included soliciting the expertise of a diverse group of global researchers and clinicians, as well as input from civil society groups and other key stakeholders. The WHO conducted formative field trials soliciting opinions of psychiatrists and psychologists[4,5] and revealing their internal representations of psychopathology.[6,7] These studies informed the structure and content of the ICD-11 CDDG with the goal of improving clinical utility.

Working groups were also appointed to review the scientific literature and information about global clinical practice, to consider the global applicability of the emerging DSM-5 and, on this basis, to recommend changes from the structure and content of the ICD-10 CDDG in a standardized manner.[8] Trilateral meetings were held with the WHO, American Psychiatric Association and US National Institute of Mental Health to harmonize the overall structure of the ICD-11 and the DSM-5. An attempt was been made to avoid trivial differences; if the ICD and the DSM were to diverge it should be in intentional and meaningful ways (e.g., the ICD-11 includes Complex PTSD, whereas the DSM-5 does not).[9] From the beginning, the development of the ICD-11 was multidisciplinary, with the International Union of Psychological Science formally representing psychology and core support provided by the American Psychological Association.

A major consideration in developing the ICD-11 CDDG was optimization of clinical utility,[10] conceptualized as the classification's value to clinicians in enhancing communication, its implementation characteristics (e.g., how accurately it describes patients), how easy it is to use and its value in informing clinical decisions, including treatment selection. Developers were also mindful of ensuring adequate reliability and validity of the ICD-11. However, the added focus on clinical utility was perceived as a priority because classifications that are too burdensome to use or do not reflect the way clinicians think are unlikely to be used or used as intended.

The WHO also conducted two types of developmental field trials to assess the specific proposed revisions by evaluating reliability, validity and clinical utility to inform further development of the ICD prior to release. The first were conducted over the Internet and tested specific proposed changes between the ICD-10 and the ICD-11 (e.g., disorders specifically associated with stress[11]). Participants for these studies were clinician members of the WHO's Global Clinical Practice Network,[12] which now consists of more than 15,000 mental health and primary care professionals in 156 countries. The second were conducted in 14 countries in clinical settings and focused on disorders with the highest disease burden and service use, as well as those for which significant revisions were made based on the Internet trials. Overall, results of the reliability and clinical utility of the ICD-11 CDDG significantly improved on the ICD-10.[13,14] Field study results were also used to make further improvements to the CDDG.

Although the ICD-11 employs a descriptive phenomenological approach, it provides clinicians with a set of *essential features* for each diagnostic category consisting of those features of the clinical presentation that a clinician should reasonably expect to see in all cases. The ICD-11 CDDG avoids using cut points such as absolute time frames for the duration and number of symptoms required (e.g., four out of nine) when no empirical basis for these rules exist. This is in contrast to the rigid criteria and polythetic "pick lists" employed in the DSM-5. The ICD-11 is intended to provide flexibility and appropriate scope for clinical judgment and global variation in presentation. Results of the field trials affirm that this approach is at least as reliable as a strict criteria-based approach.[13]

> A core constitutional responsibility of the WHO is to produce standardized international classification systems used by its 194 member states, including Canada, to gather and report health information, monitor disease, allocate resources and organize clinical care.

There are many distinct advantages to using the ICD-11 CDDG in Canada: 1) clinicians and researchers from diverse cultural backgrounds participated in its development, which will benefit Canada's increasingly diverse population; 2) its development focused on optimizing clinical utility, which is anticipated to result in better health data; 3) extensive field testing, including in Canada, was conducted for reliability and clinical utility with results informing subsequent revisions prior to publication; 4) a single classification system can be used from clinical encounter to health systems; 5) parity and recognition of mental health services is facilitated by integration as part of the same international classification system for all of health; and 6) the ICD-11 is available at relatively low cost to its users.

We encourage readers to join and explore GCP.Network, which includes draft versions of ICD-11 CDDG, links to key scientific articles on ICD-11, contributions by developers and summaries of the findings from the field trials. A concerted implementation and training effort is underway, and training materials were developed for member states.

Note: Unless specifically stated, the views expressed in this article are those of the authors and do not represent the official policies or positions of the WHO.

For a complete list of references, please go to www.cpa.ca/psynopsis

CPA HIGHLIGHTS

Below is a list of our top activities covering spring and early summer 2019. Be sure to contact membership@cpa.ca to sign up for our monthly CPA News e-newsletter to stay abreast of all the things we are doing for you!

