

### Letter to the Editor

#### CONVERGENCES AND DIVERGENCES IN THE ICD-11 VS. DSM-5 CLASSIFICATION OF MOOD DISORDERS

#### Dear Editor,

The chapter on mental, behavioural and neurodevelopmental disorders of the 11th revision of the International Classification of Diseases and Related Health Problems (ICD-11) has been now finalized. Reporting of health statistics by Member States to the World Health Organization (WHO) using the new diagnostic system will begin in 2022.

The section on mood disorders of the ICD-11 is overall consistent with the corresponding section of the ICD-10. However, the definitions of a depressive and a manic episode have been slightly changed, making them consistent with the DSM-5 (see below), and an independent category of bipolar II disorder has been introduced.

A significant effort has been made by the WHO and the American Psychiatric Association to harmonize the diagnostic systems they produce (the ICD-11 and the DSM-5). Indeed, the organizational framework (“metastructure”) is now the same in the two systems. Nonetheless, several intentional differences between the two classifications remain, or have emerged as a consequence of changes made in the DSM-5. Here we briefly summarize the convergences and the divergences between the ICD-11 and the DSM-5 regarding the section on mood disorders (see Table 1).

A major convergence between the two diagnostic systems regards the minimum number of symptoms required for the diagnosis of major depression (“depressive episode” in the ICD-11). In the ICD-11, contrary to the ICD-10, the threshold for the diagnosis of depression is the same as in the DSM: at least five depressive symptoms. However, the ICD-11 requires at least five symptoms out of a list of ten (instead of nine as in the DSM-5). The additional symptom is “hopelessness”, which has been found to outperform more than half of DSM symptoms in differentiating depressed from non-depressed people (McGlinchey et al. 2006).

**Table 1.** Some Main Differences Between ICD-10, ICD-11 and DSM-5 Concerning the Diagnosis Of Mood Disorders

|   | ICD-10  | ICD-11  | DSM-5  |
|---|---|---|--|
| Threshold for diagnosis of depressive episode                                     | At least four out of ten symptoms, two of which must be depressed mood, loss of interest and enjoyment, or increased fatigability | At least five out of ten symptoms, one of which must be depressed mood or diminished interest or pleasure | At least five out of nine symptoms, one of which must be depressed mood or diminished interest or pleasure |
| The threshold for the diagnosis of depression is higher if the person is bereaved | Not made explicit   | Yes   | No   |
| Antidepressant-related mania qualifies as a manic episode                         | No  | Yes   | Yes  |
| Mixed episode is a separate diagnostic entity                                     | Yes   | Yes   | No   |
| Dysthymia is a separate diagnostic entity   | Yes   | Yes   | No   |
| Bipolar II disorder is a separate diagnostic entity                               | No  | Yes   | Yes  |
| “Qualifiers” (“specifiers”) for the diagnoses of mood disorders are provided      | No  | Yes   | Yes  |

The ICD-11 is also following the DSM-5 in requiring the presence of increased activity or a subjective experience of increased energy, in addition to euphoria (or irritability or expansiveness), for the diagnosis of a manic episode, in order to reduce the chance of false positive cases. The two diagnostic systems also converge in considering that a manic or hypomanic syndrome arising during antidepressant treatment, and enduring beyond the known physiological effects of that treatment, qualifies as a manic or hypomanic episode. Bipolar II disorder has become an independent category in the ICD-11 (it was just mentioned as an example of “other bipolar affective disorders” in the ICD-10). Furthermore, for the first time, the ICD follows the DSM in introducing “qualifiers” (corresponding to DSM-5 “specifiers”) to the diagnoses of mood disorders, based on specific aspects of symptomatology or course.

There are, however, three important aspects in which the two diagnostic systems diverge. All of them are a consequence of changes made in the DSM-5 that the relevant ICD-11 Committee has regarded as not sufficiently supported by the available research evidence.

