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International Classification and Diagnosis: Critical Experience and Future Directions

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Evolving Adaptations and Annotations of thé International Classification

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French Classification for Child and Adolescent Mental Disorders

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Abstract
This report présents thé French Classification of Child and Adolescent Mental Disorders (CFTMEA), operational since 1983 and validated through a broad multicentric study. CFTMEA is now thé classification of reference for French child psychiatrists, who appear to be comfortable with it because it fits their diagnostic and therapeutic work. It bases its clinical categories on a psychopathological approach which includes an appraisal of potentials and prognosis. CFTMEA is deliberately built on two quite distinct axes: Axis I: basic clinical categories, and Axis II: associated and possibly etiological factors. The CFTMEA favors a broad appraisal of thé disorders that it classifies, seeking whenever possible to establish a structural diagnosis based on psychodynamic psychopathology. The CFTMEA does not daim to be atheoretical, but does not impose a theoretical allegiance, because it is compatible with any etiological concepts. The CFTMEA's last revision (R 2000) is in an advanced phase of validation.

Introduction

The French Classification for Child and Adolescent Mental Disorders (CFTMEA) was created in 1983 by a task force led by Prof. Roger Mises with one major goal: to offer French child psychiatrists an alternative to DSM-III. French child psychiatrists worried that DSM-III was quite different from the clinical process that most of them were using for diagnosis decision making. They also worried that the DSM-III could drastically change clinical practices by focusing ail of the clinical and therapeutic attention on isolated symptoms rather than taking into account structural psychopathological configurations. The CFTMEA was thus created in response to this concern.

This Classification tried to find definitions and criteria to fit its clinical orientation, basing its clinical categories on a psychopathological approach, which included an appraisal of potentials and prognosis. Treatment often offers an opportunity to change the diagnosis of the first evaluation. Therefore, it would be helpful to give special consideration to clinical and psychopathological signs, indicating if the disorder is fixed or progressive and their possible consequences on adolescent and adult mental health.

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In France, CFTMEA is used by child psychiatrists with various theoretical orientations and was validated through a broad multicenter study with the participation of professionals from most French child psychiatric public facilities. French Classifications have been widely used in epidemiological studies, outcome studies and clinical research in recent times [Mises and Quemada, 1993 ; Mises et al., 1988].Furthermore, CFTMEA incorporates concepts on disability assessment. It is biaxial and a glossary was created to define inclusion and exclusion features. This glossary is more inclusive than those of DSM or ICD-10 and does not rely on checklists.

The CFTMEA Multiaxial System

As in DSM, the axes of he classification are quite independent from each other.
Axis 1 refers to basic clinical categories, as follows :

1 Autism and Psychotic Disorders
2 Neurotic Disorders
3 Borderline, Personality Disorders
4 Reactional Disorders
5 Mental Retardation
6 Specific Developmental Disorders of Instrumental Functions
7 Behavior and Conduct Disorders
8 Psychosomatic Disorders
9 Variations from normality

The appendix displays a full listing of Axis 1 Clinical Categories.
Axis II refers to associated and possibly etiological fac tors which are divided into two headings: organic factors (10-17) and environmental factors (20-29).
Clinicians are thus asked to separate clearly the step of classification of clinical categories and the further step of coding for associated and possibly etiological factors. This allows the syndromic classification to remain neutral with regard to etiology, thereby minimizing the restrictions of ideological determinism.
Most of the basic clinical categories in Axis 1 have been traditionally used by French psychiatrists. Some have been identified relatively recently, but ail correspond to widely acknowledged categories. This becomes clear when one compares the categories in ICD-10 and those in the CFTMEA Axis I, which reveals a substantial correspondence between these two classification Systems.
This correspondence was even greater when the latest CFTMEA revision (R-2000) was examined. This revision is now in the last phase of its validation process. Nevertheless, a discrepancy remains between the two classifications, a discrepancy that becomes clear when we consider the hierarchical architecture of the French Classification and the procedures for its use

Procedures for the Use of the CFTMEA

On Axis I: Basic Clinical Categories
The priority here is to choose a main clinical category among the first 4 categories (1-4), which are considered to be mutually exclusive. If none of the previous categories are appropriate, the selection of the main category has to be made among the next set of clinical categories (5-9).
After selecting a main category, one may then select 1 or more complementary categories (those coded as 5, 6, 7, 8, and 9). These categories are not mutually exclusive, and several of them can be selected in the diagnostic formulation.

