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Diagnosis and classification are considered essential but dry and uninteresting topics by mental health practitioners and trainees. Here is a book that will dispel this notion and bring alive the excitement and nuances of diagnosis of mental health conditions. Led by world-renowned editors and a global cast of authors, this publication is a must-read for all in the caring profession.

—**Shekhar Saxena, MD,** Professor of the Practice of Global Mental Health, Harvard T. H. Chan School of Public Health, Boston, MA, United States

This book is a gift of invaluable knowledge to the global community of mental health professionals, crafted by scientists from the international elite. The clinician is equipped with in-depth explanations of psychopathology pivotal for *ICD-11* diagnostics and treatment planning. A key companion to WHO's *Clinical Descriptions and Diagnostic Requirements (CDDR)* covering changes of diagnostic definitions from *ICD-10* to *ICD-11*, epidemiology, maintaining factors for psychopathology, and prospects for new diagnoses. Momentous and handy!

—**Klaus Pedersen, MSc,** Specialist Psychologist in General Psychiatry, Psychopathology & Psychotherapy, Aarhus University Hospital Psychiatry, Aarhus, Denmark

This volume is a comprehensive compendium for classification and diagnosis of behavioral and mental disorders. The editors have assembled an outstanding cadre of chapter authors from around the world who are recognized for their expertise and scientific contributions to the field of behavioral and mental disorders. The insightful chapters detail the update of the *ICD* supported by an exceptionally strong evidence base developed through innovative methodology and confirmatory field studies. This important contribution fulfills the need for a psychological understanding based on robust empirical and clinical information for the global professional community serving mental health needs.

—**Michael C. Roberts, PhD, ABPP,** Professor Emeritus, Clinical Child Psychology Program, University of Kansas, Lawrence, KS, United States

A timely new perspective from leaders in the field. This book masterfully bridges the gap between diagnosis and treatment to support a more holistic, psychologically informed approach. Essential applied reading!

—**Corinna Hackmann, PhD, DClinPsy,** Norfolk and Suffolk Foundation Trust, University of East Anglia, Norwich, England

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# 1

# A Psychological Approach to Diagnosis

Andreas Maercker, Tahilia J. Rebello, Pierre L.-J. Ritchie, and Geoffrey M. Reed

This book is intended as an essential resource for mental health practitioners and educators around the world who will implement the World Health Organization's (WHO's) *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders* (*CDDR*; WHO, 2024) in their clinical practice, teaching, and training. This book is not intended to replace the *CDDR* and does not duplicate their text. Rather, it is intended as an important tool to be used together with the *CDDR* to facilitate understanding as well as accurate and skillful implementation of the *International Classification of Diseases–11th Revision* (*ICD-11*) classification of mental, behavioral and neurodevelopmental disorders in health care and other clinical settings.

*A Psychological Approach to Diagnosis: Using the ICD-11 as a Framework* offers a structured approach to implementing the *CDDR* in clinical practice that is vital not only for practitioners and trainees in psychology but also for mental health professionals in psychiatry, nursing, social work, and other disciplines who aim to deliver high-quality, empirically informed mental health care. A psychological approach to diagnosis is one that focuses on psychological mechanisms and principles as an aspect of diagnostic practice and case formulation, regardless of professional discipline. It considers the psychological factors—including cognitions, emotions, and behaviors—involved in the development and maintenance of each major grouping of mental disorders and their linkage with treatment considerations.

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*A Psychological Approach to Diagnosis: Using the ICD-11 as a Framework*, G. M. Reed, P. L.-J. Ritchie, and A. Maercker (Editors)
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The etiologies of mental, behavioral, and neurodevelopmental disorders are complex and, in most cases, not clearly understood. There are some exceptions, such as specific genetic syndromes that are linked to certain neurodevelopmental disorders (see Chapter 3). The classification of neurocognitive disorders includes specific forms of dementia that are attributable to identified underlying disease processes (Chapter 18), and the use of psychoactive substances has been shown to cause a variety of substance-induced mental disorders (Chapter 15). Even in these cases, where the etiology is considered established, there is a broad spectrum of symptom expression and co-occurring disorders that vary unpredictably across individuals.

For the majority of disorders, there is not a one-to-one relationship between a particular etiology and a particular syndrome. A variety of genetic, epigenetic, familial, neurochemical and neurophysiological, emotional, psychological, social, and environmental factors have been identified as risk and protective factors in the development, symptomatic expression, and course of mental, behavioral, and neurodevelopmental disorders. Even in posttraumatic stress disorder (PTSD), which is generally believed to have a clear etiology because it develops in response to an event or situation of an extremely threatening or horrific nature, other factors are clearly relevant. Many people who experience these events do not develop a mental disorder, whereas others do not develop PTSD but rather other disorders such as anxiety disorders, depressive disorders, or disorders due to substance use (see Chapter 10).

One reason it is important to emphasize the issues related to etiology is that neither the editors nor any of the authors of this book intend to communicate that the psychological mechanisms described for a particular disorder or set of disorders represent the necessary and sufficient cause of the disorder. Rather, evidence described in the chapters suggests that these psychological mechanisms can be relevant to how disorders and specific symptoms develop, how they relate to one another, and how they are maintained over time. They represent an important basis for case conceptualization and signal important avenues for psychological intervention. Although a detailed discussion of disorder-specific psychological interventions is beyond the scope of this book, a large body of evidence indicates that the most effective interventions for a wide range of disorders are psychological ones (Nathan & Gorman, 2015). For other disorders, psychological interventions are often combined with pharmacological interventions, and such combination treatment has generally been found to be more effective than either alone (Leichsenring et al., 2022).