The first of these divergences concerns the issue of bereavement. In the ICD-11, in line with the DSM-IV and ICD-10 approach, it is stated that “a depressive episode should not be considered if the depressive symptoms are consistent with the normative response for grieving within the individual’s religious and cultural context”. However, the diagnosis of depression is not excluded if the person is bereaved; the diagnostic threshold is just raised, exactly as it happens in ordinary clinical practice. A depressive episode during bereavement is suggested by the persistence of symptoms for at least one month, and the presence of at least one symptom which is unlikely to occur in normal grief (such as extreme beliefs of low self-worth or guilt not related to the lost loved one, presence of psychotic symptoms, suicidal ideation, or psychomotor retardation). In contrast, the special status conferred by the DSM-IV to bereavement among life stressors has been eliminated in the DSM-5. However, two independent follow-up studies (Mojtabai 2011, Wakefield and Schmitz 2012) have reported that, in people with baseline bereavement-related depression, the risk for the occurrence of a further depressive episode during follow-up is significantly lower than in individuals with baseline non-bereavement-related depression, and not significantly different from the risk of people without a baseline history of depression to develop a first depressive episode during follow-up. This research evidence strongly supports the ICD-11 (and DSM-IV) approach. Furthermore, an intensive public debate has highlighted the consequences that the DSM-5 approach to the bereavement issue could have in several cultures, including a high rate of false positives and a trivialization of the concept

of depression and consequently of mental disorder (Kleinman 2012).

A second divergence between the ICD-11 and DSM-5 sections on mood disorders concerns mixed states. The category of mixed episode is kept in the ICD-11, defined by several prominent manic and depressive symptoms which either occur simultaneously or alternate very rapidly (from day to day or within the same day) during a period of at least two weeks. The mood state is altered throughout the episode (i.e., the mood should be depressed, dysphoric, euphoric or expansive for at least two weeks). When depressive symptoms predominate, common contrapolar symptoms are irritability, racing or crowded thoughts, increased talkativeness, and increased activity. When manic symptoms predominate, common contrapolar symptoms are dysphoric mood, expressed beliefs of worthlessness, hopelessness, and suicidal ideation. This definition is in line with the ICD-10 and completely consistent with both classic and recent research evidence, as well as with clinical experience. In contrast, the DSM-5 solution to eliminate the category of mixed episode and to introduce a specifier “with mixed features”, applicable to manic, hypomanic and depressive episodes, has had the consequence to reduce the visibility of “mixture” in ordinary clinical practice (especially since the specifier is not codable, and is therefore at risk of not being recorded in clinical settings). Moreover, the DSM-5 definition of major depression with mixed features, requiring the presence of at least three “classic” manic symptoms (such as elevated mood, grandiosity, and increased involvement in risky activities) has been criticized for being inconsistent with the concept of mixed depression as delineated in both the classic and recent literature (e.g., Koukopoulos and Sani 2014).

A third divergence between the two diagnostic systems consists in the fact that the ICD-11 has not followed the DSM-5 in combining dysthymic disorder and chronic major depressive disorder into a single category (“persistent depressive disorder”). In fact, the relevant ICD-11 Committee expert considered that the evidence that the two disorders represent the same condition, to be addressed therapeutically in the same way, is insufficient. The category of dysthymic disorder is kept in the ICD-11, while a qualifier “current episode persistent” is to be used when the diagnostic requirements for depressive episode have been met continuously for at least the past two years.

For a discussion of other aspects of the classification of mood disorders, with the relevant therapeutic implications, as well as for information about the differences between the ICD-11 and the DSM-5 concerning other sections of the classification of mental disorders, we refer the reader to previous contributions (Demyttenaere et al. 2015, Fried et al. 2016, Haroz et al. 2017, Boschloo et al. 2019, Bryant 2019, Forbes et al. 2019, Fusar-Poli et al. 2019, Gureje et al. 2019,

Reed et al. 2019, Kendall 2019, van Os et al. 2019, Cuijpers et al. 2020, Fava and Guidi 2020, Gaebel et al. 2019, 2020, Hasler 2020, Jarrett 2020, Kato et al. 2020, Maj et al. 2020, Reynolds 2020, Sanislow 2020, Stein et al. 2020).

An International Advisory Group has been established to supervise the activities of translation, training of professionals and implementation of the ICD-11 chapter on mental disorders (see Giallonardo 2019, Poci 2019, Perris 2020). The experience in the field will tell whether the above divergences from the DSM-5 in the ICD-11 classification of mood disorders are justified. Indeed, divergences in the description of the same mental health condition may sometimes be useful in order to allow the empirical comparison of different approaches to issues that are controversial.

Arcangelo DI CERBO 

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MD., University of Campania L. Vanvitelli, WHO Collaborating Centre for Research and Training in Mental Health, Naples, Italy.

**Dr. Arcangelo Di Cerbo, e-mail:** ardice77@gmail.com

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