

## Time to choose – DSM-5, ICD-11 or both?

Peter Tyrer

### Summary

DSM-5 was published in May 2013, and ICD 11 is not due to be published until the end of 2015 at the earliest. Nevertheless, it is possible to make a comparison at this early stage as much of the main decisions have been made with both classifications. DSM-5 aimed to make a paradigm shift by providing objective, independent measures of classification, but in this respect it clearly failed. It did respond to previous criticisms that there were too many diagnoses in the classification and that eliminated some conditions in favour of larger groupings (eg, autism spectrum disorder), but it has still come in for heavy criticism. ICD 11 deviates from DSM-5 in radically different classifications of personality and stress disorders and in general has pursued a different pathway, concentrating on clinical utility as the main guide to the classification. It is up to practitioners to choose which they prefer, but ICD 11 will be in a much stronger position than ICD 10 was when it was published in 1992.

classification / diagnosis / DSM / ICD / CFTMEA

### INTRODUCTION

The pace of classification has slowed down in psychiatry. Between 1980 and 1994 there were three revisions of the DSM classification, but it has taken 20 years to produce DSM-5, published in May 2013 [1]. There has been the longest ever gap between the ICD revisions, with ICD-10 published in 1992 [2] but with the ICD-11 not published until 2015 at the earliest and possibly as late as 2017. But despite less change the debate about classification has become even more intense, and has been noted too in this journal [3, 4], which has also involved the French classification for child and adolescent mental disorders, CFTMEA [5].

So which classification should we choose? This is as much a political decision as a psychiatric one. For example, the UK is a 'DSM-free zone' as far as clinical practice is concerned, whereas in the USA DSM is dominant, but even in the US national statistics have to follow the ICD classification. But in practice all psychiatrists have to make a choice, and many will 'mix and match'. They will use different classification terms for different disorders, irrespective of national requirements, if they seem to be more suitable for an individual patient or group of disorders, and this is particularly true in child psychiatry where there is great concern over inappropriate labelling. The goal of complete harmonisation of classifications is now a very long way off. In this paper the criticisms and assets of each will be compared.

---

**Peter Tyrer:** Centre for Mental Health, Imperial College, London, W6 8RP, UK. **Correspondence address:** p.tyrer@imperial.ac.uk. Presented at a special meeting of the Lithuanian Psychiatric Association in Vilnius. 11th April 2014

**Declaration of Interest:** The author is the Chair of the ICD-11 Working Group for the Revision of the Classification of Personality Disorders.

### DSM-5

At the May meeting of the American Psychiatric Association in San Francisco DSM-5 was launched. Many involved in the long and arduous task of revision will have been disappoint-

ed by the reaction to its publication. Perhaps the hopes of practitioners may have been raised too much by the high-flown rhetoric preceding the new classification but there has been heavy criticism in the following areas:

1. The original aim of the classification was to make it independent of clinical description - the overused words 'paradigms shift' were used to describe this in the hope that we would have biomarkers and other independent measures at the core diagnosis. This was a very optimistic hope and was not achieved in any way. The call was made to science but it remained unanswered.
2. There was much criticism of the influence of pharmaceutical companies on Task Force members in making the final recommendations. This may have been a little unfair but had a long history. Although the arrangements for including people on the Task Forces, and for their declaration of interests to be published, the influence of Big Pharma was still perceived to be a problem
3. The boundary between normal variation of pathology was deemed to have been crossed too often in the revised diagnoses. The removal of bereavement is an exclusion for major depression, the adding of premenstrual dysphoric disorder, disruptive mood dysregulation disorder, illness anxiety, hoarding, binge eating and minor neurocognitive disorder, were all seen to have crossed this boundary with the needless addition of extra pathology. One of the most trenchant critics was Allen Frances, Chair of the Task Force for the DSM-IV revision, and the title of his book 'Saving Normal' encapsulates this concern [6].
4. The National Institute of Health in the US (the most prestigious research body in psychiatry in the US) was critical of the new classification and has supported the development of an alternative one, RDoc, which is still far too premature to introduce into psychiatric practice but which will be based on independent biological and neuropsychological variables [7].
5. Some of the diagnoses of earlier revisions were retained in DSM-5 even though field trials had demonstrated poor reliability (eg, generalized anxiety disorder), so it was felt that proper scientific process had not been followed.

There have also been long-standing concerns about diagnoses such as 'major depressive episode' that is alleged to have promoted excessive drug prescribing [8] and the absence of a classification for probably the most common disorder in psychiatry, mixed anxiety and depression [9], and these were not answered in the new classification.

### ICD-11

ICD 11 will not be published for at least another 18 months, but it has the advantage of being able to respond to some extent to the criticisms that have followed the publication of DSM-5. The main problem with the ICD 11 reclassification system is that it is very poorly resourced compared with DSM, Perhaps this avoids arguments about conflict of interest as there is virtually no financial benefit to be gained by anyone in helping with this revision. It would be premature to outline the current plans for the new diagnostic system as it is some way for publication but the following points ought to be remembered:

(I) the International Classification of Diseases is the official world classification of all diseases and DSM has been the only competitor (in the case of psychiatry). The DSM classification was set up in the face of poor use of the earlier ICD classifications and there were good reasons for stimulating a new classification, which was illustrated by the tremendous success of DSM-III when it was published in 1980. We therefore need to be good reasons for continuing with DSM in the longer term, as it represents an anomaly.

(II) have referred, somewhat mockingly, to the letters DSM as standing for either diagnosis for simple minds or diagnosis as a source of money [9]. Like all short summaries. This can be regarded as unfair, but there is absolutely no doubt that the relatively simple way of recording DSM diagnoses is sometimes a substitute for proper thought, and that financial influences of strongly to bear when deciding on the structure of DSM-5.