This book is written to be useful to practitioners, residents, interns, teachers, and students in psychology and to be responsive to the unique context of psychological practice. Moreover, an understanding of psychological mechanisms and principles as they relate to the diagnosis of mental disorders also has a place in the unique body of knowledge and training of a range of mental health disciplines and health disciplines. Accordingly, although many of the chapter authors are renowned psychologists from across the world, experts from psychiatry and other disciplines are also important contributors to this book.

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## STRUCTURE AND CONTENT OF THIS BOOK

This first chapter provides the conceptual framework for the psychological approach to diagnosis, which serves as a unifying perspective across the book. The second chapter focuses on *ICD-11*'s global approach, embodied in its development and testing, its characteristics, and its implementation. The largest block of chapters, comprising Chapter 3, on disorders of intellectual development and developmental learning disorder, through Chapter 18, on neurocognitive disorders, cover the major groupings of *ICD-11* mental, behavioral, and neurodevelopmental disorders. Each of these chapters further elaborates the ways in which an awareness of psychological mechanisms and principles contributes to diagnosis and case conceptualization in each respective disorder area.

In most cases, the content of these chapters corresponds to the major disorder groupings in the *ICD-11*, such as schizophrenia and other primary psychotic disorders (Chapter 5), anxiety and fear-related disorders (Chapter 8), and personality disorders and related traits (Chapter 17). The order of the chapters in this book correspond to the order of the groupings in the *ICD-11*. This order is intended to approximate a developmental perspective on psychopathology based on the stages of life in which their onset is most typical, although the *ICD-11* does not adhere perfectly to this principle. An exception to the correspondence between chapters of this book and the groupings of the *ICD-11* is neurodevelopmental disorders, which is the longest section in the *CDDR*. Specific components of neurodevelopmental disorders are highly important to psychological practice, so these have been divided across Chapter 3, which covers disorders of intellectual development and developmental learning disorder; Chapter 4 on autism spectrum disorder; and Chapter 14, which covers attention deficit hyperactivity disorder (ADHD; a neurodevelopmental disorder) alongside the *ICD-11* grouping of disruptive behavior and dissocial disorder due to their overlapping presentations and high rate of co-occurrence. Similarly, the *ICD-11* overarching grouping of mood disorders is covered by Chapter 6, on depressive disorders, and Chapter 7, on bipolar and related disorders. This book's treatment of the *ICD-11* grouping of disorders due to substance use and addictive behaviors, which contains more categories than any other grouping of mental disorders, is also divided across Chapter 15, on disorders due to substance use, and Chapter 16, on disorders due to addictive behaviors. Although disorders due to substance use and those due to addictive behaviors have overlapping symptoms, psychological mechanisms, and assessment strategies, there are also important differences. Chapter 16 also includes a discussion of compulsive sexual behavior disorder, which shares the characteristic of behavioral dysregulation but is not classified as an addiction but rather as an impulse control disorder.

Three additional chapters cover areas that, although not classified as mental disorders, are directly relevant to the psychological practice and with which it is important that psychologists and other mental health professionals be conversant. The first of these is sexual dysfunctions and sexual pain disorders (Chapter 19) and the second is sleep–wake disorders (Chapter 20). The

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classification of both these areas in *ICD-10* (WHO, 1992a, 1992b) relied on their now obsolete division into organic and nonorganic disorders. The term *organic* implied that a disorder had some basis in the brain or some "real" medical causation, whereas *nonorganic* denoted that it was "functional" or purely psychological (i.e., the possibility of medical etiology had been ruled out). We wish to emphasize that this is not at all how the term *psychological* is used in this book.

The current state of the evidence clearly demonstrates that most sexual dysfunctions and sleep–wake disorders—like most mental disorders—involve both physiological and psychological/behavioral components that are further influenced by a variety of environmental and other contextual factors (American Academy of Sleep Medicine, 2014; Reed et al., 2016). A major innovation in the *ICD-11* was the introduction of two new chapters—on conditions related to sexual health and sleep–wake disorders, respectively—that bring together categories comprising these two sets of disorders that were previously distributed across several chapters in the *ICD-10*. These innovations more accurately reflect current scientific knowledge about these two groups of disorders, eliminate the "mind–body" split on which their previous classification was based, and provide clinicians with an integrated and accurate guide that serves to enhance understanding and improve diagnostic accuracy (Reed et al., 2019).

The final chapter of the book (Chapter 21) focuses on relationship problems and maltreatment. This chapter starts from WHO's (1946) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The chapter observes that social well-being depends on the health of the relationships individuals form, most notably those with parents (or other primary caregivers), intimate partners, children, and other family members, that strongly affect individuals' mental and physical health and well-being. Sometimes the behaviors that occur within these relationships are disturbed enough to constitute maltreatment or abuse. This may create specific legal and ethical obligations for psychologists and other mental health professionals to protect vulnerable parties.