1 2018 CP Best Article Award

We are pleased to announce that the award for best paper published in *Canadian Psychology (CP)* in 2018 goes to Christopher D. Green, Sahir Abbas, Arlie Belliveau, Nataly Beribisky, Ian J. Davidson, Julian DiGiovanni, Crystal Heidari, Shane M. Martin, Eric Oosenbrug, and Linda M. Wainewright for their article: "*Statcheck in Canada: What proportion of CPA journal articles contain errors in the reporting of p-values?"* The award was presented at our 2019 national convention in Halifax, and the article is available open access.

2 IIMHL Council on Clinical Leadership

On April 1-2, we attended the International Initiative for Mental Health Leadership's Council on Clinical Leadership meeting in Washington, D.C. This meeting of mental health leaders from around the world focused on knowledge mobilization and information sharing on population health, mental health promotion, and community engagement.

3 New Editor: Canadian Journal of Behavioural Science

We are pleased to announce that our board of directors has appointed Dr. Allison J. Ouimet as the new Editor for the *Canadian Journal of Behavioural Science* (2019-2021). Many thanks to Dr. E. Kevin Kelloway for his work in this role.

4 Meeting with ACPRO

Representatives from our leadership and Accreditation Panel and from the Association of Canadian Psychology Regulatory Organizations came together on April 29 to discuss issues and trends affecting accreditation, regulation, training, and practice. We look forward to ongoing collaboration over the coming months.

5 Membership renewals

We will be launching our membership renewals in November. Keep an eye on your inbox for your membership renewal information.

6 Disability Advisory Committee

As co-chair of the Disability Advisory Committee (DAC), Dr. Karen Cohen participated in the first report back to the Minister of National Revenue on the DAC's recommendations about tax measures for persons with disability. The DAC met in June to develop an action plan for 2019/20 based on these recommendations.

7 New fact sheet

We recently published a new "Psychology Works" fact sheet on enuresis and encopresis in children, common risk factors for these disorders, and how psychologists can help. Visit our website to download this and other informative psychology fact sheets.

8 Mental Health Advisory Group – Veterans Affairs

On April 30, we attended a meeting as member of the Mental Health Advisory Group. The group's mandate is to advise the Minister of Veterans Affairs and Associate Minister of National Defence about issues relevant to the mental health of Veterans, members of the Canadian Armed Forces, members of the RCMP, and their families.

9 2018 CJBS best article award

We are pleased to announce that the award for best paper published in the *Canadian Journal of Behavioural Science (CJBS*) in 2018 goes to Debora D'Iuso, Keith S. Dobson, Leah Beaulieu, and Martin Drapeau for their article: *Coping and Interpersonal Functioning in Depression*. The award was presented at our 2019 national convention in Halifax, and the article is available open access.

10 New member benefits

We are pleased to offer CPA members new benefits. Members and affiliates can now take advantage of exclusive 20% savings on a wide variety of print and copy products and services with Staples. Members and affiliates can now also save up to 30% on travel experiences around the globe with Trip Merchant, which works directly with travel suppliers to offer you exclusive offers, last minute deals, unique travel experiences, group departures, travel tips, and more.

FAITS SAILLANTS des activités de la SCP

Voici la liste des principales activités menées au printemps et au début de l'été 2019.
Écrivez à membership@cpa.ca pour vous abonner à notre bulletin électronique mensuel, les Nouvelles de la SCP.
Vous serez ainsi au courant de tout ce que nous accomplissons pour vous!

1 Prix du meilleur article paru dans PC en 2018

Nous sommes heureux d'annoncer que le prix du meilleur article paru dans *Psychologie canadienne (PC)* en 2018 est remis à Christopher D. Green, Sahir Abbas, Arlie Belliveau, Nataly Beribisky, Ian J. Davidson, Julian DiGiovanni, Crystal Heidari, Shane M. Martin, Eric Oosenbrug et Linda M. Wainewright pour leur article intitulé « *Statcheck in Canada: What proportion of CPA journal articles contain errors in the reporting of p-values?*» Le prix a été présenté lors de notre congrès national de 2019, à Halifax et l'article est disponible en libre accès.

