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THE PRESENTATION AND COURSE OF PSYCHOTIC DISORDERS IN DEVELOPING COUNTRIES – IMPLICATIONS AND SOME SUGGESTIONS FOR ICD-11

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The two main classification systems are in the process of revision. The revision of DSM-IV by American Psychiatric Association is in advanced stage and the arrival of DSM-V is expected in near future. World Health Organization has started the process of development for ICD-11. Professor Wolfgang Gaebel who is the chair of the psychosis working group of the WHO for the development of ICD - 11 highlights the issues relevant to classification of psychosis in the guest editorial of this issue.

A recent editorial in British Medical Journal raised the question whether Schizophrenia should be renamed[1]. The Japanese classification has already renamed schizophrenia as "integration disorder"[2]. Translation of the word "schizophrenia" to Japanese "Seishin Bunretsu Byo" means "mind-split-disease"[3] and it was considered that the term is pejorative to the patients and their families. The new term "Togo Shitcho Sho", with the meaning of "integration disorder", is considered as more positive to the patients and their families. However, the debate about classification of Psychosis has generally been less informed by the problems and issues from developing countries perspective. This article will try to highlight these issues.

It must be realized that the debate about the classification is not just an academic exercise and disagreements about the classification categories should not be seen as futile intellectual exercise. Diagnostic labels in Psychiatry have much wider implication than just describing pathology. This is often not realised. It is well known that Schizophrenia is the most serious and malignant disorder that can affect the mind. Utmost care should be taken in diagnosis and classification of Schizophrenia just like that of a somatic malignant pathology. Diagnosis of cancer may involve multidisciplinary input from Pathologists, Radiologists, Physician and sometime long observation of the pathology before a firm conclusion could be reached. Similarly classification of various cancers is much more problematic and there are extensive studies and debates. The debates about the classification of Psychosis lies at the heart of clinical practice and should not be left to the researchers alone.

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The question arises, why focus on classification of psychotic disorders in developing countries? After all, the diagnostic categories are universal and it should not matter if one lives in Paris or Peshawar. Someone suffering from typical psychotic symptoms in any part of the world should be classified as suffering from schizophrenia. The argument seems to be more compelling for a diagnostic category like Psychosis which has much more biological underpinning than many other psychiatric disorders. However, variation in presentation, course and etiological factors underlying various diagnostic disorders in developing countries and many non western populations is now well documented [4]. In fact, one of the most well established finding in the epidemiology of Schizophrenia relates to developing countries.

The International Pilot Study on Schizophrenia demonstrated substantial differences in the course of schizophrenia between developed and less developed countries. Considering that the course of illness has remained the cardinal principle on which the Kraeplinian dichotomy of psychotic disorders is based, one wonders how easily the evidence which demonstrates substantial differences in the course of Schizophrenia disorders from developing countries is dismissed. This is more alarming in view of the fact that Schizophrenia is amongst the top ten causes of the years of lived with disability in developing countries.

The concept of acute psychosis as it presents in developing countries also challenges the traditional Kraepelinian dichotomy. The data from WHO studies suggests that these psychoses have unique features. Analyzing the data gathered in a 10-nation study of psychoses by the World Health Organization (WHO), Susser et al found that nonaffective acute remitting psychosis were 10 times more common in developing than in industrialized countries and two times more common in females than males[5]. The latter finding is more important as generally the incidence of Schizophrenia is almost equal in men and women. The data from another WHO study (the India site of the Acute Psychosis Study) suggested that nonaffective acute remitting psychosis is distinguishable from schizophrenia with acute onset on the basis of a bimodal distribution of duration. More importantly, in a 15-year follow-up at an Indian site of the Ten Country Study, the cases of nonaffective acute remitting psychosis exhibited a remarkably distinct benign long-term course [6-8]. Such dramatic differences beg for explanations and more importantly need to be taken into account in the classifications.

Although a category of Acute and Transient Psychotic Disorders (ATPD) exist in ICD-10 but it remains problematic[9]. This needs to be revised in ICD-11 for a variety of reasons. One practical problem is that the current ICD-10 proposes four subcategories of ATPD. As stated in ICD-10, there is little empirical evidence to support the proposed sub-classification of acute and transient psychotic disorders into specific disorders[10]. The bigger problem, however, is that these subcategories hinder the application of this diagnostic category in clinical practice which is generally characterised by heavy workloads with meagre resources leaving little time for considering the nuances of different subtypes.

It is important that clinicians from developing countries are involved in the classification process fully. It is surprising that clinicians who are one of the major end users of the classification systems are often excluded from the process of classification. Computers which perform complex factor analysis of various symptom groups often have greater role! There is virtually no information available that illuminates how clinicians actually use ICD-10 in clinical practice settings. The studies which examine how the present diagnostic categories in ICD - 10 are being used in the field by clinicians need to be conducted. The ease of implementation in the field should be one the major considerations in ICD-11.

The field trials must be informed by systematic review of the existing evidence. There is dearth of literature on Acute and Transient Psychosis, like the evidence from developing countries in general, but experience suggests that a number of these studies are published in local and regional journals which are not often indexed by mainstream data-bases such as Medline, thus hindering an exhaustive search of the literature and evidence[11].

The Field Trials of ICD-11 in developing countries should be accompanied with treatment studies. It may be unethical to conduct trials for clarifying a diagnostic label when the treatment may cost less than two Dollars and more than 90% patients suffering from Schizophrenia may not be receiving any treatment[12].

In coming decades Schizophrenia and other psychotic disorders will be amongst the most common Non Communicable Disorders to afflict the developing countries. This is mainly because of the age structure of these countries. Most developing nations have more than one third of their population below 45 years of age, the age group of maximum risk for developing most psychotic disorders including Schizophrenia, and it is estimated that around 41.7 million people with schizophrenia are in need of care in these countries. The clinicians and researchers need to join the forces in defining what they are going to classify and treat in the name of psychosis and Schizophrenia.

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