Each of these chapters contains a set of common elements. They begin by describing the overarching logic for the classificatory arrangement of the disorders discussed in the chapter. The arrangement of mental disorders categories within the *ICD-11* was partly based on studies conducted for this revision on how clinicians think about mental disorders and their relationship to one another (Reed et al., 2013; Roberts et al., 2012). Each chapter also provides a discussion of the elements of a psychological approach to that set of disorders, including psychological models for conceptualizing their symptoms and recommendations for psychological assessment. The chapters also discuss presentations and symptom patterns for the disorders covered, specifiers and subtypes, boundaries with normality, differential diagnoses, co-occurring disorders, developmental course, cultural and contextual considerations, and gender-related features. This material parallels and supplements the *CDDR* for the same set of disorders.

Together, these chapters cover the majority of conditions with which people are likely to present in the clinical practice of psychologists and other mental

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health professionals. However, their coverage of the *ICD-11* mental, behavioral, or neurodevelopmental disorders is not completely comprehensive. Practice in certain areas, such as elimination disorders, paraphilic disorders, and factitious disorders, is not covered in this book and will require more specialized resources.

Another major change in the *ICD-11* that has important implications for psychological practice is that transgender identity is no longer considered to be a mental disorder (Reed et al., 2016, 2019). The *ICD-10* chapter on mental and behavioral disorders included a grouping called gender identity disorders. Two of the categories in this grouping have been renamed and reconceptualized in the *ICD-11* and have been moved from the mental disorders chapter to the new chapter on conditions related to sexual health. The new categories are gender incongruence of adolescence and adulthood and gender incongruence of childhood; other categories from the *ICD-10* grouping of gender identity disorders have been eliminated. The *ICD-11* explicitly states that gender variant behavior and preferences alone are not sufficient for a diagnosis of gender incongruence (WHO, 2023). Gender incongruence was not proposed for elimination in the *ICD-11* because in many countries a qualifying diagnosis is required to access health services. The new conceptualization of gender incongruence and its removal from the *ICD-11* chapter on mental disorders were supported by a large study of transgender people in Mexico City (Robles et al., 2016), as well as replications in five other countries (Robles et al., 2022).

Psychologists and other mental health professionals should adopt a clinical stance consistent with WHO's policy that being transgender is not a mental disorder. They should recognize the particular vulnerability of this population to stigmatization and violence, as well as the difficult history and negative experiences many transgender individuals have had with the health system (Robles et al., 2016; WHO, 2015). All mental health professionals should be prepared to assess and provide equitable and nonstigmatizing services responsive to the mental health needs of transgender individuals. At the same time, the diagnosis of gender incongruence per se is a rapidly evolving and controversial area, and the interested clinician is referred to more specialized resources (Coleman et al., 2022) for further information.

In all areas, it is expected that psychologists and other mental health professionals "provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (American Psychological Association, 2017). This book, along with the *CDDR*, provides a fundamental step toward competent diagnostic practice using the *ICD-11*.

## DEFINING A PSYCHOLOGICAL APPROACH TO PSYCHOPATHOLOGY

The science of psychopathology is in large part the systematic description of mental disorders and their correlates and substrates, starting with the identification of emotions, thoughts, and behaviors that are characteristic of mental

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disorders and the disturbances in psychological processes that underlie them. When these experiences and behaviors reach an agreed-upon threshold of severity, dysfunction, or distress, they may be characterized as symptoms. In this regard, the diagnostic process proceeds from an understanding of psychopathology.

A psychological approach to psychopathology is grounded in an understanding of how people think, feel, and act as individuals as well as in the context of their intimate and other proximate relationships and their broader social and environmental context. While the psychological approach is person-centered, emotions, thoughts and actions are most often subjectively experienced through interactions with others and with the environment. This is a distinct and scientifically informed strategy anchored in inquiry regarding relevant cognitive, emotional, motivational, interpersonal, and other psychological processes.

The chapters of this book describe psychological models that are relevant for conceptualizing the expression of disorders in a particular individual. For example, Chapter 5, on schizophrenia and other primary psychotic disorders, reviews evidence of a very strong genetic component in schizophrenia but also indicates what appears to be inherited is a vulnerability to schizophrenia and related disorders rather than the disorder. The likelihood that this vulnerability will be expressed in a diagnosable disorder is increased by factors that have a psychological impact, such as exposure to childhood trauma, migration, and discrimination. Factors associated with symptom expression and maintenance also vary across symptoms. For example, negative symptoms may be linked to social withdrawal, and incoherent speech to interpersonal stress. The *ICD-11* therefore provides an inherently more psychological model of psychotic symptoms, which has replaced the *ICD-10* system of schizophrenia subtypes (e.g., paranoid, hebephrenic), which has been shown to lack validity, with ratings of specific symptom domains (e.g., positive symptoms, negative symptoms, cognitive symptoms) as they are currently experienced. These symptom domains provide a stronger basis for conceptualizing currently needed interventions and can be used to assess change and improvement over time, making them more compatible with a recovery-based approach.

The discussion of psychological mechanisms in obsessive-compulsive disorder (OCD) in Chapter 9 emphasizes cognitive factors including misappraisals of intrusive thoughts as informative, important, dangerous, or predictive of harm, leading to increased anxiety and distress. In turn, compulsions are aimed at reducing these emotions or reducing the likelihood of the feared catastrophic consequence, thus strengthening and maintaining the symptom through negative reinforcement. Dysfunctional beliefs such as an inflated sense of responsibility, perfectionism, or the belief that thoughts are equivalent to actions can increase the likelihood of misappraisals. Although there is no question that important neuroanatomical, neurochemical, and genetic features are etiologically important in OCD, an understanding of psychological processes in OCD is important in conceptualizing the development and maintenance of obsessions and compulsions as well as suggesting avenues for intervention. This model

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relates directly to the provision of specifiers in the *ICD-11* for the level of insight associated with OCD and related disorders. The use of cognitive intervention strategies would be appropriate for individuals with fair to good insight, allowing them to consider, at least some of the time, that their thoughts may not be true and possibly to accept an alternative explanation. For people with poor to absent insight, more purely behavioral strategies such as exposure and response prevention are more likely to be effective.

