The WHO ICD And Service User Inputs 2022 – Pivotal

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Here is an interesting article, from Mad In America, on WHO (the World Health Organization) and its International Statistical Classification Of Diseases And Related Health Problems (ICD), the ICD-11, to be released in 2022, updated from the ICD-10. The article is about a study that talked to service users (patients and individuals) about the clinical classification scheme and unstructured inputs, then made recommendations to WHO.

From the article:

> To inform the forthcoming change, an international team of researchers led by Corinna Hackmann gathered input from those most directly impacted by the disease categories and their criteria: people with lived experience.
> …
>
> Although the first edition of the ICD was published in 1893, the eleventh edition will be the first to integrate service user perspectives formally.

The article:

> Integrating Patient Voices in ICD-11 Development
> By Sadie Cathcart
> 2019 August 12
> Mad In America
> https://www.madinamerica.com/2019/08/integrating-patient-voices-icd-11-development/

This article is key because it means a pivot point. The researchers submitted their results to WHO, and said that user participation is "essential". As quoted in the article, the study says, "Crucially, our study validates the essential engagement of service users and the essential role of co-production."

I also have a suspicion about colonialist attitudes: the1893 date, through to now, and givens and assumptions behind colonialization (there was some idea, I feel, behind European colonialism 1500-2000 that a priori decisis "had a standpoint" that imperiled countless indigenous, and of course never asked (!), and never asked, "Why", "What", or "How").

From Z Magazine, I have some observations about the colonial standpoint, that piques my interest.

But this move by WHO is pivotal.

In addition, from the Perspectives On ICD-11 study:

> Data analysis
>
> A critical realist epistemological stance was used for the analysis; recognising that participants have their own experience of reality, but analysing data at face value, using the perspectives of individuals as they represent themselves during the focus group discussions. This approach was selected to capture the nuance of individual experience and develop useful feedback for WHO.
>
> https://www.thelancet.com/action/showPdf?pii=S2215-0366%2819%2930093-8
>
> pp 779-780

Consistent with Mvo-P! Then, this reality can be probed, and it should read reality in a broad sense. (It should really be an inquiry… data points and worlds.) But: "the perspectives of individuals as they represent themselves..." !

Endnote – Colonial Attitudes As A Possible Part Of The Idea Behind Psych Unit Psychiatry

In the conclusion to the excellent study (and the words of the service users are profoundly important, in the study), it reads in part:

> Diagnoses could also support a shared understanding between service users, families, and clinicians. This consequence is best achieved when there is an understanding between the service user and clinician of both the clinician's reasoning and service user's experience.

It could read, with a little further insight on the part of those running the study, and a further shift in perspective:

> Diagnoses could also support a shared understanding between service users, families, those in **society**, and clinicians. This consequence is best served when there is an understanding between the service user and clinician of both the clinician's **reasoning, field experience, and insight**, and the service user's **reasoning, experience, and insight**.

I suggest these modifications for several reasons. First, society: the individual (service user) is in a societal context, not just or even primarily a family context. He or she may have books, authors, music, theory, ideas, friends, a sense of "tribe", church, secular group, education, work experience, politics, economic mobility, etc., that all are important. Family may be important, also, and so these should be set side by side. One may, for instance, even if around family, have found that to find a deeply resonant place in the universe, one needed to step outside of family and its expectations! This is relevant. Second, reasoning, experience, and insight: it should be and must be acknowledged that each individual has these to bring to the table, to varying degrees, just as the clinician has these, to varying degrees. Reason and insight are flatly contradicted by the psych unit psychiatrist, as things the individual possesses or has available. And experience is denied as relevant or existent, or dismissed as

not real. There is then of course nothing tractable to work with, along with psych unit psychiatry's vacuous theory that lies outside of all meaning, so the individual is denied right and opportunity to participate or to even speak, really, of relevant things: including reasoning, experience, and insight.

