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PG Cert/PG Dip/MSc Assessment

7PCSFMHC, Mental Health in the Community: Coursework essay submission

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This essay will consider the International Classification of Diseases (ICD), and The Diagnostic and Statistical Manual of Mental Disorders (DSM) as the leading and most widely used contemporary diagnostic frameworks used in the diagnosis of mental distress with the purpose of identifying some of their shortcomings. It then considers how these frameworks could be enhanced, and the arguments for doing away with these frameworks altogether. We will then consider, with particular reference to the Research Domain Criteria (RDoC) project, what a modern diagnostic framework should look like, and how an integrated, holistic approach to diagnosing patients with mental ill-health is the way forward.

The latest iteration of the ICD is its 11th (ICD-11) and has been under the purview of the World Health Organization since 1948. It is a globally accepted system that covers all illnesses in the world[i], and which was introduced and adopted in the United Kingdom in the 1960s. The DSM is in its 5th iteration (DSV-V) and is an American system of classification produced by a single national professional association, the American Psychiatric Association, and is largely used in America, and other countries such as New Zealand and Australia.

These two diagnostic frameworks differ fundamentally in terms of the rigidity of their diagnostic criteria[ii] however they have in common an Aristotelian view of mental disorders as individual, discreet entities that are based on a set of specific predefined symptoms[iii]

Every iteration of ICD requires approval from the World Health Assembly, which consists of Health Ministers from around the world, while the DSM is approved by the American Psychiatric Association. While there was some initial historical convergence between the two frameworks, DSM 3 and ICD 6[iv], they subsequently diverged as the APA's focus on creating a increasingly homogenous diagnostic criteria differed from that of the WHO's, which was not as

focused on standardizing diagnoses, and was less rigid on diagnostic criteria. This has led to the DSM having a more specific diagnostic criteria and accepted operationalized definitions[v], while the ICD provides a lot more freedom in diagnosis,[vi] and indeed sought to expand the range of psychiatric diagnoses. It departed from cause and effect dichotomies, and instead recognized various other contributing factors and causes to mental distress[vii]

Despite these frameworks being the main diagnostic tools and are widely used, they both face criticism in that their development over the years led to the lowering of diagnostic thresholds in existing criteria, and the conception of new, arguably unnecessary diagnoses.[viii] Both the DSM and ICD have also been criticised for having highly specified categories, and for categorizing the disorders that one may develop as contrasted to categorizing one with a disorder.[ix]

The RDOC Initiative

Since 2009, the Research Diagnostic Criteria (RDoC) which was launched by the National Institute of Mental Health (NIMH)
has gained traction as an alternative system of mental illness classification, and as a useful tool to supplement both the ICD-and DSM as existing diagnostic frameworks.

The RDoC is a research classification system rather than a diagnostic framework intended for day-to-day clinical practice. It takes a broader, holistic approach to in that it views the root cause of psychopathology as a product of disfunction in one's neuro-circuitry. In direct contrast, where DSM emphasized the dimensionality aspect of a patient mostly as a function of symptom severity, RDoC is committed to studying the whole range of variation in behaviour, from normal to abnormal[x].

One of the more stark differences with the DSM is that RDoC places equal emphasis on biological and behavioural analysis in diagnosing. In viewing psychopathology as caused by disorders of brain curcuits (Cuthbert, 2013), RDoC tends to view diagnosis as more of a form of useful communication between the care provider and the patient, rather than a fact, as is so with the DSM and ICD frameworks.

RDoC differs with ICD in particular in that it has a system of continuous improvement and incremental growth built-in,[xi] as is with the DSM-V which was developed with the ability to make future incremental additions in mind. In the case of RDoC, it was developed with the intention of building a system of psychobiological markers which are linked to both one's adaptive and maladaptive functioning (Lilienfield, 2016).

To do this, it makes four critical assumptions, among them its multidisciplinary transdiagnostic approach, which provides for a more holistic and patient-oriented approach to mental health care. This is because the RDoC's dimensional framework is not based on the demarcation of brain processes but at their continued and sustained operation. Additionally, by focusing on symptoms rather than experiences, individuals can come to be viewed as no more than a diagnosis, when in reality, each person is a complex human with unique experiences, memories, trauma, opinions and views. Translational research is equally important to convert basic research findings more efficiently into clinical practice. Another assumption is supported by the adoption of a dimensional framework to support the belief that most brain circuit activity is constantly and continuously being distributed, and there being no clear demarcation of normality and abnormality. Another feature of the RDoC is that it gives equal weightage to the various data used in its analysis (Cuthbert, 2013).

Nevertheless, the RDoC does have its pitfalls. As it is a constantly developing body of data, some feel that the RDoC's focus on biological mechanisms might underemphasize its research into clinical symptoms. However, its framework protects against that by taking in myriad factors as data. With the use of computational tools, and armed with new findings, these data may help researches to then make new advances in diagnostic criteria.

However, that view would run contrary to the view of those in the psychiatric community which support the removal of diagnostic frameworks altogether; they argue that their very existence tends to stigmatize patients.[xii] Allen Frances—one of the people who coordinated the development of the DSM-IV admits that "the power to label is the power to destroy" and that if "we look hard enough, perhaps everyone will eventually turn out to be more or less sick." This however has been proven to the contrary, as more open discussion about mental health issues tend to melt away the stigma associated with it. The concept of dediagnosis or the reduction in mental health diagnoses, has been put forth as a method for reducing the amount of mentally-ill,[xiii] however that is a flawed and extreme view. The answer thus lies somewhere in the middle – to treat each patient / individual as totally separate, while leveraging on existing guidelines, without the rigidity and diagnostic overfocus of DSM, and with the support and network that the ICD has, supplemented by the various data from having multidimensional axis approach with RDoC.

Taking the view that human beings are complex and require significant interpersonal engagement in order to properly provide a diagnoses, sees mental distress as human even if we dont understand it yet. The use of human language rather than mental health terminology, and the frame of mind of determining what is happening to one, rather than what is wrong with one,

all play a role in ending the stigma associated with mental health patients, in order to provide them support based on need, not necessarily diagnoses alone.

DSM and ICD however should be maintained insofar as they have functional, working attributes. For example, DSM has been credited with the advent of cognitive behavioral therapy for the psychological treatment for specific disorders.

There is little doubt among the mental health community that DSM has accelerated scientific progress regarding the treatment of mental disorders, but it is about time to adopt a wider, dimensional axis approach as with the RDoC. In terms of the ICD, the WHO, which has the resources to drive a global initiative, could consider the integration of various aspects of the RDoC framework in an attempt to provide standardization in diagnostic criteria.

However, in the long run, there is little justification for maintaining the DSM as a separate diagnostic system from the ICD particularly given the U.S. government's willingness to engage with WHO in the area of classification systems. A single unified codification system would be ideal, however it is unlikely to happen given the widespread use and popularity of the ICD and DSM. What should be attempted then is the standardization of diagnostic procedures. Developments are of little use on a global scale if they are not standardized. RDoC may shift the focus of psychiatry towards the goal of precision medicine, which is to is to target the right treatments to the right patients at the right time.

Cultural acceptance and social norms also play a big role in the application of standardized diagnostic procedures. Moving forward, mental health practitioners and care givers should utilize the DSM and ICD, but still exercise full clinical discretion. It is important to bear in mind

their fundamental nature of being manuals (ICD, DSM) as opposed to RDoC which is a classification system, which when used to supplement each other, and with the use of other Data Driven approaches[xiv] under RDoC would provide mental health patients with the best possible diagnosis and treatment.

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