Chapter 16, on disorders due to addictive behaviors and compulsive sexual behavior disorder, applies the urgency–premeditation–perseverance–sensation-seeking (UPPS) impulsivity model to these disorders. The *urgency* component of the UPPS model encompasses emotion-related impulsivity and reduced inhibitory control; the (lack of) *premeditation* component is related to inability to delay rewards, poor decision-making, and poor problem-solving; the (lack of) *perseverance* component relates to difficulty remaining focused on tasks that are boring or cognitively demanding, increasing the likelihood of memory intrusions that promote subjective states of urge or craving; and the *sensation-seeking* component is a risk factor for the initiation of various problematic behaviors (e.g., drug use, delinquent acts, gambling, risky sexual behaviors), although other aspects of the model appear to be more important in their maintenance.

A psychological approach promotes a comprehensive understanding of disorder or dysfunction by considering the person's subjective experience, whether they are distressed by it, and whether they negatively impact the lives of others, especially those in their proximate interpersonal context. A psychological approach leads to more informed and deeper case conceptualization, regardless of the presumed etiology of disorder, strengthening intellectual coherence and supporting the clinical application of the *CDDR*. Moreover, many of the effective clinical interventions for mental disorders, either alone or in combination with other therapies (e.g., pharmacotherapy), are based on psychological treatment methods (Norcross et al., 2016). This book focuses on diagnosis, and thus a detailed discussion of interventions is beyond its scope. However, the preceding examples make clear that a psychological approach to diagnosis informs clinical interventions to improve the mental health and functioning of the person who is experiencing a mental disorder.

## HOW DO THE *CDDR* SUPPORT A PSYCHOLOGICAL APPROACH?

The *CDDR* draw on research and clinical findings in psychology in their description of the disorders covered in this book. The *CDDR* guide clinicians in making a diagnosis through evidence-informed descriptions of the presentations and symptom patterns and other diagnostic material in a consistent manner across all diagnostic categories in the *ICD-11* chapter on mental, behavioral, and neurodevelopmental disorders (First et al., 2015). These elements, shown in Box 1.1, support clinicians in making a differential diagnosis and developing a case formulation based on a psychological approach. Multilingual field testing of the *CDDR* through Internet- and clinic-based studies involving

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BOX 1.1 | **INFORMATION PROVIDED FOR THE MAIN DISORDER CATEGORIES IN THE *CLINICAL DESCRIPTIONS AND DIAGNOSTIC REQUIREMENTS FOR ICD-11 MENTAL, BEHAVIORAL AND NEURODEVELOPMENTAL DISORDERS***

Essential (required) features
Additional clinical features
Boundary with normality (threshold)
Course features
Developmental presentations
Culture-related features
Sex- and/or gender-related features
Boundaries with other disorders and conditions (differential diagnosis)

*Note. ICD-11 = International Classification of Diseases–11th revision.*

thousands of mental health professionals from across the world also allowed for the validation and evidence-based improvements in clinical utility, global applicability, and reliability of the *CDDR* for assessment and diagnosis (Keeley et al., 2016; Reed et al., 2019). When used by well-trained clinicians, the *CDDR* provide considerable enhancements that increase the probability of accurate diagnoses. They provide practical means for collecting useful information and enable clinicians to make evidence-informed ratings of functioning and impairment through detailed descriptions and examples of functional impact for disorders, at varying severity levels, across a range of domains. The use of multidimensional assessments and profiles in diagnosis and management is a key feature of the psychological approach. The use of psychological tests and other forms of psychometric assessment is an integral part of this practice.

### A Dimensional Approach to Psychopathology

One of the most profound changes in the *ICD-11* classification of mental, behavioral, and neurodevelopmental disorders is that structural innovations in the now fully digital classification have made it possible to create linkages among categories and integrate dimensional assessments in the context of the categorical classification system (Reed et al., 2019). As mentioned previously, this is the case for schizophrenia and other primary psychotic disorders, where severity and functional impact can be specified as none, mild, moderate, or severe for six classes of symptoms: positive and negative symptoms, depressed and manic mood, psychomotor symptoms, and cognition (see Chapter 5). The *CDDR* include detailed guidance for assigning these ratings to generate a detailed and individualized profile of symptoms and functional impact at a given point in time. Also consistent with a psychological approach, improvement in these

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symptom domains may be a critical outcome of treatment, which might be more directed at improving functioning and quality of life than on curing or eliminating the underlying disorder. This is in marked contrast to the process of assigning a label in *ICD-10* (e.g., paranoid schizophrenia, undifferentiated schizophrenia) that supposedly represented a type of schizophrenia with the implication that this pattern would be durable over time.