2 Council on Clinical Leadership de l'IIMHL

Les 1er et 2 avril, nous avons participé à la réunion du Council on Clinical Leadership de l'International Initiative for Mental Health Leadership, qui se tenait à Washington, D.C. Cette réunion, qui rassemble des dirigeants du domaine de la santé mentale des quatre coins du monde, portait sur la mobilisation des connaissances et l'échange d'information sur la santé de la population, la promotion de la santé mentale et l'engagement des collectivités.

3 Nouvelle rédactrice en chef : Revue canadienne des sciences du comportement

Nous sommes heureux d'annoncer que notre conseil d'administration a nommé la Dre Allison J. Ouimet au poste de rédactrice en chef de la *Revue canadienne des sciences du comportement* (2019-2021). Un grand merci au rédacteur en chef sortant, le Dr E. Kevin Kelloway, pour son excellent travail.

4 Réunion avec l'AOCRP

Des représentants de notre conseil d'administration, du Jury d'agrément et de l'Association des organisations canadiennes de réglementation en psychologie se sont réunis le 29 avril afin de discuter de différentes questions et tendances qui ont une incidence sur l'agrément, la réglementation, la formation et la pratique. Nous nous réjouissons de poursuivre cette collaboration au cours des prochains mois.

5 Renouvellement de l'adhésion

Nous lancerons la période de renouvellement de l'adhésion en novembre. Surveillez vos courriels car vous recevrez sous peu de l'information sur le renouvellement de l'adhésion.

6 Comité consultatif des personnes handicapées

En tant que co-présidente, la Dre Karen Cohen a participé dans le premier rapport du Comité consultatif des personnes handicapées (CCPH) au ministre du Revenu national sur ces recommendations sur des mesures fiscales pour les personnes handicapées. Le CCPH a tenu une rencontre en juin pour développer un plan d'action pour 2019-2020 fondé sur ces recommendations.

7 Nouvelle fiche d'information

Nous avons publié récemment, dans la série « La psychologie peut vous aider », une fiche d'information sur l'énurésie et l'encoprésie chez l'enfant, dans laquelle sont expliqués les facteurs de risque courants de l'énurésie et de l'encoprésie et les interventions psychologiques qui peuvent aider les enfants qui en souffrent. Visitez notre site Web pour télécharger cette fiche, et d'autres fiches instructives de la série « La psychologie peut vous aider ».

8 Groupe consultatif sur la santé mentale – Ministère des Anciens Combattants

Le 30 avril, nous avons assisté à une réunion à titre de membre du Groupe consultatif sur la santé mentale. Le groupe a pour mandat de conseiller le ministre des Anciens Combattants et ministre associé de la Défense nationale sur différentes questions relatives à la santé mentale des anciens combattants, des membres des Forces armées canadiennes, des membres de la GRC, et leurs familles.

9 Prix du meilleur article paru dans la RCSC en 2018

Nous sommes heureux d'annoncer que le prix du meilleur article paru dans la *Revue canadienne des sciences du comportement (RCSC)* en 2018 est remis à Debora D'Iuso, Keith S. Dobson, Leah Beaulieu et Martin Drapeau pour leur article intitulé « *Coping and Interpersonal Functioning in Depression* ». Le prix a été présenté lors de notre congrès national de 2019, à Halifax et l'article est disponible en libre accès.

10 Nouveaux avantages offerts aux membres

Nous sommes heureux d'offrir de nouveaux avantages aux membres de la SCP. Les membres et les affiliés peuvent désormais profiter d'économies de 20 % sur une grande variété de produits et de services d'impression et de reprographie chez Staples. Les membres et les affiliés peuvent également économiser jusqu'à 30 % sur une gamme d'expériences de voyage dans le monde entier avec Trip Merchant, qui travaille directement avec des fournisseurs de voyage pour vous proposer des offres exclusives, des offres de dernière minute, des expériences de voyage uniques, des voyages de groupe, des conseils de voyage, et plus encore.

Avez-vous des idées pour nos prochains numéros?

Veuillez nous envoyer vos suggestions de thèmes, de rédacteurs en chef invités et d'articles à psynopsis@cpa.ca! Visitez cpa.ca/psynopsis pour en apprendre d'avantage.