For example, a Specific Instrumental Functions Developmental Disorder will be coded with category 6. If it is associated with a previously selected main category, category 6 classification will appear as a complementary category. For instance, a Neurotic Disorder (broad category) Mainly Phobic (specific category, indicated by a code following the decimal point) with prevailing Specific Speech Developmental Disorder will be coded 2.02 (main category), 6.10 (complementary category). For another example, a Borderline, Personality Disorder associated with a Conduct and Behavior Disorder will be coded as follows
<3.00,700>.

Some more specific coding issues are listed below;

(1) For Mental Retardation, category 5 is used as the
first number in the code. The second number is for the level of retardation and the third for the type of retardation. For example, a Disharmonic Mental Retardation with an IQ of60 will be coded 5.05. If it is associated with an Early-Onset Deficit Psychosis, the whole first axis code will be : 1.02,5.16.

(2) For Substance Abuse Disorders, category 7 will be used as the first number: the second number refers to the abuse type, and the third one refers to the substance used.
For example, occasional cocaine abuse will be coded 7.3.14.

(3) For Neurotic Disorders, it is possible to code the association of two syndrome characteristics. For example, a Neurotic Disorder with phobic and obsessive symptoms will be coded 223.

(4) One of the main particularities of this classification is its strong position against defining depression as a specific category. In this classification System, depression is agreed to be basically a symptom, which can be part of many different main clinical categories. Dependingon the global structural psychopathological functioning in which it is included, the coding of a depressive state can be indicated as follows :

a As subcategories, in category 1 : Child Affective Disorders (1.40), Adolescent Affective Disorders(1.41)
(which includes many subcategories), Depressive State after a Psychotic Episode (1.5)
b In category 2: Neurotic Depression (2.5)
c In category 3: Borderline Depression (3.4)
d In category 4: Reactional Depressive Episode (4.0)
e In category 9: Depressive Moment as Variation from Normality (9.1)
f On an infant-annexed classification, Axis I: Infant Depression

On Axis II : Associated and Possible Etiological Factors

As noted above, one may select many items in each of the two domains: organic and environment factors. For example, item 25 (peculiar family context) serves to code items that can be observed in this field, eve if they are
not seen as etiological factors.

This method clearly indicates the steps one has to follow to select a diagnosis. It may appear complicated, but it
is very close to the natural clinical process, which is widely used by French child psychiatrists in regular clinical
work.

Field Trial

CFTMEA was tested in 1988 in a broad multicenter national field trial on ail French public child psychiatric institutions. This experiment had two main objectives: to study the use of this

classification and to know more precisely what pathology these public child psychiatric services were treating.

Data gathered in this study were used in many statistical investigations on diagnosis, age groups, concomitant or earlier and possible etiological factors. Two examples of this work (on mental retardation and on psychosis) are presented below:

Methodology

The studied population included all the children who consulted at a public child psychiatric service in France during the first 2 weeks of May 1988 (5,760 cases). A senior child psychiatrist, using CFTMEA categories and criteria, diagnosed ail of the cases.

Results

Mental Retardation. As main diagnosis, Mental Retardation was found in 5 % of the studied population. More specific findings included the following: Harmonic Mental Retardation, 15 % (828 children) ; Disharmonic Mental Retardation, 13 % (724 cases) ; Mental Retardation with Polyhandicap, 12 % (651), and Dementia, 5 % (288).

Apart from this group, mental retardation was also found in two other contexts. As a main category, Deficit Psychosis appeared in 27 % (1,461 cases). Additionally, it appeared complementary to a main diagnosis of Psychotic Disharmony 6 % (338), to other Psychosis 5 % (250), to Neurotic Disorders 4% (225), and to Borderline, Personahty Disorders 12 % (660).

Psychosis. This CFTMEA investigation found a psychosis category in 1 5% (840) of the studied population ; with a sex ratio of 2 boys for 1 girl. Peak ages were around 7 years in both genders. In the psychotic group, the investigation found Psychotic Disharmony, 45 % ; Kanner Autism, 8 % ; other forms of Autism, 15 % ; Early-Onset Deficit Psychosis, 18 % ; Childhood Schizophrenia, 5 %, and other Psychotic Disorders, less than 3%. In the psychotic group, it was also found that 9 % were treated in an ambulatory System, 46 % in a day clinic, and 46 % in a full time hospital.

Discussion

This investigation did not examine disorders in the general population but only in the specific population seen at a specialized public facility- It did not take into account the Specialized Educational System for Mentally Disabled Children, which is not included under psychiatric services in France. This System is generally designed for children with fixed mental handicaps that in general were not evaluated in this study.