Similarly, in disorders of intellectual development, diagnosis and assessment is supported by inclusion in the *CDDR* of behavioral indicators by age group (early childhood, childhood and adolescence, adulthood) to capture a person's intellectual functioning as well as their adaptive behavior functioning in the domains of conceptual, social, and practical skills (see Chapter 3). Impairment or limitations in each area experienced by the individual being assessed can be rated as mild, moderate, severe, or profound, and these scores are integrated to form an overall rating of disorder severity. These ratings show specific areas in which people with disorders of intellectual development need support as well as what they are able to do on their own, consistent with a psychological approach.

To take another example, syndromal diagnoses of dementia (see Chapter 18) are rated for severity (mild, moderate, severe) and are linked to diagnosis of the underlying cause, if known (e.g., Alzheimer disease, cerebrovascular disease, chronic use of alcohol, Parkinson disease, HIV). In addition, specifiers for behavioral or psychological disturbances in dementia (psychotic symptoms, mood symptoms, anxiety symptoms, apathy, agitation or aggression, disinhibition, and wandering) can be appended to the diagnosis. As many of these specifiers can be used as necessary to describe specific needs for intervention for the individual being evaluated.

The area of personality disorders has also undergone a profound shift toward both a dimensional model and the integration of a psychological approach, as described in Chapter 17. In the *ICD-10*, there were general diagnostic requirements for personality disorder, followed by nine specific personality disorders (e.g., paranoid personality disorder, dissocial personality disorder, emotionally unstable personality disorder, borderline type), plus additional categories for "other" and "unspecified" personality disorders. The *ICD-11* has retained updated general diagnostic requirements for personality disorder. If these are met, the severity of the disorder is classified, based on (a) the degree and pervasiveness of disturbance in the person's relationships and their sense of self; (b) the intensity and breadth of the emotional, cognitive, and behavioral manifestations of personality dysfunction; (c) the extent to which these patterns and problems cause distress or psychosocial impairment; and (d) the level of risk of harm to self and others. This approach clearly locates personality disturbance along a continuum with normal functioning. The severity-based classification is important because severity is a major driver of the need for complex treatments compared with simpler treatments. It is also intended to be useful in nonspecialist settings and to assist in tracking changes in the severity of the disturbance over time.

The personality disturbance can be further characterized by five trait domain specifiers that are based on extensive psychological research (see Chapter 17)

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and continuous with personality traits in individuals who do not have personality disorders. The trait domains are negative affectivity, detachment, dissociality, disinhibition, and anankastia. Multiple specifiers may be applied, as necessary, to describe characteristics of the personality disturbance in an individual case. The trait domain specifiers are not diagnostic categories; rather, they represent a set of dimensions that correspond to the underlying structure of an individual's personality. The model provided by the *ICD-11* of how traits interact in the expression of personality is specifically psychological. To fully operationalize and reliably implement a more complex and individualized dimensional model compared with a categorical one, the development of reliable and valid psychological tests will be important and indeed is well underway (e.g., Bach et al., 2021; Clark et al., 2021; Oltmanns & Widiger, 2021).

### A Developmental Approach

Consistent with the perspective of developmental psychology, the *ICD-11* has adopted a lifespan approach to the classification and description of mental disorders, reflected in the material provided in the *CDDR* and in this book. This approach emphasizes the continuity of expressions of psychological distress and mental health conditions among children, adolescents, and adults, including older adults. In the *ICD-11*, separate disorder groupings specific to childhood and adolescence were eliminated, and these disorders distributed to corresponding groupings. For example, separation anxiety disorder was moved to the anxiety and fear-related disorders grouping, and adult presentations are specifically described. For all main disorder categories, the *CDDR* provide information, where available, describing variations in the presentation of the disorder among children and adolescents as well as among older adults. Although the diagnosis of neurodevelopmental disorders requires that they have their onset during the developmental period (before the age of 18), adult presentations are also described. Important examples include disorders of intellectual development (see Chapter 3), autism spectrum disorder (see Chapter 4), and ADHD (see Chapter 14). Adult forms of disruptive behavior and dissocial disorders are also considered (see Chapter 14).

To expand on the example of ADHD, Schmidt and Petermann (2009) describe the ways in which ADHD manifests over the life course. From an early age, people who are later diagnosed with ADHD already show a higher motor activity level and increased negative emotionality. At preschool age, problems with attention and difficulty following instructions develop. If the disorder is recognized and treated at this early point, the symptoms can diminish, but otherwise they will typically intensify. At school age, there are notable ADHD symptoms; these may be accompanied by symptoms of other conditions such as dyslexia or dyscalculia. Intervention at this developmental stage can mitigate the effects of the disorder and yield positive outcomes at home, school, and in social lives. If ADHD persists or worsens in adolescence and adulthood, the core symptoms may expand to include disorganization, emotional reactivity, and a higher risk of co-occurring disorders such as disorders due to substance use,

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depressive disorders, and anxiety or fear-related disorders. The *CDDR* support the early detection and consistent monitoring of ADHD by describing its manifestations throughout the life course. The *CDDR* include sections on Course Features and Developmental Presentations that provide clinical guidance regarding typical onset and natural history of each disorder.

