

## ***Some general considerations***

### **The use of classification systems in France**

Since 1983 the majority of French Child and Adolescent psychiatrists use the French Classification of Child and Adolescent Mental Disorders (CFTMEA), originally created by a task force led by Prof. Roger Mises.

Its clinical categories are based on a psychodynamically oriented psychopathology; however its framework has been well accepted by clinicians with various theoretical backgrounds

This Classification has been widely used, also being the reference for hospital statistics until 2006. However, since the publication of ICD 10 (1993 in French), the CFTMEA task force has made efforts to guarantee the best possible compatibility of the French Classification with the WHO Classification, leading to several revisions of the CFTMEA. In the most recent version, issued in 2010, almost all items can be transcoded to ICD 10 items.

At the same time, use of ICD 10 among French psychiatrists has progressively increased, particularly since 2006 when it became the official and only reference for hospital statistics.

### **The requirements of a classification system in CAP**

The CAP classification should take into account the various aspects of clinical practice, in order to allow each clinician to engage in research in his(her) field, communicate with fellow physicians and also to report his(her) activity to the administration (hospital or other institution). In France, the psychiatric classification is not only used by medical doctors: allied professions (psychologists, speech therapists, etc...) also refer to it. Furthermore, It can be used in various institutional settings (special education, justice, etc...). We believe that a classification system should be applicable in these various settings, although (at the same time) we are very concerned by the risk of stigmatization and social segregation related to certain

diagnoses which may have been improperly or prematurely applied to young children.

## ***Remarks and proposal for ICD 11***

### CHILDHOOD SPECIFICITIES

For child and adolescent psychiatry teams, one of the main specificities and advantages of ICD-10 is that it takes into account the specific aspects of child and adolescent clinical expression: items F80-F89 (disorders of psychological development) and F90-F98 (behavioral and emotional disorders with onset usually occurring in childhood and adolescence) cover these specific disorders. It is important to maintain and improve this childhood specificity, either by maintaining and extending these particular items, or by introducing in each general category new items concerning the specific variants of each disorder in children and adolescents. For example, depressive disorder in childhood could be described as a sub-category of depressive disorders, or in a childhood section. We believe that it is very important to avoid under- or over-inclusions.

We wish to emphasize one of the peculiarities of clinical CAP: the frequent occurrence in children and adolescents of transient symptoms emerging within the context of relational events, or symptoms reflecting psychological changes during development. All health professionals working with children and adolescents have regularly to examine children with clinical manifestations that do not correspond to well-defined and long lasting disorders. Therefore, it seems useful and scientifically correct that ICD-11 offers the possibility to classify these manifestations or symptoms as “transient disorders” as the set of symptoms may change, and classifying them too early in a “strong” diagnostic category could contribute to stigmatization. This notion of transitory symptomatology should apply, in particular, to anxiety symptoms, hyperactivity, conduct issues, sleeping or eating problems...).

### INFANT SPECIFICITIES

in the same argumentative line, we suggest to introduce a specific block concerning infant mental health. Knowledge within the fields of infant psychiatry, infant

developmental psychopathology and early attachment has considerably increased in recent years. Specific clinical aspects are now better and better described and extensively studied. Specific infant psychopathology plays an increasingly important role in taking into account early disorders and risk factors, prevention of comorbid disorders and complications. Its recognition and integration into future ICD-11 would be very useful to health professionals working in early infancy mental health. The Diagnostic Classification of Mental Health And Development Disorders Of Infancy and Early Childhood: DC:0-3R (published in 1994 and recently revised) could serve as a support to develop this special section.

## **PDD**

The APA has recently announced that the section on PDD within DSM-V will comprise only one item: ASD. This modification is mainly justified by the difficulties that have appeared to differentiate Asperger Syndrome from High Functioning Autism. If maintained, the diagnosis of ASD will include an extremely large (nearly 1% of the general population) but also very heterogeneous population, confounding subgroups of patients presenting a great variability of clinical presentations, prognoses, and also very different needs in terms of therapy and social support. One might doubt whether research findings apply all along this spectrum, and also if the same types of care or interventions are appropriated for every patient receiving a diagnosis of ASD.

Most French CA Psychiatrists do not agree with this major change. We advocate for the maintenance of at least some ASD subgroups.

One should notice that PDD-NOS will also be included in the ASD, although only few studies – if any – have been performed on this poorly defined but numerically important subgroup.

