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VIEWPOINT

Discrepancies in the Diagnostic Guidelines Pertaining to Bipolar and Related Disorders

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Abstract

The diagnostic framework has been an evolving field that intends to provide a structure to the relative fluid field of psychiatric disorders. Over the years, psychiatric classifications have been reliant on the phenomenological description of disorders. Diagnostic classifications over the years have also been able to unearth the various intricacies in psychiatric disorders and have been the backbone of conducting research in psychiatry. In 2022, we are potentially at the threshold of an interesting era in psychiatry with the sanction of official use of the International Classification of Diseases (ICD 11) and also the advent of fifth edition of Diagnostic and Statistical Manual for Mental Disorders (DSM 5) text revisions. At this juncture, the current manuscript reviews the newer changes that have been adopted in the classification of bipolar disorder. The manuscript reviewed the extent to which the changes aligned ICD 11 to DSM 5 and also reviewed the background of where the two systems chose to differ. The manuscript also looks forward to what can be expected in further revisions.

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Introduction

Bipolar affective disorder (BPAD) is an episodic illness that is considered as a severe mental illness and contributes significantly to the morbidity in patients in terms of disability adjusted life years. Interestingly, BPAD is parallelly also appreciated as an enigmatic disorder owing to the manifold complexities in its presentation. This complexity has also translated to difficulty in conducting and interpreting research and also in deciding the best course of intervention. Even more intriguing that these issues continue to persist despite multiple and substantial revisions of the various concurrent diagnostic criteria. The first version of the Diagnostic and Statistical Manual for Mental Disorders (DSM 1) was published in 1952 with 106 psychiatric diagnoses. That number has been steadily increasing over the subsequent editions with the fifth edition of DSM (DSM 5) having 265 diagnoses (without the specifiers). But, in spite of that we are still far away from a situation where the concurrent diagnostic criteria are perfectly aligned. Additionally, the current framework is still considered as unscientific by various authors. That belief further substantiates significant diag-

nostic orphans encountered in the clinical practice. In this background, the current manuscript looks into the existing diagnostic framework to discuss its discrepancies and implications on clinical practice.

The year 2022 should be considered as very important from the point of view of clinical psychiatric practice. The 11th edition of the International Classification of Diseases (ICD 11) has been officially introduced for clinical practice worldwide. Additionally, the text revision of DSM 5 (DSM 5 TR) has also been published, placing us at a crossroads of multiple new diagnostic concepts evolving. This becomes also very important in the context of the historical evolution of BPAD as a diagnostic entity. Since its inception, BPAD has seen fair amount of diagnostic transition. Though there is mention of '*melancholia*' and '*mania*' in the texts of Hippocrates, it was later in the works of Falret and Baillarger that BPAD was identified as a cyclical disease.[1] Emil Kraeplin in his subsequent work also identified 'manic depressive insanity' as an entity with a cyclical disorder, but with good prognosis and inherently different from dementia precox.[2] However, DSM seemed to have been indecisive in how it conceptualized BPAD. DSM I had an entity called as 'manic depressive reactions' under the heading of psychotic disorders. The nomenclature changed in DSM II to 'manic depressive illness and was classified under affective disorders. It was only in DSM III that bipolar disorder as an entity came into being.[3] However, things remained unsettled in terms of BPAD across the subsequent diagnostic criteria, i.e., DSM IV, DSM IV-TR, DSM 5 and now DSM 5 TR, which along with the discrepancies with ICD 10 and ICD 11 will form the basis of the current manuscript.

Epidemiological Issues Arising due to Discrepancies

The advent of newer diagnostic criteria comes with new hope of improving validity and providing greater clinical utility. But the transition is often fraught with practical clinical challenges. In the UK Bipolar Disorder Research Network study by Gordon-Smith et al. it was found that the prevalence of BPAD decreased by 6% when the sample initially diagnosed with DSM IV criteria was evaluated with DSM 5 criteria.[4] A similar result was also seen in the Zurich cohort maintained by Angst et al., where the sample evaluated with the ICD 11 criteria showed a decrease by 6% as compared to the initial diagnosis using the ICD 10 criteria.[5] In another study by Fredskild et al. 387 patients of BPAD were initially diagnosed with ICD 10 criteria. When that sample was again re-evaluated using the DSM 5 criteria, the prevalence of mania or hypomania reduced by 60%.[6] A similar discrepancy was observed in the study by Machado-Vieira et al. where a 48% reduction was seen in the number of manic/hypomanic episodes when using the DSM 5 criteria versus the DSM IV criteria.[7]