Another aspect of this developmental perspective relates to the longitudinal course of disorders. Many mental disorders are chronic, but most are also episodic such that phases of adaptation, maladaptation, and positive changes can alternate several times over a person's life. For example, a child might develop depressive episodes that remit during adolescence, then reappear in adulthood. The person may recover again and regain a stable sense of well-being that can last into old age, or they may continue to suffer recurrent depressive episodes for the remainder of their life. These trajectories and their determinants and outcomes have been studied for a variety of mental disorders (e.g., Hoffmann et al., 2021; Veldman et al., 2015). The *ICD-11* provides a variety of mechanisms for specifying the course of mental disorders in a particular case (e.g., schizophrenia, first episode, currently symptomatic; acute and transient psychotic disorder, multiple episodes, in partial remission; recurrent depressive disorder, current episode severe, without psychotic symptoms, with seasonal pattern; bipolar type I disorder, current episode manic, with psychotic symptoms). These specifiers provide a substantial amount of valuable information about a person's clinical trajectory, with important implications for treatment.

## A PSYCHOLOGICAL APPROACH TO DIAGNOSTIC ASSESSMENT

A diagnostic evaluation is most commonly prompted when a person seeks care due to either (a) subjectively experienced distress, impairment, or related dysfunction that reduces their psychological, physical, or interpersonal well-being or (b) initiation by someone else who is close to the person and is distressed, concerned, or otherwise affected by the person's behavior (e.g., a spouse or partner, a parent or child, a workplace manager). Diagnostic evaluations may also be requested based on a person's interaction with the legal system, which raises a complex set of issues related to practice in the forensic context that is largely beyond the scope of this book.

There are a range of methodologies for assessing psychopathological symptoms, disturbed psychological process, and related mental and interpersonal distress. Much information about symptoms experienced by the person as distressing can be obtained through self-report. This can be aided by appropriately normed and valid self-report measures. All chapters of this book that focus on specific groups of disorders contain information about measures that may be relevant in assessing those disorders, with priority given to instruments freely available in multiple languages.

In some cases, information necessary for making a diagnosis must be gathered more directly by the clinician through direct observation or clinician-administered psychological tests. For example, this is considered the optimal

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approach for diagnosing disorders of intellectual development and developmental learning disorder (as described in Chapter 3) as well as neurocognitive disorders (as described in Chapter 18). Structured clinical interviews are also being developed for *ICD-11* that are intended to be useful as a means of systematically gathering information about symptoms and differential diagnoses. Interviews with other informants (e.g., parents or other caretakers, teachers) are typically important for children or adolescents, as well as for adults with certain types of problems. For example, during some phases of certain disorders, the person may not be aware of the dysfunction associated with their symptoms (e.g., euphoric mood during a manic episode, hallucinations during an episode of schizophrenia, hoarding behavior).

Establishing a diagnosis is a fundamental step toward developing a treatment plan. A diagnosis is made based on an integrative evaluation of the collected findings from all available sources of information. Depending on the presenting problems, these may include a summary of symptoms, functional assessments, clinical interviews, and case history including personal, educational/vocational, family, medical, and social history, as well as results from psychological and other tests. It is critical for the clinician to be aware that the diagnostic process can be prone to errors, particularly those due to the clinician's biases or customary patterns of practice (Kildahl et al., 2023; Liu et al., 2022). Using multiple assessment methods and multiple sources of information reduces the risk of the clinician leaping prematurely from an initial clinical impression to a diagnosis without adequately assessing pertinent and potentially contradictory information.

A fundamental strategy for reducing the impact of bias is the systematic and objective consideration of differential diagnoses when the evaluation reveals elements that could be indicative of more than one diagnosis. All essential features included in the *CDDR* for the disorders being considered in the differential should be carefully evaluated. The person being evaluated may also be experiencing co-occurring disorders, and multiple diagnoses may be warranted. Clinicians should be aware of the potential for the symptoms of one disorder (e.g., a disorder due to substance use) to mask those of another (e.g., a depressive disorder). The *CDDR* provides extensive information on differential diagnoses for each disorder. Similarly, alternative explanations for the observed findings (e.g., a medical condition, the effects of a substance or medication, intense anxiety in the testing situation) must be considered.

The *CDDR* also provide information on distinguishing each disorder from normal variation or subclinical presentations. The mere presence of symptoms does not necessarily warrant a diagnosis. For example, significant symptoms of grief that impact functioning which are present in response to the recent loss of a spouse or partner would not be considered a disorder. However, when the nature, severity, and duration of these symptoms markedly exceeds social, cultural, or religious norms for the individual's culture and context and results in significant impairment in personal, family, social, educational, occupational, or other important areas of functioning, a diagnosis of prolonged grief disorder may be warranted.

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A psychological approach considers people within their social and environmental context. When significant variations in affect, behavior, and thinking meet established requirements, a diagnosis can be made. Nonetheless, competent practitioners will exercise informed clinical judgment in determining whether a diagnosis is warranted. Clinical judgment is not an expression of individual beliefs or externally driven ideology. Rather, it is a thoughtful consideration of factors (e.g., culture, learned adaptive behaviors) that may explain behavioral variations. For example, expressions of unusual thoughts may make others uncomfortable but are not inherently an expression of a psychotic disorder. The absence of crying in response to an important loss when crying is culturally normative is most often not due to a lack of empathy or avoidance of grief. However, in both instances, the person or others in their environment may be concerned about atypical behaviors or the absence of socially mandated expressions. When the clinician concludes that a diagnosable disorder is not present, it may be important to assist the person in recognizing that there is nothing inherently problematic about their individual experience and expression, even if it varies from the norms of their community, culture, or family. Clinicians may also assist others in close relationships with the identified patient to understand, accept, or at least tolerate behavior they consider to be unusual.