Among the main findings were then following : (1) the classification was found useful by French child psychiatrists with many different theoretical backgrounds; (2) the classification was found to be helpful to account for psychopathological processes underlying a mental disorder.

In the case of mental retardation, for example, it allows a diagnostic differentiation between fixed mental retardation and mental retardation as part of a complex and still progressive process. Such a differentiation may be helpful to select a proper treatment strategy and formulate a prognosis.

Conclusions

CFTMEA emphasizes a global psychopathological diagnosis that does not rely only on symptom checklists or descriptions, but takes into account how these symptoms relate to one another and to the structural organization of the whole disorder in which they are included. This psychopathological diagnosis personality characteristics and takes consideration a psychodynamically oriented psychopathology. CFTMEA is, thus, not pretending to be atheoretical. This allows this Classification to keep closer to clinical work, which is rarely atheoretical, even when limited to a symptomatic description.

Mises/Quemada/Botbol/Burzsteijn/
Garrabe/Golse/Jeammet/Plantade/Portelli/ Theveno

Appendix

Axis : Clinical Catégories

1 Autism and psychotic disorders
1.0 Early onset psychosis (pervasive developmental disorders)
1.0.0 Childhood autism: Kanner's type
1.0.1 Atypical autism
1.0.2 Early onset deficitary psychosis or mental retardation with autism or psychotic disorders
1.0.3 Asperger's syndrome
1.0.4 Psychotic disharmony
1.0.5 Childhood disintegrative disorders
1.0.8 Other early onset psychosis or pervasive developmental disorders
1.0.9 Early onset psychosis or pervasive developmental disorders not otherwise specified
1.1 Schizophrenia
1.1.0 Childhood schizophrénie disorders
1.1.1.1 Adolescent schizophrénie disorders
1.1.1.0 Prodromic type
1.1.1.1 Complete type
1.2 Delusional disorders
1.3 Acute psychotic disorders
1.3.0 Acute polymorphic psychotic disorders without symptoms of Schizophrenia
1.3.1 Acute polymorphic psychotic disorders with symptoms of Schizophrenia
1.3.8 Other acute psychotic disorders
1.4 Mood [affective] disorders
1.4.0 Childhood dysthymic psychosis
1.4.1 Adolescence affective disorders
1.4.1.0 Manic episode
1.4.1.0.0 Manic episode in bipolar disorders
1.4.1.0.1 Manie episode without psychotic symptoms
1.4.1.0.2 Manic episode with psychotic symptoms
1.4.1.0.3 Mixed affective épisode
1.4.1.0.4 Hypomania
1.4.1.1 Depressive episode
1.4.1.1.0 Depressive episode m bipolar disorder
1.4.1.1.1 Major depressive episode without melancholic features
1.4.1.1.2 Major depressive episode without melancholic features and with psychotic symptoms
1.4.1.1.3 Major depressive episode with melancholic features
1.4.1.1.4 Major depressive episode with delusional melancholy
1.5 Depressive episode following a psychotic episode
1.8 Other psychotic disorders
1.9 Psychotic disorders not otherwise specified
2 Neurotic disorders
2.0 Neurotic disorders predominantly anxious
2.1 Neurotic disorders predominantly hystérie
2.2 Neurotic disorders predominantly phobie
2.3 Neurotic disorders predominantly obsessive
2.4 Neurotic disorders predominantly inhibited
2.5 Neurotic depressive episode
2.6 Neurotic characters. neurotic personality disorders
2.7 Neurotic disorders with prevailing specific instrumental functions developmental disorders
2.8 Other neurotic disorders
2.9 Neurotic disorders not otherwise specified

3 Borderline. personality disorders
3.0 Developmental disharmonies
3.1 Borderline. personality disorders with prevailing personality disorders

3.2 Borderline. personality disorders predominantly schizotypic
3.3 Borderline disorders with prevailing behavior and conduct disorders
3.4 Depressive episode related to borderline. personality disorders
3.8 Other borderline, personality disorders
3.9 Borderline. personality disorders not otherwise specified

4 Reactional disorders
4.0 Reactional depressive episode
4.1 Other reactional symptoms
4.2 Posttraumatic stress disorders

5 Mental retardation
5.0.X IQ 50-69
5.1.X IQ 35-49
5.2.X IQ 20-34
5.3.X IQ<20
5.9.X IQ nonspecified
5X 1 Harmonic mental retardation
5X2 Disharmonie mental retardation
5X3 Mental retardation with sensorial or motor polyhandicap
5X4 Dementia
5X9 Mental retardation not otherwise specified