This study is key and pivotal because it does give voice to intelligent statements about and observations of the current system and diagnostic paradigm. Such awareness of intelligence, reasoning, experience, and voice is precisely the type of thing that is needed in psych unit psychiatry.

The authors to the study note several times that this is the first time they're aware of where service users are included in the diagnostic criteria process. The MIA article that led me to this study notes, "Although the first edition of the ICD was published in 1893, the eleventh edition will be the first to integrate service user perspectives formally."

This all brings to mind the following paragraph from Z Magazine, a progressive social, cultural, economic, and political critique magazine, from its August 2019 issue:

> Much has been said about the subtle racism in Kushner's words [regarding the Palestinians], reeking with the stench of old colonial discourses where the **natives** were seen as **lesser, incapable of rational thinking**, **beings who needed the civilized "whites" of the western hemisphere** to help them **cope** with their **backwardness and inherent incompetence**.
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> – Z Magazine, August 2019, p. 12

I think that many individuals in a psych unit setting are capable of reason. Views will differ. So they can be worked with, and this or that sorted out, in many cases. Dilemma and no-dilemma should be acknowledged alike, the grades of dilemma (crisis dilemma, significant dilemma, part dilemma, no dilemma, no-dilemma), for the domains of life (the mental, the existential, the social, the societal, the experiential, the physical).

Setting the specifics of Kirshner and his critics aside, with respect to what he may or may not have said (I don't have quotes, or a detailed critique, and thus have no opinion, although I might form one, and enjoy author Ramzy Baroud's critiques), the idea that this is in colonial thought, if the above is correct, may be pervasive in current psych unit psychiatry – and form an ideological basis for it. It would explain, to this or that degree: 1) the pejorative, prosecutorial treatment in psych units by many of the psych unit psychiatrists of the individual; 2) the fundamental attitude, to omit reason, reason on the table, and to not permit it; 3) the to-omit and to-contradict all of 'all of the above' as relevant; 4) a-priori decisis and unilateral; 5) a theory and praxis that reifies the umpteen years of psychiatric training "that cannot be explained" and that places itself outside the domain anything accessible to the individual, or is explanatory, or deals with – yes, it does not – with the mind, the mind itself, that we all have access to, describe, and work with – in natural and accessible technical language: perception, active, contemplative, thought, thought space, consciousness, intention, the non-intentional, energy states, traversal, speech, and action – and a mutually co-arising world-space; 6) rejects any and all form of acknowledging reason and merit on the part of the individual.

There's more to it than colonial attitudes – the scientific reductionism materialist view, a false interpretation of science (science tries to look at all relevant factors (which Minsky tries to do in his

books on us-and-the-mind, and which would acknowledge ‘all of the above’) whereas psychiatry has picked up a false notion of ‘to isolate the subject’ (in experiment, where it really should be seen as ‘to simplify’) and applied that as its theory/praxis), a lack of equability, a self-supporting system that refuses to look outside its own theory/praxis to see the entire world-space – and for the genuine psychiatrist, it's also a matter of awareness, and ‘to study the mind’, and 'the truth of this world'.

So, a few tweaks, and it’s a fundamental shift, this study, from this dismal colonial attitude (if the Z description is correct). The above quote from the study, along with my modified quote, indicate this, along with the rest of the study. The study contributes so much. But it's a fundamental shift that is required. This study is, again, excellent, and in the spirit of further inquiry. Recommended, and oh, so key.

References

The WHO Study
“Perspectives on ICD-11 to understand and improve mental health diagnosis using expertise by experience (INCLUDE Study): an international qualitative study”
Contributors: Dr Corinna Hackmann, PhD, Dr Yatan Pal Singh Balhara, MD, Kelsey Clayman, BA, Dr Patricia B Nemec, PsyD, Dr Caitlin Notley, PhD, Prof Kathleen Pike, PhD, et al.
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https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30093-8/fulltext

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