The essential features of most *ICD-11* mental, behavioral, and neurodevelopmental disorders include significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Systematic assessment of these areas of functioning, in terms of how each is being affected by the presenting symptoms, provides a much more comprehensive understanding of the person. The functional impact of mental disorders is often cumulative and interacts with symptoms over time; earlier episodes can affect behaviors, choices, and opportunities that may confer greater vulnerability to later episodes. Moreover, the same disorder has different impacts on the psychosocial functioning of affected persons, producing different forms of subjective suffering and differing degrees of impairment. Sometimes people who are experiencing substantial emotional and psychological distress may avoid showing overt dysfunction such as relationship disruption or problems in occupational performance through significant additional effort. However, having to expend this degree of effort can be considered a type of functional impairment. For example, the *CDDR* describe how some individuals with autism spectrum disorder may function adequately in many contexts through exceptional effort, such that their deficits are not apparent to others. A diagnosis of autism spectrum disorder is still appropriate in such cases when other diagnostic requirements are met. Often, functional impairment emerges over time—for example, as developing children are faced with increasing social demands that eventually exceed their capacity to compensate.

### Individual History

History-taking is also a part of diagnostic assessment because it helps the clinician to understand the impact of the individual's disorder in terms of its risk

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factors, precursors, onset, and course over the person's life as well as the experiences, vulnerabilities, strengths, and resources that may affect case conceptualization and treatment. History may be collected in an unstructured, semistructured (e.g., with coverage of specific prescribed areas), or fully structured (e.g., a standard history interview) manner. Although there are common generic features, the process of history-taking varies across the lifespan, requiring different methodologies, expertise, and experience.

As an illustration, key information collected during history-taking via a detailed clinical interview with adult persons may include the following:

- Sociodemographic: age, gender, education, occupation, religion, relationship status, and contact details; biographical and family information such as childhood characteristics, emotional relationship to the nuclear family, peer relationships, psychosexual development, nonnormative life events such as abuse, traumatic life events, or any legal issues
- Social–interpersonal: relationships in adulthood, previous occupational history, family composition, financial circumstances, and notable transitions such as children moving out of the home or retirement
- Mental disorders: any previous episodes of the presenting complaint as well as any other past or ongoing mental health problems; pertinent family history, such as the presence of mental disorders within the nuclear and extended family across the current and previous two generations
- Medical/biological: current and previous illnesses (e.g., cardiovascular, respiratory, endocrine, gynecological, renal) and systemic illnesses (e.g., autoimmune, infectious, cancers, intoxication); current and previous medications

The social–interpersonal and psychological components of history-taking provide important information for case conceptualization (discussed next), including factors related to the development and maintenance of the current mental disorder(s) as well as starting points for interventions. It is also important that the patient's current social environment is evaluated (e.g., to enable planning social support measures for isolated persons with severe mental disorders). In addition to its diagnostic importance, the medical/biological component facilitates integration of care and coordination among health professionals who are concurrently treating comorbid medical conditions.

### Case Conceptualization

Case conceptualization, also known as case formulation or problem formulation, often represents an important product of a psychological approach to assessment. The case conceptualization consolidates different sources of diagnostic and contextual information about the individual based on a comprehensive bio-psycho-socio-cultural framework that supports a comprehensive understanding of the person. Elements of such a framework are shown in Box 1.2, which is intended to be illustrative and does not include all the factors that may merit detailed inquiry in an individual case.

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BOX 1.2 | **EXAMPLE ELEMENTS OF A BIO-PSYCHO-SOCIO-CULTURAL FRAMEWORK AS A BASIS FOR CASE CONCEPTUALIZATION**

**Biological elements**

Are there indications of genetic, metabolic, neurological, autoimmune, and other influences on the disorder?

Is it known whether a first-degree relative had a severe mental disorder such as bipolar disorder, dementia, or schizophrenia?

**Psychological elements**

What are the important affective, cognitive, motivational, values, and other characteristics that enable coping and resilience?

Are there individual, family, or other experiences such as developmental problems, financial issues, personal autonomy or relatedness, or issues related to sexual orientation or gender identity?

**Social elements**

What is the person's social situation—their social, occupational, and other relationships?

What are other socioenvironmental factors? These might include poverty, unemployment, social conflict, or exposure to civil conflict or war.

**Cultural elements**

What is the role of religion or spirituality in the person's life? How might basic cultural factors such as individualistic versus collectivistic values be relevant to the person's experience and their expression of distress and symptoms?

Are there culturally determined gender role differences (e.g., norms or rules about contact with the other sex or childcare and work outside the home), or identity-forming affiliations with specific ethnic groups or subcultures (e.g., activities/programs to reinforce ethnic identity)?

The use of stand-alone mental disorder diagnoses has long been criticized for being overly medicalized, uninformative regarding etiology, and unhelpful for intervention (Macneil et al., 2012). The assignment of a diagnosis has also sometimes been contrasted with both case conceptualization and recovery-based approaches (British Psychological Society, 2011). In truth, they are not incompatible. As a part of their systematic review of service user, clinician, and caregiver perspectives on mental health diagnosis, Perkins and colleagues (2018) pointed out that the many clinicians who value diagnosis are supportive of recovery-based approaches. They concluded that the experience of diagnosis can be improved by integrating principles of psychological case conceptualization, including "collaboratively developing a holistic understanding of a person's difficulties that addresses etiology, and then using diagnosis as a tool to guide treatment and recovery" (p. 761).