(III) Both ICD and DSM share much more than they differ, but when they do differ. It is impor-

tant that practitioners are aware of the reasons for this and can decide to choose.

(IV) Researchers generally preferred DSM for classification purposes because its criteria are much tighter than those in ICD. ICD-11 will however be published with other material to aid researchers and this will partly compensate for the past deficiencies in the classification.

What is already clear is that there will be many differences between DSM-5 and ICD-11 that cannot be papered over as minor variation. Two examples will suffice in explanation.

### POST-TRAUMATIC AND OTHER STRESS DISORDERS

Post-traumatic stress disorder (PTSD) is one of the more controversial diagnoses in psychiatry because, unlike almost all others, it combines aetiology with diagnosis. It has been noted previously that many patients develop all the symptoms of PTSD but in the context of normal stress rather than exceptional trauma [10]. It is diagnosed remarkably frequently whereas the related concept of adjustment disorders is very infrequently diagnosed but would be expected to be much more frequent [11]. In ICD-11 the definition of post-traumatic stress disorder is much tighter than in DSM-5, so the diagnosis cannot be based entirely on non-specific symptoms. It also includes a new complex PTSD category that comprises three clusters of intra- and interpersonal symptoms that overlap with personality change, and which also includes the core symptoms of PTSD. It also redefines the disorders associated with grief as a new diagnosis - prolonged grief disorder – a condition in which patients suffer an intensely painful, disabling, and abnormally persistent response to bereavement. There is also a major revision of adjustment disorder involving much tighter specification of symptoms; and a conceptualization of “acute stress reaction” as a normal phenomenon that still may require clinical intervention. These changes will set ICD-11 stress disorders on a different path from DSM-5.

### PERSONALITY DISORDERS

The ICD-11 classification of personality disorder removes all the existing categories of personality disorder from ICD-10 apart from the main one, the presence of personality disorder itself. Because personality dysfunction is best represented on a continuum or dimension, different levels of severity are defined to indicate the point on the continuum that represents the person's personality functioning at the time of the assessment, including the relatively recent past. The severity of personality disturbance ranges from no personality dysfunction to personality difficulty and mild, moderate and severe personality disorder [12]. Personality difficulty is not a disorder but is classified in the part of the classification that relates to non-disease entities (Z codes in ICD-10). If this new classification was embraced by the profession and the public, it would be a major help in destigmatising the diagnosis of personality disorder and alleviating the tendency to regard it as a reason for non-intervention. It would also help the practitioner to feel reassured about making the diagnosis during adolescence, as the diagnoses would be seen as subject to change and not as a lifelong label.

The level of severity is qualified by a description of domain traits. These indicate which of the main facets of personality are most prominent in the individual concerned. These trait domains are not categories of personality disorder, but they help to describe the nature of any personality pathology. The ones that have been proposed and will be subject to field testing are negative emotional (affective); dissocial; disinhibited; anankastic; and detached domains.

There are likely to be other surprises when ICD-11 is published. It will certainly not be following tamely in DSM's footsteps, and when it comes to the case of DSM-5 personality disorders, there is no real competitor to ICD-11, as the American Psychiatric Association did not accept the recommendations of the Task Force and decided to revert to the DSM-IV classification.

As with all classifications, in the end it is the clinicians who will decide. If a classification does not help the clinician it will not be used, and so clinical utility will be the yardstick of success. But if ICD-11 can be topped off with a helping of sci-

ence as well as pragmatism, as Ghaemi [13] has suggested, its reputation will be aided greatly.

## REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual for Mental Disorders, 5<sup>th</sup> Edition. Washington: APA, 2013.
2. World Health Organisation. International Classification of Diseases, 10<sup>th</sup> Revision. Mental and Behavioural Disorders. World Health Organisation, Geneva: 1992.
3. Squillante MV. Classifications in child and adolescent psychiatry. *Arch Psychiat Psychother* 2014; 16: 15–19.
4. Cozuc J-Y. Why the DSM? *Arch Psychiat Psychother* 2014; 16: 63–65.
5. Misès R, Quemada N, Botbol M, Burzstejn C, Garrabé J, Golse B et al. French classification for child and adolescent mental disorders. *Psychopathol* 2003; 35: 176–180.
6. Frances A. *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*. New York: William Morrow, 2013.
7. Cuthbert BN & Insel TR (2013). Toward the future of psychiatric diagnosis: the seven pillars of RDoC. *BMC Medicine*, 11:126.
8. Shorter E. The 25th anniversary of the launch of Prozac gives pause for thought: where did we go wrong? *Br J Psychiatry* 2014; 204: 331–332.
9. Das-Munshi J, Goldberg D, Bebbington PE, Bhugra DK, Brugha TS, Dewey ME, Jenkins R, Stewart R, Prince M. Public health significance of mixed anxiety and depression: beyond current classification. *Br J Psychiatry* 2008 ;192: 171–177.
10. Maercker A, Brewin CR, Bryant RA, Cloitre M, van Ommeren M, Jones LM, et al. Diagnosis and classification of disorders specifically associated with stress: proposals for ICD-11. *World Psychiatry* 2013; 12: 198–206.
11. Casey P, Doherty A. Adjustment disorder: implications for ICD-11 and DSM-5. *Br J Psychiatry* 2012; 201: 90–92.
12. Tyrer P, Crawford M, Mulder R, Blashfield R, Farnam A, Foshati A, et al. The rationale for the reclassification of personality disorder in the 11<sup>th</sup> Revision of the International Classification of Diseases. *Personal Ment Health* 2011; 5: 246–259.
13. Ghaemi SN. Against 'pragmatism' in DSM/ICD: a commentary on prodromal psychosis. *Acta Psychiatr Scand* 2013; 127: 253.