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Editorial

ICD–10: A Neuropsychiatrist's Nightmare?

Five problems introduced with the term 'organic'

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The collected clinical descriptions comprising the ICD–10 categories are here (World Health Organization, 1992) and the international field trials refining earlier drafts are now published (Sartorius *et al*, 1993). Readers of the latter are told that development of the classification is intended still to continue in the light of comments on the text. I would like to respond to the spirit of this open invitation by noting what I consider to be a flaw lurking close to the conceptual heart of the new classification: how ICD–10 has chosen to use the term 'organic'.

The 'O' word has a long and chequered history in psychiatry. Its use has been criticised by various commentators, often non-psychiatrists, for over a century (Gowers, 1886). The main problem with the term 'organic' is that, although many think they know what it means, no one actually does. At its safest, it is used purely descriptively to denote mental states characterised by cognitive impairment. Although often overlooked, this was the status quo in ICD–9, where the term 'organic psychotic disorders' was used to describe clusters of particular symptoms and, explicitly, *not* to imply an organic 'cause'. This use of the term changed in DSM–III and has changed further in ICD–10, with some bizarre results.

In ICD–10, the problem crystallises with a new group of organic mental disorders designated "Other disorders due to brain damage and dysfunction and to physical disease" (F.06). This group subsumes disorders with names like 'organic hallucinosis', 'organic schizophrenia-like disorder', 'organic mood disorder', and so on. The text of ICD–10 gives two reasons for redrafting this part of the classification: firstly, "growing evidence that . . . cerebral and systemic diseases are causally related . . . to psychiatric symptoms"; and secondly that it "makes the use . . . easier than the arrangement in ICD–9" (pp. 44–45, 60–69). With these words ICD–10 ushers us into a neuropsychiatric nightmare.

The first problem is that the word 'organic' introduces an inevitable paradox, which is blandly and unapologetically put in the text thus: "use of the term 'organic' does not imply that conditions elsewhere in this classification are 'non-organic' ". This confusing statement sits uneasily in a classification which aspires to being exhaustive and mutually exclusive.

Secondly, subsidiary terms used are often tautologous and often inconsistent. For instance, a subdivision of 'organic' disorders is attempted into those due to a "primary cerebral dysfunction" or dysfunction '*secondary*' (their italics) to systemic physical disease affecting the brain (similar to DSM–III–R's 'endogenous' and 'exogenous' organic factors). Yet, a page later (p. 45) we read, "The term '*symptomatic*' [my italics] is used for those organic mental disorders in which cerebral involvement is secondary to a systemic extracerebral disease". So, which is it – 'secondary' or 'symptomatic'? The general sense of intellectual woolliness is heightened too by inconsistencies in what to call the putative organic cause, referred to variously as 'brain damage', 'brain dysfunction', 'brain disease', 'overt brain disease', 'cerebral disease', 'brain injury', and so on, and by misleading grammatical errors, such as:

> "Their [organic mental disorders] inclusion here is based on the hypothesis that they are directly caused by cerebral disease or dysfunction rather than resulting from either a fortuitous association with such disease or dysfunction, or a psychological reaction to its symptoms, such as schizophrenia-like disorders associated with epilepsy."

Does this dangling subclause really mean that the authors consider the psychoses of epilepsy to be some psychosomatic disorder?

Thirdly, the guidelines by which to identify the F.06 organic mental disorders are illogical. One of the two requirements to justify a provisional diagnosis is "a temporal relationship (weeks or a few months) between the development of the underlying disease and the onset of the syndrome". This condition would make sense if discussing precipitating factors, such as life events, but makes no sense with regard to organic aetiological factors, as is made plain by the list of examples of relevant organic disorders given in ICD–10's very next paragraph, which includes epilepsy, Huntington's disease, and even vascular malformations. Years often elapse before these disorders cause psychiatric complications.

The fourth problem is that these guidelines are disingenuous. One of the two reasons given for reorganising the 'organic' section is that it ostensibly

makes the classification easier to use. But it does not, since the onus is now on the poor diagnostician to investigate fully all cases of schizophrenia or depression or anxiety to exclude the possibility of organic disease. Without such a search, an ICD-10 diagnosis of schizophrenia, for example, can only ever be provisional. How hard should one look for underlying organic causes? We are not told, although the section on organic delusional disorder includes reference to "enlarged cerebral ventricles visualized on computerised axial tomography" (*sic*), implying that this at least should be a routine investigation. The implications of such resource-driven diagnoses detract from the chief potential strength of ICD-10: its international perspective. All competent psychiatrists from Aarhus to Zaïre can recognise schizophrenic symptoms, but the ability to exclude, say, underlying demyelination depends on the psychiatrist having a magnetic resonance scanner.

In my view, the authors of ICD-10 have fallen into a trap largely generated out of psychiatry's continuing bedazzlement by the illusory distinction between organic and functional disorders. Splitting a syndrome in two, depending on whether or not it has an organic cause, commits the sin, identified by Birley (1990), of "scholasticism, which is treating what is vague as if it were precise". And it is unnecessary, prompting the neurologist Reynolds (1990) to comment drily, "Psychiatrists might profitably spend less time taking sides in inappropriate conflicts between false dichotomies". And it confuses, which leads to my fifth and possibly most serious criticism of this section of ICD-10: it is unreliable. This much is clear from the field trials (Sartorius *et al*, 1993): the kappa statistics for the F.06 categories were much lower than for their non-organic counterparts, a reversal of the usual situation in psychiatry where the more severe the disorder, the more reliably it is recognised. The authors acknowledge that the main inter-rater differences were "caused by disagreements about attribution of the condition to an organic cause".

Sadly, this section of the ICD-10 seems almost to epitomise the increasingly embattled image of the World Health Organization itself (*Lancet*, 1993). What is the solution? The forthcoming research edition of ICD-10 needs to reintroduce some clarity if it is to be usable. DSM-III-R avoided many of these problems in its corresponding section by being precise, clear and honest about areas of ignorance: its corresponding section is entitled "organic mental disorders . . . associated with physical disorders . . . *or whose aetiology is unknown*" (my italics). Significantly, some of the authors of DSM-IV have, in a well reasoned article (Spitzer *et al*, 1992), proposed abandoning the term 'organic' altogether and suggested less problematic alternatives[1]. Certainly, ICD-10 has induced in me symptoms of poor concentration, irritability and pessimism, which I recognise in some colleagues too: will "classificatory fatigue disorder" earn a place in ICD-11?

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1. Since submitting this paper, I have seen the draft DSM-IV criteria (American Psychiatric Association, 1993), which read: "The term 'organic mental disorder' is no longer used in DSM-IV because it incorrectly implies that the other mental disorders in the manual do not have a biological basis".

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