What's in a name? Mental disorders, mental health conditions and psychosocial disability

The constitution of the World Health Organization (WHO), adopted upon its founding in 1948 and now a part of its treaty arrangement with 194 member states, defines health as "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity"[1]. Clearly, WHO's founders intended to include mental health as a part of health, although they did not define it explicitly.

The WHO provided a more expansive definition of mental health in the 2022 World Mental Health Report: "a state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities"[2]. This definition suggests that mental health is not only more than the absence of mental disorders, but depends in part on access to opportunities to achieve one's potential.

These positive aspects of mental health – for individuals and for populations – are therefore construed as falling within the WHO's mission in a way that builds on the initial definition of health provided more than 75 years before. Health promotion, protection of vulnerable populations, and mitigation of social and other determinants that drive health inequities are fundamental to the global public mental health approach, although the World Mental Health Report acknowledges that responsibility for some of the steps critical to improving mental health falls outside the health sector.

The WHO's constitution also tells us that two of the twenty-two core purposes for which the organization was founded are "to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices", and "to standardize diagnostic procedures as necessary"[1]. The most important realization of these two constitutional functions throughout WHO's history has been the International Classification of Diseases (ICD). The 11th revision of the ICD (ICD-11) was approved by the 72nd World Health Assembly, comprising the Ministers of Health of all 194 WHO member states, in May 2019. The Assembly's approval is required because the ICD confers obligations on WHO member states, and such approval underscores and contributes to the ICD's considerable force and importance as an aspect of global health policy.

The ICD-11 defines mental disorders as "syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes that underlie mental and behavioural functioning; these disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning"[3].

However, except when reporting epidemiological data, the World Mental Health Report uses the term "mental health conditions", described as "a broad term covering mental disorders and psychosocial disabilities; it also covers other mental states associated with significant distress, impairment in functioning, or risk of self-harm"[2]. Thus, mental health conditions comprise symptoms and experiences associated with psychological distress or functional impairment, whether or not they meet the diagnostic requirements for specific mental disorders. They include, for example, acute stress reactions, personality difficulty, hazardous substance use, and burnout, which the ICD-11 does not classify as mental disorders but rather as "factors influencing health status or encounters with health services". Based on a dimensional conceptualization of mental health, the term "mental health condition" encompasses a portion of the population that would likely benefit from public policy and systems interventions, including population-based health promotion and prevention efforts, rather than treatment aimed at specific mental disorders.

Mental health professionals and policy makers may find the concept of "mental health condition" conceptually and practically useful in encouraging people to seek the help they need and far too few receive. Some subthreshold conditions have been shown to be as impairing as corresponding above-threshold mental disorders[4], and, in the context of a persistent and progressive disorder, early identification may provide an important opportunity for effective treatment[5]. On the other hand, available data suggest that the ability of subthreshold presentations to predict above-threshold mental disorders in the general population is rather low, and varies substantially by disorder[6]. The use of the term "mental health condition" may also raise questions about the value of investing in mild and subthreshold conditions that are imprecisely and poorly defined and even more common than mental disorders, which could complicate discussions about coverage and reimbursement, and potentially lead to a recapitulation of the arguments historically raised in opposition to insurance parity between mental disorders and physical diseases.

The World Mental Health Report clarifies that the term "mental health condition" was used in an effort to bring together the widest possible group of stakeholders, some of whom viewed the term "mental disorder" as stigmatizing. However, stigma can migrate from one term to the next almost as soon as the new term catches on. In addition, given that these terms are meant to apply to the global context, the semantic distinctions between them may not be meaningful in languages other than English. The translation may be the same for both terms, or their connotations may be different across languages. For example, *condición* in Spanish often refers to intrinsic and stable characteristics, whereas *trastorno* (the term used for "disorder") is closer to a disturbance or upheaval which may be temporary. Therefore, in some languages, "mental health condition" may be experienced as more stigmatizing than "mental disorder".

The second component of the World Mental Health Report's definition of "mental health condition" is "psychosocial disability", which "arises when someone with a long-term mental impair-

ment interacts with various barriers that may hinder their full and effective participation in society on an equal basis with others"[2]. This definition is consistent with WHO's International Classification of Functioning, Disability and Health (ICF)[7], which describes disability as the result of the interaction of individuals who have a health condition with their environment, influenced by the nature and severity of the health condition, the characteristics of the person, and the physical and social characteristics of the environment.

Although the World Mental Health Report uses the term "psychosocial disability", in fact the impairments, activity limitations and participation restrictions experienced by people with mental disorders are not limited to the psychosocial domain. The Report links the term to the United Nations' Convention on Rights of Persons with Disabilities[8], which has been a powerful tool for dismantling discriminatory attitudes, actions and laws that contribute to human right violations among people with mental disorders, and for redressing physical, attitudinal, communication, social and legal barriers to their complete self-determination and participation in society. However, some disability rights advocates go considerably beyond that, arguing that the construct of "psychosocial disability" should replace the conceptualization of mental disorders as problems that should be clinically defined and treated. This view emphasizes acceptance and provision of support and accommodations, and sometimes positions the "medical model" as the source of human rights violations[9]. WHO's use of the term, however, is not an endorsement of an anti-psychiatry stance.

In the context of the terminology discussed above and the trends it represents, psychiatrists and other mental health professionals will likely continue to be primarily focused on the identification and treatment of mental disorders. They will also be increasingly called upon to collaborate with, teach and supervise other personnel involved in the mitigation of mental health conditions through population-based health promotion, protection and prevention efforts, as well as the provision of lower-intensity and less complex interventions (e.g., through "task shifting" initiatives).

We can align ourselves more fully with a global public mental health approach by expanding and deepening our focus on the impact of our interventions on functional status, particularly as it relates to self-determination and social participation, and on the mitigation of social determinants of health in order to reduce health inequities in our communities and around the world.

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The value and limitations of self-administered questionnaires in clinical practice and epidemiological studies

In the past few decades, there has been a proliferation of self-administered questionnaires aimed to assist clinicians in improving the identification of various disorders, and researchers in estimating disorder prevalence rates in community-based epidemiological settings. Most of these questionnaires focus on a single disorder, such as major depressive disorder, bipolar disorder, or generalized anxiety disorder. A minority evaluate a range of the most common disorders encountered in outpatient mental health settings.

Self-administered questionnaires are not a substitute for an interviewer-based diagnostic evaluation. They are *screening instruments*, and their use represents the first phase of a two-stage diagnostic procedure. The purpose of a screening test is to cast a broad net to ensure that most patients with the disorder are captured in that net. Thus, a screening test is intended to reduce the frequency of missed diagnoses. That test is expected to be followed by a more definitive diagnostic assessment, an evaluation that is generally more expensive and/or invasive than the screening procedure. In psychiatry, a self-administered screening questionnaire is intended to be followed by a diagnostic interview. In studies of the performance of screening questionnaires, a semi-structured interview is the usual "gold standard".

The two most commonly reported statistics when describing the performance of a screening measure are sensitivity and specificity. Sensitivity refers to how well the test identifies individuals with the disorder, whereas specificity refers to how well the test identifies individuals without the disorder. Two other statistics important in understanding a screening test's clinical utility are positive and negative predictive value. Positive predictive value refers to the probability that a person who screens positive on the test has the disorder. Negative predictive value refers to the probability that a person who screens negative on the test does not have the disorder. Positive and negative predictive values are less commonly used to describe a screening test's performance, because