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Dawson and Moghaddam (2015) developed evaluation criteria to promote the coherence and quality of case conceptualization. These are (a) clarity and parsimony, where key concepts are used specifically and nonredundantly; (b) precision and testability, meaning that the components of the case conceptualization are potentially measurable and/or lead to testable hypotheses that are relevant to diagnosis, treatment, and outcomes; (c) comprehensiveness and relative generalizability—for example, the case conceptualization is applicable across a range of situations and clinical phenomena; (d) utility—that is, it facilitates shared meaning among clinicians as well as between clinician and patient; and (e) applied value, related to the effectiveness of interventions based on the conceptualization.

A solid case conceptualization facilitates the selection of treatments from the wide spectrum of evidence-informed psychological interventions that are available for mental disorders. Additional forms of intervention such as pharmacotherapy and social–environmental interventions (e.g., supported employment for individuals living with schizophrenia) may also be indicated. A case conceptualization should provide a coherent integration of multiple intervention methods based on the patient's individual combination of cognitive, developmental, personality, relational, social, and other factors in combination with the characteristics of one or more mental disorders. To ensure that the various methods are coordinated in a goal-oriented manner, each treatment should have a specified focus and objectives to orient the contributions of multiple clinicians. As Perkins and colleagues (2018) concluded, a case formulation approach "could enable the diagnostic process to be implemented in a way that is concordant with recovery principles. It particularly supports collaboration, person centered care, and service user agency and empowerment, reflecting recommendations about service user participation" (p. 761).

Consistent with a case conceptualization approach, an important component of the diagnostic process is effective communication of the results of the assessment to the person being evaluated. Thoughtfully prepared communication is a fundamental responsibility of clinicians. When appropriate, and with the patient's consent, feedback may also be given to others in close relationships with the person. It is important for the clinician to be aware of those aspects of the diagnostic formulation that have the potential to be experienced as confusing or even stigmatizing, as documented in *ICD-11* field studies conducted with service users (Askevis-Leherpeux et al., 2022; Hackmann et al., 2019).

As the preceding discussion suggests, the psychological approach is a collaborative one, emphasizing shared decision-making based on the principles of autonomy and self-determination (Joosten et al., 2008). These principles can be operationalized by several components: (a) agreement between the clinician and patient that assessment results and diagnoses will be communicated; (b) comprehensive information is provided about the disorder and treatment options, including evidence and alternatives; (c) patient preferences are determined, and the clinician's recommendations are made explicit; (d) understanding the options and asking about alternatives are encouraged; and (e) in the case of severe mental disorders, when applicable, full adherence to the legal

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framework for substitute decision-making during a temporary assumption of responsibility by the clinician or a designated other person, often a partner or family member.

Participatory decision-making generally has beneficial effects on compliance (e.g., fewer premature terminations of treatment, greater adherence to therapeutic protocols), treatment success, and patient satisfaction (Joosten et al., 2008; Thompson & McCabe, 2012). Of course, these principles must also be implemented in a way that is congruent with the patient's need for a diagnostic assessment conducted by a competent clinician-expert. In providing diagnostic information, conclusions, and recommendations, the clinician's challenge is to be authoritative without being controlling or authoritarian.

## CONCLUSIONS

The development of the *ICD-11* chapter on mental, behavioral, and neurodevelopmental disorders as well as the *CDDR* included an unprecedented degree of leadership and participation by psychologists in the development of the classification and diagnostic guidance, as well as participation of thousands of psychologists across the world in field-testing the proposed guidelines before their finalization and publication. At the same time, it is critical to emphasize that the entire process was multidisciplinary in nature, incorporating the most current knowledge and best practices from psychiatry and other disciplines. When we refer to a psychological approach, we do not mean one that is exclusive or proprietary to the discipline of psychology. Rather, a psychological approach focuses on psychological mechanisms and principles as an aspect of diagnostic practice and case formulation, regardless of professional discipline.

Each disorder-specific chapter in this book highlights the ways in which the *CDDR* promote the application of the core principles of a psychological approach. Along with the *CDDR*, this book equips clinicians to understand the core aspects of the relevant clinical phenomena as well as to use their clinical judgment and their understanding of the person (e.g., developmental stage, social and cultural environment) to consider whether a given patient meets the diagnostic requirements for a given diagnosis. The *CDDR* are intentionally flexible to allow for clinical judgment and cultural variability; this flexibility has been shown to improve clinical utility without sacrificing reliability (Reed et al., 2018, 2019). The dimensional elements of the *ICD-11* and the *CDDR* allow for more granular tracking of a patient's clinical course, which can be valuable in assessing responsiveness to treatments (e.g., the person transitions from a severe to a moderate personality disorder after an intervention) and assessing clinical trajectories and prognoses. A range of specifiers are provided that allows for a more nuanced diagnosis and the incorporation of current and historical information.

In summary, the *CDDR* align strongly with core psychological principles, and their implementation is further guided by this book. Together, this book and the *CDDR* provide mental health professionals, primary care clinicians,

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educators, and trainees with essential tools for the competent practice of diagnosis using the *ICD-11* as a framework. As editors of this book, our intention is to facilitate the implementation of the *ICD-11* around the world, contributing to reducing the global disease burden of mental disorders by helping to bridge the gap between those who need psychologically competent services and those who receive them.

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