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2019 Robert Sommer Award for best student paper in environmental psychology

The Environmental Psychology Section is pleased to announce that Mr. Youval Aberman is the 2019 winner of the Robert Sommer Award for his paper, "Evaluating the effectiveness of nation-level versus individual-level numeric data in climate change communication." Mr. Aberman is a PhD Candidate at the University of Toronto, and his work showing the potential shortcomings of climate change communications that focus on large numbers impressed reviewers. The Robert Sommer award commemorates Dr. Sommer's research accomplishments at the Saskatchewan Hospital in Weyburn, as well as his significant impact on the emerging field of environmental psychology in the 1950s. The $150 award is judged by an independent panel of three reviewers based on an extended abstracts of students' original research in environmental psychology. Congratulations to Youval for his outstanding work!

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Dr. Victor M. Catano
(1944-2019)

E. Kevin Kelloway, PhD, Canada Research Chair in Occupational Health Psychology and Professor, Saint Mary's University and Arla Day, PhD, Canada Research Chair in Industrial/Organizational Psychology and Professor, Saint Mary's University

Dr. Victor M. Catano – our colleague, mentor, and friend – passed away May 10, 2019. Vic was scheduled to retire in September after 48 years on faculty at Saint Mary's University in Halifax, NS. He is survived by his wife of 50 years, Janis, and his sons Victor and Michael and their partners. He is mourned by a large community of students, coworkers, practitioners, military members, and others whose lives he touched in his many professional activities.

Vic was one of the leading industrial/organizational (I/O) psychologists in Canada. He founded the graduate program in I/O psychology at Saint Mary's University and oversaw it as it grew to become one of the largest in North America. He actively promoted the development of psychology throughout his career. An active researcher, he exemplified the model of the scientist-practitioner – working with many organizations to ensure their practices and policies were based in evidence. He had broad research interests within I/O, but had published extensively on issues related to the psychology of unionization and personnel selection in organizations.

In addition to numerous journal publications, book chapters and technical reports, Vic co-authored the first (and only) Canadian textbook on I/O psychology, and was the senior author of the leading text on recruitment and selection in Canada. He received the Distinguished Contribution to I/O Psychology Award from the Canadian Society for Industrial and Organizational Psychology, was a Fellow of the Canadian Psychological Association, and a recipient of the CPA Award for Distinguished Contributions to Education and Training in Psychology. Just before his death, Vic received Presidential Recognition as a Scientist Practitioner from the Society for Industrial and Organizational Psychology. Throughout his career, he served on numerous editorial boards including two terms as editor of *Canadian Psychology.*

In his first, and only, sabbatical, Vic spent a year working at the Canadian Forces Personnel Applied Research Unit, beginning a long and productive involvement in military psychology. Vic conducted numerous projects with the Canadian Armed Forces, including studies of utility analysis, job families, selection systems, ethics, and retention. He wrote over 50 technical reports for the military, and supervised and mentored 17 members of the Forces in their graduate degrees at Saint Mary's. Vic received many commendations for his contributions, including one signed by Her Majesty Queen Elizabeth II.

Vic valued professional service and was a member of numerous professional associations. He was one of the few I/O psychologists who maintained registration as a psychologist in Nova Scotia. At various times, he served as a member of the Nova Scotia Board of Examiners in Psychology as well as President of the Association of Psychologists of Nova Scotia. He was a two-term chair of the Canadian Society for Industrial and Organizational Psychology and an active member of the military section of the CPA. He was active in the Canadian Council of Human Resources Association, serving as the Chair of their Exams and Capabilities Task Force and as Chair of their Independent Board of Examiners. At Saint Mary's, Vic served as long-term Chair of the Department of Psychology, a member of Senate, a member of the Board of Governors, as well as on numerous committees.

Vic was also a dedicated unionist. Active in the formation of the Saint Mary's University Faculty Union, Vic served in virtually every executive position, including President and Chief Negotiator. The collective agreements that he negotiated served as "model clauses" for other faculty unions across Canada, and Vic was frequently called on to advise other faculty unions in their negotiations and work actions. Vic served the Canadian Association of University Teachers (CAUT) as Chair of the Collective Bargaining and Economic Benefits Committee, Chair of the Academic Freedom Committee and, ultimately, as President. His contributions were recognized by his receipt of the Donald. C. Savage Award in 2009.

Vic was known for his tireless commitment and passion to his work. He loved to travel and attended many international conferences, establishing a strong international reputation for himself and for Saint Mary's. Despite his many involvements and accomplishments, Vic always had time for his students and colleagues, and there would often be a line of people in the hall waiting for his advice. Vic was also known for being a tough, but fair, professor, demanding the best from his students and colleagues. His 'seemingly gruff' exterior was matched by a kind and caring heart, and he would fight for fair treatment of students, faculty, and workers in general. His life was a model of how to live as an academic, professional psychologist, and human being. His death is a loss not only to the department and university, but to the entire profession.