Discrepancies Amongst Current Diagnostic Systems

In the subsequent section, I will be discussing the various points in regards to BPAD where the existing diagnostic systems are misaligned and the possible clinical challenges that can arise out of those situations. For the purpose of this review, we will mostly be discussing about ICD10, DSM 5, ICD 11 and DSM 5 TR.

Mania

One of the most important changes that was adopted in DSM 5 was the inclusion of 'increased goal directed activity or energy' in the criteria A (essential criteria) for the diagnosis of mania. This change was welcomed as an essential change to improve upon the clinical validity of the criteria.[8] Thus, the criteria A of mania currently stands as "a distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently goal-directed behavior or energy". However, a close look at the criteria depicts that a very similar criteria is also seen in the criteria B (three of which is required to be present for diagnosis of mania). Thus, if a patient has qualified for 'increased goal directed activity or energy' in criteria A, he/she automatically qualifies for the same in criteria B and thus mere presence of two more criteria will suffice for the diagnosis. This will bring down the diagnostic threshold for mania.

The ICD 11 criteria for mania are also very similar to that of DSM 5. But there are subtle differences like ICD 11 doesn't specify the minimum number

of symptoms required for diagnosis unlike DSM 5. ICD 11 also includes affective lability as a criterion, whereas DSM 5 only includes in the text narrative and not in the criteria. In ICD 11, "increased goal-directed activity" is formulated as "increase in sexual drive, sociability or goal-directed activity". In general, ICD 11 deliberately moves to a position against providing strict threshold as opposed to DSM 5.

Hypomania

The major difference pertaining to hypomania and mania in DSM 5 is that hypomania has a lesser duration cut-off and the dysfunction is less in hypomania. The criteria per se for mania and hypomania are very similar. ICD 11 on the other hand provides different diagnostic criteria for hypomania and mania. ICD 11, much like ICD 10, provides an elaborate description of the episodes. DSM 5 criteria in that sense other than a text description also provides a stringent set of criteria with minimum qualification cut-offs.

Another point of contention has been the actual utility of hypomania as a diagnostic entity because of the blurred distinction between the boundaries of mania and hypomania. Hypomania obviously becomes a very useful entity in context of bipolar II. The DSM 5 work-group meetings had spent considerable time deliberating over the fact whether to decrease the duration cut-off of hypomania to 2 days. The rationale behind it was the fact that the family history of BPAD using this criterion for bipolar II was comparable to that bipolar I. It was argued that this will better validity to the bipolar II construct.[9] But this was not finally accepted as a criterion and DSM 5 chose to retain the DSM IV criterion.

Depression

The DSM 5 criteria for major depressive disorder requires the presence of five out of nine symptoms to be present for at least 2 weeks, with significant change from previous functioning. The criteria also require the presence of either depressed mood or loss of interest or pleasure as one of the essential criteria to be present. The criteria also specifies that similar symptoms may occur in response to significant loss (bereavement, financial loss, natural disaster, etc.). Though, DSM 5 allows a diagnosis of Major depressive disorder in the context of bereavement (the relaxation of bereavement exclusion), it requires exercise of clinical judgement based on the clinical presentation and knowledge of the subject's socio-cultural milieu in the related context.

This has been one of the major talking points regarding the advent of DSM. Some criticism of this criteria has been worsening the inter-rater reliability in the DSM 5 field trials.[10] However, as one of the distinct departures from DSM 5, ICD 11 has practically retained bereavement exclusion. ICD 11 allows a diagnosis of depressive episode in the context of a bereavement only if the duration of symptoms extend over one month (as opposed to 15 days in any other situation) and the diagnostic threshold is crossed by excluding overlapping symptoms which can also be present in the context of a significant loss.

Depression is also one of the few examples where ICD 11 has given a very strict diagnostic threshold by fixing the number of minimum criteria to be satisfied. ICD 11 requires the presence of at least five symptoms for the diagnosis of depression (up from 4 of ICD 10).