6 Specific developmental disorders of instrumental functions
6.0 Specific developmental disorders of speech and language
6.0.0 Articulation disorders
6.0.1 Specific developmental disorders of language
6.0.2 Aphasia
6.0.3 Mutism
6.0.3.0 Total mutism
6.0.3.1 Elective mutism
6.0.4 Stuttering
6.0.8 Other specific developmental disorders of speech and language
6.0.9 Specific developmental disorders of speech and language not otherwise specified
6.1 Specific developmental disorders of cognitive functions and scholastic learning
6.1.0 Specific lexicographic developmental disorders
6.1.0.0 Dyslexia
6.1.0.1 Orthography disorders without reading disorders
6.1.1 Specific disorders of arithmetic skill (dyscalculia)
6.1.2 Reasoning disorders (cognitive disharmonies)
6.1.3 Attention disorders without hyperkinesia
6.1.8 Other specific developmental disorders of cognitive functions and scholastic learning
6.1.9 Specific developmental disorders of cognitive functions and scholastic learning not otherwise specified
6.2 Psychomotor disorders
6.2.0 Psychomotor retardation
6.2.1 Tic disorders
6.2.1.0 Isolated tics
6.2.1.1 Gille de la Tourette disease
6.2.8 Other psychomotor disorders
6.2.9 Psychomotor disorders not otherwise specified

7 Conduct and behavior disorders
7.0 Hyperkinetic disorders
7.0.0 Attention and hyperactive disorders

7.0.8	Other hyperkmetic disorders
7.0.9	Hyperkinetic disorders not otherwise specitied
7-1	Eating disorders
7.1.0	Anorexia nervosa
7.1.0.0	Restrictive type
7.1.1.0	Bulimictype
7.1.1	Aypical anorexia nervosa
7.1.2	Bulimia
7.1.3	Atypic bulimia
7.1.4	Toddiers and chiidren's eating disorders
7.1.5	Infant eating disorders
7.1.8	Other eating disorders
7.1.9	Eating disorders not otherwise specified
7.2	Attempted suicide
7.3	Substance use disorders
7.30 X	Continuons
7.31 X	Episodic
7.32 X	In remission
7.38 X	Other
7.39X	Not otherwise specified
7.3X0	Alcohol abuse
7.3X1	Morphine abuse
7.3X2	Cannabis abuse
7.3X3	Hypnotic and sédative abuse
7.3X4	Cocaïne abuse
7.3X5	Other psychostimuling and psychodysleptic substance abuse (amphétamine, LSD. ecstasy)
7.3X6	Tobacco or caffeine abuse
7.3X7	Solvent sniffing
7.3X8	Polytoxicomania
7.3X9	Other or not otherwise specified
7.4	Séparation anxiety disorders
7.5	Gender identity and sexual conduct disorders
7.5.0	Gender identity disorders
7.5.0.0	Childhood gender identity disorders
7.5.0.1.1	Adolescence gender identity disorders
7.5.1	Sexual conduct disorders
7.5.2	Symptoms of excessive préoccupations about sexual development and orientation
7.5.8	Other sexual conduct disorders
7.5.9	Sexual conduct disorders
7.6S	choolphobia
7.7	Other spécifie conduct disorders
7.7.0	Pyromania
7.7.1	Kleptomania
7.7.2	Trichotillomania
7.7.3	Runningaway
7.7.4	Violent behavior against others
7.7.5	Riskconducts
7.7.6	Wandering
7.7.8	Other spécifie conducts disorders
7.8	Other conduct and behavior disorders
7.9	Conduct and behavior disorders not otherwise specified
8	Psychosomatic disorders
8.1	Psychofunctional disorders
8.2	Hypochondriac disorders
8.3	Enuresis
8.4	Encopresis
8.5	Sieep disorders
8.6	Psychogenic tailure to tlinve
8.8	Other psychosomatic disorders
8.9	Psychosomatic disorders not otherwise specified
9	Variations from thé normal
9.0	Anxiety, rituals, fears not related to any other categorv
9.1	Dépressive moment not related to any other categorv
9.2	Oppositional behavior not related to any other category
9.3	Loncliness behavior
9.4	School problems other than those related to any other category
9.5	Transient régression or retardation épisode
9.6	Original personality features
9.8	Other variation from thé normal
9.9	Variation t'rom thé normal not otherwise specified

Axis 1 Infant: Spécifie Clinical Catégories (0-3 Years)

B1 :	Infant at risk for sévère developmental disorders
B2 :	Infant's dépressions
B3 :	Infant at risk for disharmonie évolution
B4 :	Stressed states
B5 :	Pathological hypermaturity and hyperprecocitv
B6 :	Links distortion

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