For several years many French clinicians have been involved in the treatment and study of a particular group of young patients diagnosed with “disharmonic disorder” in the French Classification, who, in the absence of a more appropriate diagnostic category offered by ICD 10, received the diagnosis of PDD-NOS. Their clinical characteristics are very similar to those of the Multiplex Developmental Disorder (MDD) described some 20 years ago by DJ Cohen : these children display severe, early-appearing social and communication deficits characteristic of autism, but they do also present with some of the emotional instability and disordered thought

processes that resemble schizophrenic symptoms .

In 1998 Buitelaar and Van Der Gaag<sup>1 2</sup> renamed this syndrome “multiple complex developmental disorder (MCDD) and proposed more specific diagnostic criteria. Since then, some authors – mostly from the University Medical Centre Utrecht, Department of Child and Adolescent Psychiatry, Utrecht, The Netherlands. – have evidenced that patients corresponding to these criteria exhibit characteristic differences, compared to patients with autism or PDD-NOS:

- In their cortisol response to a psychosocial stress (Jansen 2003)<sup>3</sup>
- In patterns of comorbidity (de Bruin 2007)<sup>4</sup>
- In cerebral morphometry (Lahuis 2008)<sup>5</sup>

Data from Sprong<sup>6</sup> also suggest that adolescents with MCDD are at a relatively high risk of psychosis.

Recently, the reliability and diagnostic efficiency of a set of criteria (Diagnostic Inventory for Disharmony) have been reported.<sup>7</sup>

We propose to include a PDD chapter within ICD 11 that could be entitled “ Autism and PDD “, containing 3 subsections:

Autism Spectrum Disorder

MCDD

Other PDD (or PDD NOS)

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<sup>1</sup> Buitelaar JK, van der Gaag RJ (Diagnostic rules for children with PDD-NOS and multiple complex developmental disorder. *J Child Psychol Psychiatry*. 1998 Sep;39(6):911-9)

<sup>2</sup> Van der Gaag RJ & al. A controlled multivariate chart review of multiple complex developmental disorder. *J Am Acad Child Adolesc Psychiatry*. 1995 Aug;34(8):1096-106

<sup>3</sup> Jansen LM & al. Differences with Autistic children in cortisol response to a psychosocial stress. *Neuropsychopharmacology*. 2003 Mar;28(3):582-90

<sup>4</sup> de Bruin EI & al. Multiple complex developmental disorder delineated from PDD-NOS. *J Autism Dev Disord*. 2007 Jul;37(6):1181-91

<sup>5</sup> Lahuis BE & al MRI-based morphometry in children with multiple complex developmental disorder, a phenotypically defined subtype of pervasive developmental disorder not otherwise specified. *Psychol Med*. 2008 Sep;38(9):1361-7

<sup>6</sup> Sprong M & al . Pathways to psychosis: a comparison of the pervasive developmental disorder subtype Multiple Complex Developmental Disorder and the "At Risk Mental State". *Schizophr Res*. 2008 Feb;99(1-3):38-47

<sup>7</sup> Reliability and diagnostic efficiency of the Diagnostic Inventory for Disharmony (DID) in Youths with Pervasive Developmental Disorders and Multiple Complex Developmental Disorder

## PERSONNALITY DISORDERS

Finally, it would be very useful to discuss the developmental aspects of personality disorders (most of all borderline personality). The cutoff age of 18 years seems an artificial limit, and many clinicians observe younger children presenting features of these diagnoses. We suggest to introduce entities such as “personality style”, “developing personality disorder” or development “at risk of” personality disorder<sup>12</sup>.

## NEW ITEMS

Some items or categories could be added, - eventually in block Z – in order to take into account clinical situations in which it is not yet possible to obtain a psychiatric diagnostic. These categories may include variations of normality, but also difficult family situations, school problems (different from specific learning disorders), etc.

Suicide attempts and suicide conducts, self harm or self injuries, should also be added as specific categories, in order to allow clinicians to record frequent causes of consultations or hospitalizations.

<sup>1</sup> Westen D, Shedler J, Durrett C, Glass S, Martens A. Personality Diagnoses in Adolescence: DSM-IV Axis II Diagnoses and an Empirically Derived Alternative American Journal of Psychiatry 160:952-966, May 2003

<sup>2</sup> Rey JM, Morris-Yates, Singh M, Andrews G, Stewart GW. Continuities between psychiatric disorders in adolescents and personality disorders in young adults American Journal of Psychiatry 1995; 152:895-900