Mixed states

The mixed states have been another point of discrepancy between the various diagnostic criteria. The DSM IV required that full criteria of mania and depression is met nearly every day for 1 week. The duration cut-off in ICD 10 is higher at 2 weeks and required 'either a mixture or rapid alteration' of hypomanic, manic and depressive episodes. DSM 5 with its advent brought major changes in the construct of mixed episodes. It altogether removed mixed episodes as a type of episode and added 'mixed features' as a specifier with manic or depressive episode, which can be diagnosed if 3 contra-polar symptoms are present. ICD 11 however, chose to retain ICD 10 conceptualization of mixed episodes.

There has been subsequent evaluation of the clinical utility of the DSM 5 approach of viewing 'mixed symptoms'. The current evidence supports that mania with mixed features has good clinical validity, but depression with mixed features has poor clinical utility and considered relatively rare.[11] This is also important because DSM 5 has also introduced

Table 1: Comparison of recent changes in bipolar disorder in DSM 5 TR and ICD 11

	DSM 5 TR	*ICD 11*
Convergences		
Increased energy as a criterion	Included (like DSM IV)	Included (unlike ICD 10)
Bipolar II	Maintained	Debut
Bipolar I, single manic episode	Maintained	Debut (unlike ICD 10)
Antidepressant induced mania	Included	Included
Severity specifiers for mania	Dropped (unlike DSM 5)	Excluded
Divergences		
Mixed episodes	Dropped (now a specifier)	Maintained
Bipolar spectrum	Criteria in operation ('other bipolar disorder"	Not considered
Bereavement specifier	Practically removed	Practically retained

the specifier of 'mixed features' for major depressive disorder. The diagnostic stability of this construct also supposedly stands on very flimsy ground. The following clinical scenario can be used as an exemplar to support this. Suppose we encounter a patient with multiple episodes of depression with 3 symptoms of mania in the current episode. This patient will then be diagnosed as 'major depressive disorder-recurrent episodes- with mixed features'. However, if this patient happens to develop a 4th manic symptom, he/she also qualifies for mania, and the diagnosis changes to 'bipolar disorder'. Thus, just by the appearance of one additional symptom, the diagnosis and altogether management plan of the patient will change. In a practical clinical scenario, this can be very challenging.

Severity specifiers

The severity specifiers in DSM and ICD also differs on a few points. In DSM 5, an affective episode is considered mild, if there are few symptoms above cut-ff and the dysfunction is minor. An episode is considered severe is the symptoms are substantially in excess and cause gross dysfunction. A moderate episode slots in between mild and severe episode. But as can be appreciated, the boundaries between severe hypomania and mild mania can be very difficult to delineate. The approach of ICD 11 in this context is a bit different. In ICD 11, severity specifier is not dependent on symptom count, but rather on intensity of each symptom. Also, ICD 11 doesn't have any severity specifier for mania or hypomania. This approach has been then substantiated by DSM 5 TR, which has removed the severity specifiers for mania and hypomania.

Framework changes

Overall, the attitude of ICD 11 had been to align itself to DSM 5 for better diagnostic utility. In conjunction with that ICD 11 has introduced a number of changes. Unlike ICD 10, ICD 11 now allows a diagnosis of bipolar disorder II for patients presenting with hypomania and depressive episodes only. It has also abolished the diagnosis of unipolar hypomania/mania (F 30) or single mixed episode (F 38). Additionally, unlike ICD 10 and like DSM 5, ICD 11 now allows a diagnosis of anti-depressant induced mania, hypomania or mixed episodes.

Conclusion

As had been initially mentioned, currently we are at cross-roads of the evolution of various diagnostic criteria. A number of measures have been adopted to align the recent versions of ICD and DSM resulting in major overhaul as compared to its predecessors. But importantly the two systems chose to differ in few important points of contentions. The Table 1 depicts a summary of the major changes adopted in ICD 11 and DSM 5 TR.

To conclude, the recent changes adopted in the contemporary classificatory systems reflect commendable efforts to align our understanding of BPAD to the evidence generated by research. However, we still remain highly dependent on the phenomenological description of symptoms for classification. Thus, our objective of achieving a precise brain function dependent classification remains elusive as of now.

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