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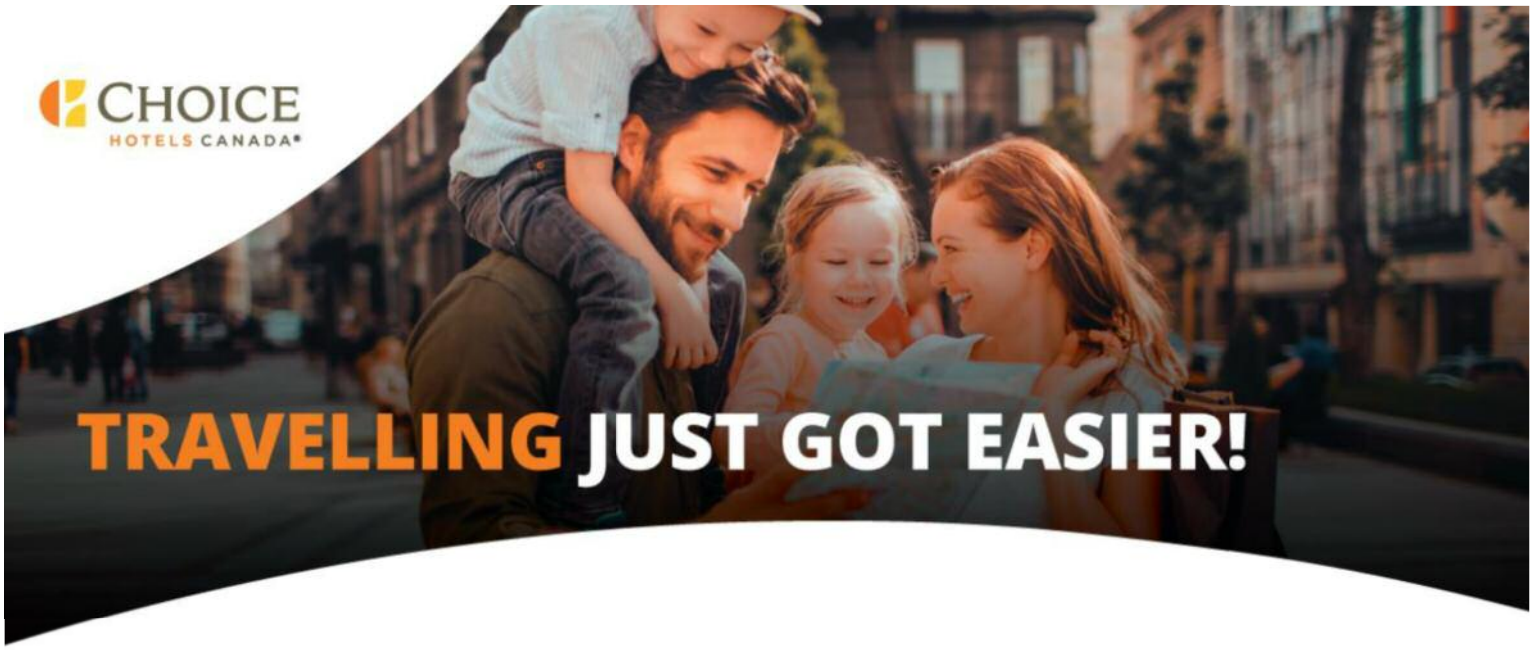

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17. For examples of studies in mental health using these data see CIHI reports such as the following: https://secure.cihi.ca/free_products/CIHI%20CYMH%20Final%20for%20pubs_EN_web.pdf https://www.cihi.ca/sites/default/files/document/opioid-related-harms-report-2018-en-web.pdf. For an example of a study using data with ICD-10-CA codes and codes from the DSM, see Barker, L. C., Gruneir, A., Fung, K., Herrmann, N., Kurdyak, P., Lin, E., Rochon, P.A., Seitz, D., Taylor, V.H. & Vigod, S.N (2018). Predicting psychiatric readmission: sex-specific models to predict 30-day readmission following acute psychiatric hospitalization. *Social Psychiatry and Psychiatric Epidemiology*, 53(2), 139-149. doi:10.1007/s00127-017-1450-5.
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